FEDERAL REPUBLIC OF NIGERIA

NATIONAL AIDS SPENDING ASSESSMENT (NASA)

FOR THE PERIOD: 2007-2008

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

March 2010

NACA National Agency for the Control of AIDS (NACA)

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Structure of the report

The report is organized into five Sections. Section one contains the background and overview of the country context which highlights the HIV/AIDS situation and the national response. It discusses the national response to the AIDS epidemic and provides further description of the current funding modalities, covering current processes and modalities for the planning, budgeting and financing of the HIV response in Nigeria.

Section two outlines the methodology and the process adopted by the NASA assessment team. It covers the data collection approach, sources of data, data processing, analysis, assumptions and estimations, challenges and remedial actions.

The results and main policy findings of the NASA are presented in Section three.

The discussion of the results is closely examined in section four including the volume of spending by funding source and by thematic areas. It also examines allocation of AIDS spending in Nigeria in relation to the objectives and targets of the National Strategic Plan and new infections.

The summary and recommendations of the study are presented in Section five.
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Foreword

This document provides much needed information on resource tracking of HIV and AIDS expenditure in Nigeria. The initial challenge of inadequate information on HIV and AIDS expenditure, informed the need for the National Agency for the Control of AIDS (NACA) to conduct a National AIDS Spending Assessment (NASA) for 2007 and 2008. This is the first National AIDs Spending Assessment in the country.

This document describes the HIV and AIDS health and non health financial flow and expenditures in Nigeria for years 2007 and 2008 according to three dimensions and six vectors. These dimensions are; Financing, Provision and Use. The vectors under **"Financing"** are Funding Sources **(FS)** and Funding Agents **(FA)**. Vectors under **"Provision"** are the Provider of HIV/AIDS Services **(PS)** and Production Factors **(PF)**. The vectors for **"Use"** are the AIDS Spending Categories **(ASC)** and the intended Beneficiary Population **(BP)**.

Furthermore, the study used standardized classifications for resource tracking of HIV and AIDS, and categories used were mutually exclusive and exhaustive. The core methodology of the study is based on the use of a transaction processing tool for each funding source, funding agent and provider of HIV/AIDS services, to represent the origin and the destination of resources in order to avoid double counting of expenditures and matrixes generated by a Resource Tracking Software for cross information on its dimensions and vectors.

In **2007** and **2008**, the total spending for HIV and AIDS tracked by funding sources was **$299,246,295.00 (N34, 413,323,925.00)** and **$394,963,881.00 (N45, 420,846,315.00)** respectively. Percentage of Public Funds for both years was 14.6% and 7.6% respectively; Percentage of Private Funds for the year 2007 and 2008 was 0.0% and 0.1% respectively, while 85.4% and 92.3% of the funding was external.

In 2007 and 2008, HIV expenditure by Public Funding Agents was $85,080,092.00 and $59,070,207.00 respectively, HIV expenditure by Private Funding Agents was $447,569.00 and $4,545,285.00 respectively while HIV expenditure by International Funding Agents was $213,718,629.00 and $331,348,389.00 respectively.

The study unfolds percentages of HIV expenditure for 2007 and 2008 by the 8 broad programmatic Areas. 12.6% and 14.7% in 2007 and 2008 respectively of the total funding was used for Prevention activities, 45.1% and 47.1% was used for Care and Treatment activities respectively, 1.9% and 2.5% was used for OVC activities respectively, 34.4 and 29.8 was used for Program Management activities respectively, 5.1% and 5.4% was used for Human Resource activities, no funding was used for Social Protection and Social Services for both 2007 and 2008, 0.9% and 0.5% was used for activities for Enabling Environment while No funding was used for Research activities for both 2007 and 2008 respectively.

This study was initiated and conducted by the National Agency for the Control of AIDS (NACA) with technical support from UNAIDS. It was funded by the National Agency for the Control of AIDS (NACA), Joint United Nations Programme on HIV/AIDS (UNAIDS) and Department for International Development (DFID)/Enhancing National response programme (ENR). The outputs of this important study will serve as important national response tools for advocacy, resource mobilization, reporting to national and international stakeholders.

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I extend these acknowledgements to the NASA national steering committee, HIV/AIDS Division of Federal Ministry of Health, Dr Greg Ashefor, Louis Edema and other staff of Monitoring and Evaluation Technical Working Group and all Development and Implementing partners and the Ministries, Department and Agencies of the Government that completed the NASA data form

Special thanks to, PEPFAR Coordinator of United State Government, Adrienne Parrish Fuentes for her special role and interest in coordinating PEPFAR inputs in this study.

This study would not have been possible without the work of the NASA Core team made up of National and international consultants, data collectors and Programme Managers of NACA and SACA at the Federal and State Levels.

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Abbreviations/Acronyms

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

PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PS	Provider of HIV/AIDS service
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on HIV/AIDS
USD	US Dollar
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Basic Fact Sheet on Nigeria HIV and AIDS Expenditure for the period 2007-2008

	2007		2008	
	Amount(USD)	%	Amount(USD)	%
HIV and AIDS Expenditure by Funding Sources				
Total Spending	299,246,295.00		394,963,881.00	
Public	43,854,033.00	14.6	30,082,450.00	7.6
Private Funds*:	Nil	0.0	300,000.00	0.1
International	255,392,257.00	85.4	364,581,432.00	92.3
HIV and AIDS Expenditure by Financing Agent				
Public	85,080,092.00	28.4	59,070,207.00	15.0
Private	447,569.00	0.1	4,545,285.00	1.0
International	213,718,629.00	71.5	331,348,389.00	84.0
HIV and AIDS Expenditure by Service Provider				
Public Providers	127,202,277.00	42.5	157,683,991.00	39.9
Private Non-Profit	143,272,305.00	47.9	209,251,453.00	53.0
Bilateral and Multilaterals	28,771,713.00	9.6	27,572,247.00	7.0
Rest of the world providers	Nil	0.0	456,191.00	0.1
HIV and AIDS Expenditure by Programmatic Area				
Prevention	37,658,494.00	12.6	58,248,833.00	14.7
Care and treatment	135,088,119.00	45.1	185,911,643.00	47.1
OVC activities	5,715,138.00	1.9	9,971,820.00	2.5
Program management activities	102,825,134.00	34.4	117,521,162.00	29.8
Human resources	15,190,419.00	5.1	21,145,533.00	5.4
Social protection and social services	138,810.00	0.0	136,119.00	0.0
Enabling environment	2,561,805.00	0.9	2,011,422.00	0.5
Research activities	68,376.00	0.0	17,350.00	0.0
HIV and Expenditure by Beneficiary in 2007 and 2008				
People Living with HIV	134,148,875.00	44.8	186,992,485.00	47.3
Most at risk populations	228,233.00	0.1	539,220.00	0.1
Other key populations	17,228,245.00	6.0	29,693,322.00	7.5
Specificòaccessibleò populations	948,240.00	0.3	2,141,459.00	0.5
General Population	26,736,563.00	9.0	34,771,728.00	8.8
Non-targeted interventions	119,956,139.00	40.1	139,932,326.00	34.8
Specific targeted populations not else where classified	Nil	0.0	893,341.00	0.2

** The NASA report does not include a full out of pocket expenditures assessment, thus only partial data on organized private funds is considered as data from organized private sources through NIBUCA was not forthcoming.*

Executive Summary

Funding for HIV and AIDS programmes in Nigeria come from three main sources: public, external (international) and organized private sources. Like many developing countries, Nigeria's national response to HIV and AIDS is to a large extent sustained by external assistance secured from international, multilateral and bilateral organizations alongside foundations and NGOs.

The assessment focused on tracking national level HIV expenditure for the period 2007 and 2008. Data collection covered domestic, external and organized private spending on HIV and AIDS, including funds channeled through the government. The assessment did not cover total household out-of-pocket expenditure on HIV and AIDS and out-of-pocket payment for services and drugs.

Most of the key sources of data (detailed expenditure records) were obtained from the majority of primary sources for the reporting period. Secondary sources were used only where primary sources were not available. In other cases costing techniques were used to estimate some of the expenditures on HIV and AIDS related activities using best available data and the most suitable assumptions. There were a number of limitations to this study. Key among them was the problem relating to unavailable HIV expenditure information especially in the sectoral ministries. It is therefore difficult to draw firm conclusions about HIV and AIDS financial flows to certain sectors. However, on the basis of information provided by funding sources and service providers, the study attempts to reconstruct some sectoral spending on HIV and AIDS programmes. It was also difficult to carry out a detailed comparison of expenditure by priority HIV and AIDS thematic areas due to the lack of a costed National Strategic Framework (NSF)

Main Findings

The NASA estimations show that overall; **Nigeria spent a total of US$ 299,246,295.00(N34, 413,323,925.00) in 2007 and US$ 394,963,881.00 in 2008 (N45, 420,846,315.00) on HIV and AIDS.** The HIV expenditure increased by 32.0% from 2007 to 2008. External financing sources accounted for 85.4% of all HIV expenditure in 2007 and increased to 92.3% in 2008. Public funds constituted 14.6% of the total HIV and AIDS expenditure in 2007 and 7.6% in 2008, while private sources of funding accounted for only 0.1% in 2008.

In both years the same pattern of distribution occurred for the financing agents with the International agents taking majority decision on what kind of goods and services are to be purchased for HIV intervention in Nigeria.

The HIV service providers were mainly from the not-for-profit private sector. They accounted for 48.0% of the services provided in 2007 and 53.0% in 2008. The public sector provided 42.5% of the services which amounted to $127million in 2007 but decreased to 39.9% of the total expenditure in 2008 despite an increase in the funds they spent to $157million.The bilateral and multilateral agencies accounted for 9.6% and 7.0% in 2007 and 2008 respectively as HIV and AIDS expenditure by service providers.

In 2007 the total spending was $299,246,295.00 and the bulk of it (45.1%) was spent on care and treatment with antiretroviral therapy as the main item followed by Programme management and administration (34.4%). A negligible amount of $37,658,494 was spent on prevention. In 2008, the pattern of the AIDS spending was similar to that in 2007. There was a marginal increase in spending on prevention which ought to be a core HIV/AIDS intervention area. Though there was a 13% increase in funding for Program management, but as a percentage of the total expenditure, the program management's budget decreased from 34.4% in 2007 to 29.8% in 2008.

The major beneficiaries of the HIV/AIDS response in Nigeria in 2007 and 2008 were the people living with HIV/AIDS on whom 45.0% and 47.0% of the total funds were spent in 2007 and 2008 respectively. This was closely followed by the expenditure of 40.1% and 35.0% in 2007 and 2008 respectively for non-targeted interventions that do not belong to a specific population. The most at-risk population who engage in behaviour that puts them at greater risk of exposure to HIV got 0.1% in 2007 and 2008 of all the HIV expenditure in Nigeria.

Conclusions and Recommendations

Substantial amounts of resources have been invested in the national response to HIV and AIDS. The growth in funding for HIV and AIDS Care and treatment has outpaced that for most other public health programmes.

The heavy reliance on external funding raises questions of sustainability of HIV and AIDS programmes in Nigeria. The internal budgetary allocation to NACA has sharply and progressively decreased in the past three years with the shortfalls covered by external sources of funding. It is worth noting that the harmonization and alignment of donor support through the channeling of resources through a common fund potentially reduces the duplication of programmes and ensures a more efficient allocation of resources.

One major limitation of the study was the inability to undertake a comprehensive assessment of out-of-pocket (OOP) payment on HIV and AIDS related needs. It is recommended that some questions related to HIV spending be incorporated into existing household surveys to track this aspect of expenditure in Nigeria. Many institutions were reluctant to release financial data on their HIV/AIDS expenditure and where they did, information provided were inadequate for a robust classification of the AIDS spending categories. Data on funding from organized private sectors(Multinational and national) was not captured as NIBUCA could not coordinate such vital inputs.

The key recommendations from this study are centered on the need to have a costed National Strategic Plan to ensure needs-driven resource allocation. The advantages of such a process are two-fold. First it helps in resource mobilization both internally and externally to ensure adequate provision of resources to areas where they are most needed. Secondly it provides the basis for an immediate assessment of funding gaps; which could justify the need for more adequate budgetary allocations to national response.

This first attempt at assessing HIV and AIDS spending in Nigeria has been largely successful despite the limitations highlighted above. It is hoped that the next attempt for 2009 and 2010 spending assessment will address challenges and limitations for this study. It is therefore imperative to institutional bi-annual HIV/AIDS spending assessment in NACA as important tool for coordination, planning, advocacy, resource mobilization, evaluation and accountability

1 Background and Overview of the Country Context

1.1 HIV and AIDS Situation

1.1.1 Regional Context

Sub-Sahara African region bears a heavy disproportionate burden of HIV and AIDS in the world. Although the region has just over 10% of the worldôs population, more than two-thirds (68%) of all people infected with HIV worldwide live in this region. Moreover, over three quarters (76%) of the worldôs AIDS-related deaths in 2007 occurred in the region. About 1.7 million [1.4 million-2.4 million] people were newly infected with HIV in 2007, bringing to 22.5 million [20.9 million-24.3 million] the total number of people living with the virus. Unlike other regions, the majority of people (61%) living with HIV in sub-Saharan Africa are women.[1] Within the region, Southern Africa is at the epicenter of the global HIV epidemic - national adult HIV prevalence exceeded 15% in eight Southern African countries in 2005.

The scale of the epidemic makes HIV and AIDS the single greatest threat to attaining Sub-Saharan Africa over-arching objective of sustainable and equitable economic growth and socio-economic development that will ensure poverty alleviation. The epidemic if unabated will continue to erode the hard won economic gains and intensify poverty and human suffering. Similarly, the level of the epidemic makes the attainment of many of the globally agreed Millennium Development Goals (MDGs) difficult.

Domestic public expenditure from governments has also significantly increased in low-income sub-Saharan Africa countries, and more moderately in middle income countries. In 2005, domestic resources reached US$ 2.5 billion (UNAIDS, 2007). In many of the Sub-Saharan countries however, the funding for prevention, treatment and care has depended largely on external sources of funding such as: the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the World Bank, the Presidential Emergency Plan for AIDS Relief (PEPFAR), and numerous other cooperation agencies that provide assistance to the region most of which are bilateral and multilateral agencies, foundations and NGOs. The availability of resources has dramatically increased for some of these countries recently, at a pace likely to overwhelm the absorptive capacity of the institutions arrangements and systems in those countries especially the health systems.

1.1.2 Nigerian Context

Nigeria is Africa's most populous country with a population of over 140 million and more than 373 ethnic groups spread across the country's land area of 923,768 square kilometers.[1] The country is a Federation, operating a 3-tier governance system: National, State and Local Government. There are 36 states, 774 local government areas, and a Federal Capital Territory made up of 6 area councils.

The country is currently under a democratic government for a third consecutive term. There have been substantial gains in political stability since the return to democratic rule in 1999. There is an increasing respect for the rule of law, an increasingly independent judiciary, and an expanding role of civil society and the mass media. The emerging economic and political reforms arising from the democratic rule have made significant impact in key sectors such as health, finance, transport, environment and agriculture.

Recent improvements in the direction and management of development policy have contributed to a positive medium term economic outlook, possibly the best in recent times. A major achievement of the government of Nigeria is the successful reduction of Nigeria's external debt of about USD 32 billion and allocation of USD 1 billion/annum of the gains

[1] UNAIDS/WHO (2007): AIDS Epidemic Update

for the achievement of the MDGs.[2]These results have been reinforced by structural reforms in the banking, ports and telecommunications sectors, rising foreign direct and portfolio investment, and a growing confidence among domestic investors.

Reflecting the cumulative effects of these changes, Nigeria has been able to meet and exceed the economic targets set in the National Economic Empowerment and Development Strategy,[3] its home grown version of the PRSP.

Despite these signs of progress, there is still an unequal distribution of wealth and developmental gains. This is evident in poor social indicators and significant disparities by income, gender and location.[4] It is estimated that 60% of the population is below the poverty line.[5]

1.1.3 Status of the epidemic in Nigeria

Since the first case of AIDS was reported in Nigeria in 1986, the epidemic has grown beyond the high risk groups to the general population, cutting across both sexes and all age groups. The countryøs median HIV prevalence of 4.6% is lower than those of many other sub-Saharan African countries.[6] However, Nigeriaøs large population has serious implications in terms of HIV burden, the rate of HIV transmission with such a large pool of infected individuals and the logistics and cost of providing services to both infected and affected persons. There is however a large window of opportunity for stemming the epidemic through comprehensive prevention interventions as the present median HIV prevalence suggests that over 95% of the population is still not infected.

Since 1991, biennial HIV/STI sero-prevalence sentinel surveillance surveys have been conducted in Nigeria to monitor the trend of the epidemic using women attending Ante Natal Clinics (ANC) as a proxy for the general population. Results of the surveys in figure 1 show a steady rise in the HIV prevalence from 1.8% in 1991 to 5.8% in 2001, a period of ten years. The prevalence dropped through 5% in 2003 to 4.4% and 4.6 % in 2005 and 2008 respectively.

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[2] *Federal Government of Nigeria (OSSAP), The Story of OPEN (2007).*

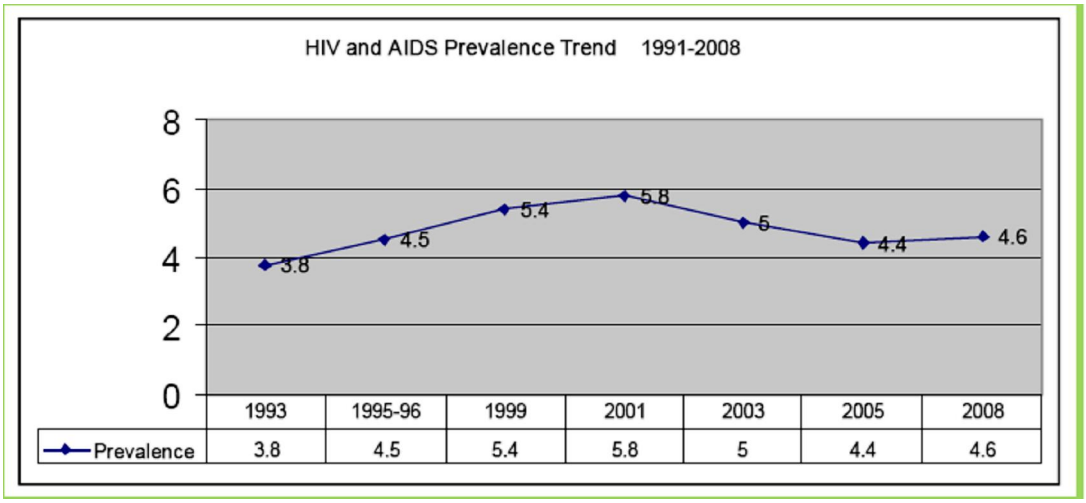
[3] *NEEDS-1: 2004-07*

[4] *The data in this paragraph, unless otherwise indicated, are drawn from the MDGR (2006); sources can be found in the same.*

[5] *Source: Human Development Report 2005*

[6] *FMOH 2008*

Figure 1: National Median Prevalence trends 1991 to 2008

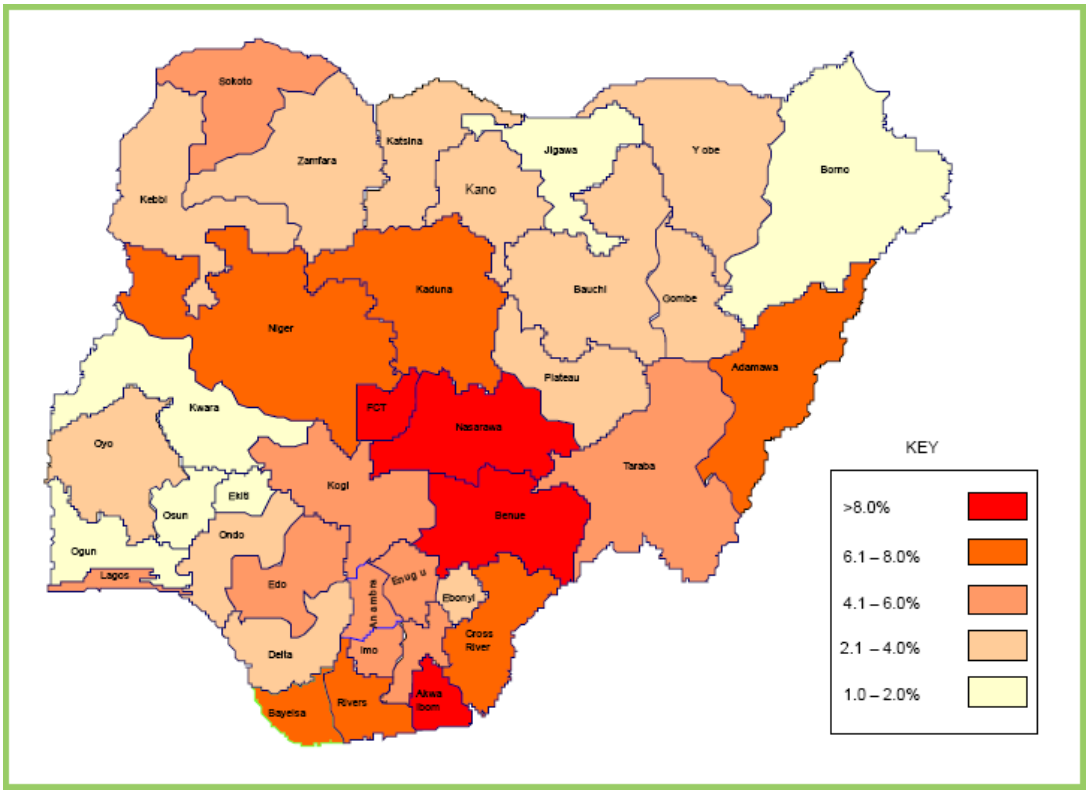


With the current median HIV prevalence of 4.6% in 2008, 2.95 million people are estimated to be living with HIV in Nigeria. This is the second largest HIV/AIDS epidemic in the world after South Africa and the largest in the West African sub-region. State level median HIV prevalence varies from 1.0% to as high as 10.6%,[7] with a higher prevalence found amongst women and girls. Examining the trend among women aged 15-24 years (commonly used as a proxy for new infections) from 2001-2008, the prevalence steadily decreased from 6.0% in 2001 to 4.2% in 2008. This may be as a result of increased prevention interventions among the youth. There are however wide variations in the ANC prevalence data by spatial distribution, gender, age group and MARPs.

The 2008 National HIV Sentinel Sero-Prevalence Survey in figure 2 also showed a wide variation between states, ranging from 1.0% in Ekiti to 10.6% in Benue. Seventeen (17) States and the FCT had prevalence of 5% and above, higher than the national median. However, the state median prevalence hides wide variations between the different sentinel sites. For example, even though the Federal Capital Territory has a median prevalence of 9.9% there is a recorded prevalence of about 22% in one of its area councils.[8]

[7] *FMOH, 2008 HIV Sentinel Sero-Prevalenve among the Antenatal Clinic Attendees in Nigeria*
[8] *United Nations Joint Programme of Support on HIV and AIDS in Nigeria 2009 - 2012*

Figure 2: HIV Prevalence by States (Nigeria 2008)



The 2007 National HIV/AIDS & Reproductive Health Survey-Plus (NARHS+), a population based survey with HIV screening that sampled women aged 15-49 and men aged 15-64 years estimates the prevalence in the general population at 3.6% (FMOH, 2007). This is consistent with studies in other countries where the findings of sentinel sero-prevalence surveys are higher than those of population based surveys.

According to the 2007 NARHS+, the HIV prevalence was higher among females (4.0%) than males (3.2%); slightly higher in the urban area (3.8%) compared with the rural area (3.5%). In both rural and urban areas, HIV prevalence was higher among female respondents than male respondents. It was highest among the 30-39 years age group (5.4%) and lowest among the 15-19 years age group (1.7%)

1.2 The National Response to the AIDS Epidemic

1.2.1 Policy Context

The Government and people of the Federal Republic of Nigeria recognize and acknowledge that the HIV/AIDS epidemic in Nigeria is on the threshold of an exponential increase in the country and consequently are committed to face the challenges of stemming the tide and reducing its impact on the nation through cost effective, socially acceptable and scientifically sound measures.

Like many other developing countries, Nigeria has passed through several phases in her response to the epidemic. The initial response was the establishment of the National Expert Advisory Committee on AIDS (NEACA) made up of mostly health professionals and headed by a hematologist as Nigeria perceived the epidemic as a health problem. In 1988, this advisory board was replaced by the National AIDS and STDs Control Programme (NASCP) coordinated by the FMOH. NASCP still exists and is presently responsible for the health

sectorôs response to HIV/AIDS. It develops guidelines on key health interventions and undertakes key HIV monitoring and surveillance responsibilities.

In 1997 the Government of the Federal Republic of Nigeria through the Federal Ministry of Health adopted the National Policy on HIV/AIDS and STI. Due to limited information on the effects of the epidemic, some essential components now regarded as necessary were not adequately addressed.

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In January 2000, the President in recognition of the need for a multisectoral response established a Presidential Committee on AIDS (PCA) and the National Action Committee on AIDS (NACA). A 3-year HIV/AIDS Emergency Action Plan (HEAP) was formulated in 2001 and succeeded by the current HIV/AIDS National strategic framework. The implementers of this plan include governmental institutions, non-governmental organizations, community based organizations, faith-based organizations, developmental partners and persons living with or affected by HIV/AIDS.[9].

Effective coordination and institutional management is at the center of an effective national response to the epidemic. The development of the HEAP was a coordination achievement in itself. The Nigeria National response is anchored in the **"three ones"** principles of one agreed framework, one coordinating body and one monitoring and evaluation system. The national response in Nigeria, in line with the country's federal constitution is coordinated through a three-tier system of administration led by the National Action Committee on AIDS (NACA), State Action Committee on AIDS (SACA), and the Local Government Action Committee on AIDS (LACA).

The HIV/AIDS National Strategic Framework (NSF) for action 2005-2009 was developed in 2005 with the goal to reduce HIV/AIDS incidence and prevalence by at least 25%, and provide equitable prevention, care, treatment, and support services while mitigating its impact amongst women, children and other vulnerable groups and the general population in Nigeria by 2009. It is an instrument for achieving the NEEDS imperative of addressing the attainment of millennium development goal on HIV/AIDS. NEEDS is the National Economic Empowerment and Development Strategy which is operational at the federal level while each state is expected to take a cue from the Federal Government and develop the SEEDS, while the LGAs are to develop the LEEDS. The NEEDS document asserted that ñHIV/AIDS is a major social and health problem that threatens the country's productivity and economy.

The plan is to improve the system of health care delivery, with emphasis on HIV/AIDS and other preventable diseases, such as malaria, tuberculosis, and reproductive health- related illness.ò This forms the fulcrum that the NSF rests upon. The NSF is thus designed to be implemented within this framework through public-private sectors partnership; being private sector-driven and public sector-regulated. The two frameworks analyzed the historic pitfalls and obstacles to the attainment of respective goals and thereafter attempt to chart the future from the present. The NSF has eleven guiding principles and eight working objectives in order to achieve the main goal which is to ñreduce HIV/AIDS incidence and prevalence by 25% in Nigeria by 2009.ò

.

NSF Objectives and Strategies

OBJECTIVE 1: To increase programme implementation rate by 50% from 2005 to 2009 through improved coordination mechanisms and effective mobilization and utilization of resources.

OBJECTIVE 2: To have 95% of the general population make the appropriate behavioral changes (safe sex, abstinence etc through social mobilization by 2009.

[9] National policy on HIV/AIDS ,2003

OBJECTIVE 3: To increase access to comprehensive gender-sensitive prevention, care, treatment and support services for the general population, PLWAs and orphans and vulnerable children by 50% in 2009, and mitigate HIV/AIDS impact on the health sector.

OBJECTIVE 4: To increase gender-sensitive non-health sectoral responses for the mitigation of the impact of HIV/AIDS by 50%.

OBJECTIVE 5: To have 95% of specific groups make the appropriate behavioral changes (safe sex, abstinence etc) through social mobilization by 2009.

OBJECTIVE 6: To strengthen national capacity for monitoring and evaluation of the HIV/AIDS response such that the national monitoring and evaluation plan is 100% implemented by 2009.

OBJECTIVE 7: To build national capacity for research, knowledge sharing, and the acquisition and utilization of new HIV/AIDS technologies.

OBJECTIVE 8: To create an enabling social, legal and policy environment by a 50% increase in the number of reviewed and operational gender-sensitive and human rights-friendly policies, legislations and the enforcement of laws that protect the rights of the general population, particularly PLWAs, by the year 2009.

1.2.2 Institutional Framework

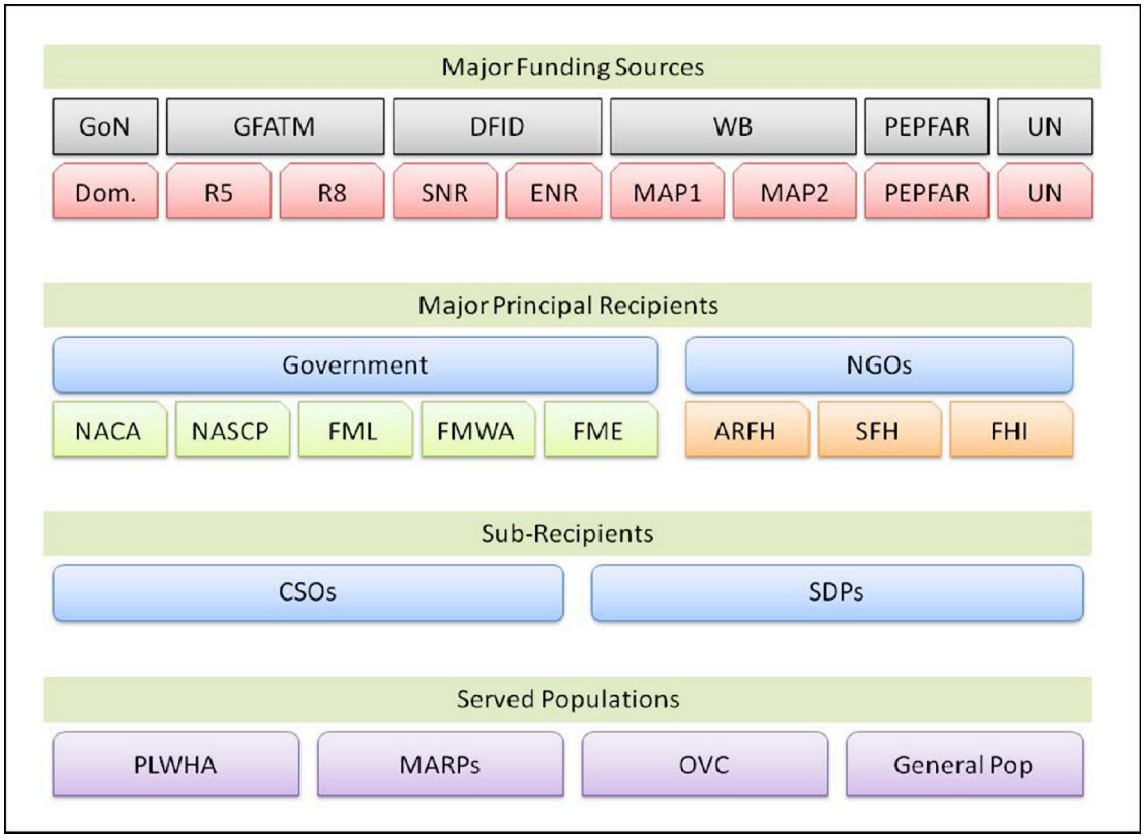
The National Agency for the Control of AIDS (NACA)

The National Agency for the Control of AIDS (NACA) was established in 2000 as a committee in the presidency to coordinate multisectoral programmes on HIV and AIDS in Nigeria. Since May 2007, the committee had transformed into an agency with mandate by its enabling Act to:-

- Plan and coordinate activities of the various sectors in the national response strategic framework
- Facilitate the engagement of all tiers of government and all sectors on issues of HIV/AIDS prevention, care and support.
- Advocate for mainstreaming of HIV/AIDS interventions into all sectors of the society
- Formulate policies and guidelines on HIV/AIDS
- Support HIV/AIDS research in the country
- Mobilize resources (local and foreign) and coordinate equitable application for HIV/AIDS activities.
- Provide and coordinate linkages with the global community on HIV/AIDS
- Monitor and evaluate all HIV/AIDS activities in the country

The national response as depicted in figure 3 is funded through multiple sources that include Governments, Bilateral donors, multilaterals, organized private sector, foundations and International non governmental donors. Many of these organizations administered the funds directly to implement HIV/AIDS programmes within the context of the NSF and Figure 4 highlights the NASA mapping of actors and flow of funds.

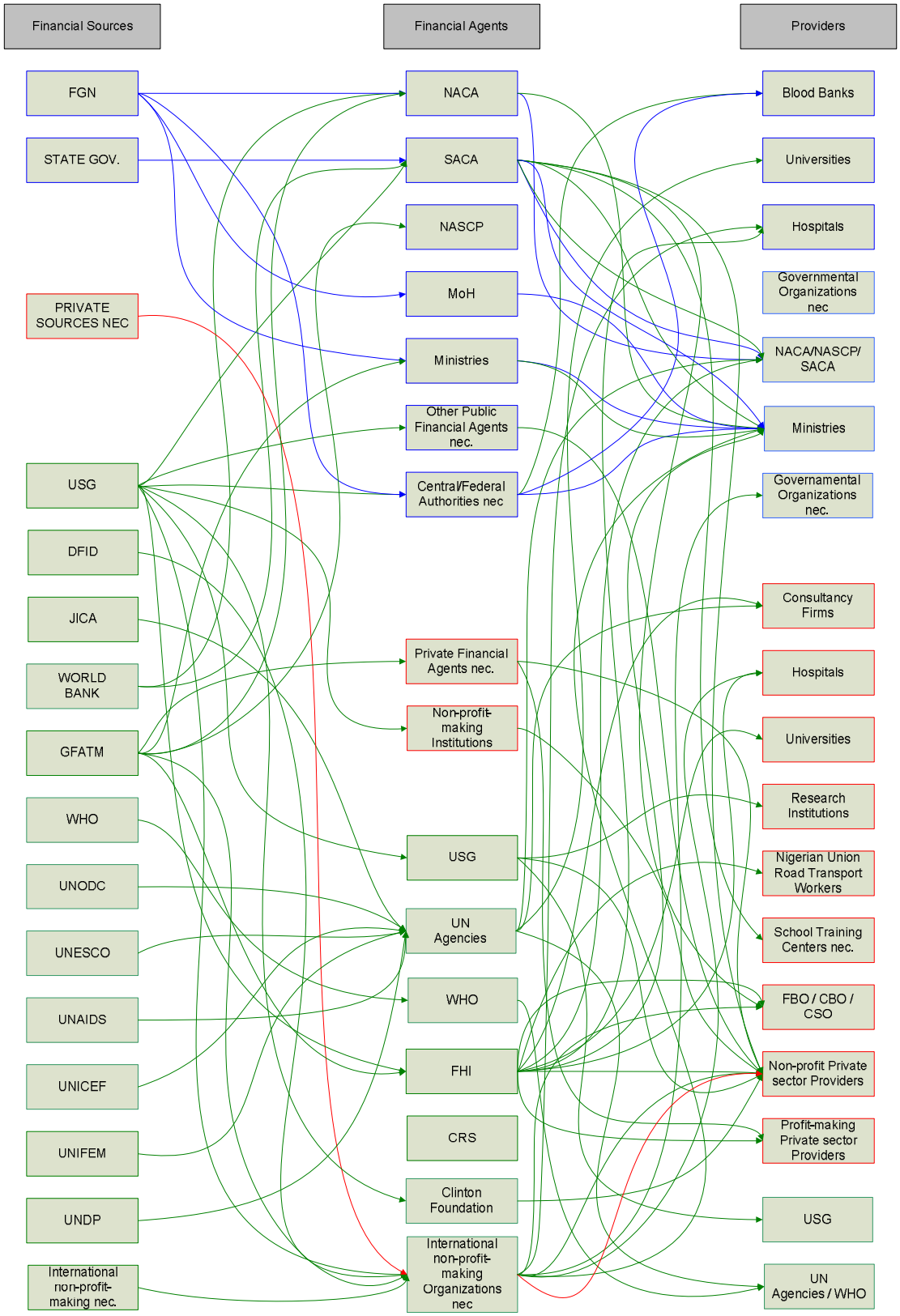
FIGURE 3: Flow of funds for Nigeria's response to HIVAIDS

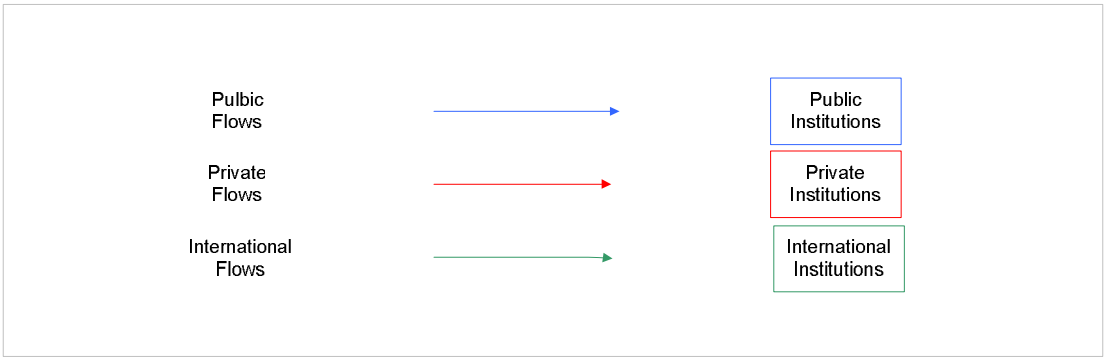


Source: HIV/AIDS Program Sustainability Analysis Tool (HAPSAT), 2009

GoN = Federal Government of Nigeria, GFATM = Global Fund for AIDS, TB, and Malaria, DFID= Department for International Development (Uk), WB = World Bank, PEPFAR = Presidentôs Emergency Plan for AIDS Relief (US), UN= United Nations, Dom = domestic, R5 = Round 5, R8 = Round 8, SNR= Strengthening Nigeriaôs Response, ENR = Enhancing Nigeriaôs Response, MAP1= Multi-country HIVAIDS Program I, MAP2 = Multi-country HIVAIDS Program II, NACA = National Agency for the Control of AIDS , NASCP= National AIDS Control and Prevention Program, FML= Federal Ministry of Labour, FMWA= Federal Ministry of Womenôs Affairs and Social Development, FME= Federal Ministry of Education, ARFH= Association for Reproductive and Family Health, SFH= Society for Family Health, FHI= Family Health International, CSO=,SDP=,PLWHA= people living with HIV/AIDS, MARP=most at-risk persons, OVC= orphans and vulnerable children, Pop = population

Figure 4: National Response – NASA Mapping of actors and funding flow





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

PEPFAR

The U.S. government contributes to the fight against HIV/AIDS through the President's Emergency Plan for AIDS Relief (PEPFAR). Since the beginning of the PEPFAR program in 2004, the American people have committed more than $1.5 billion dollars to Nigeria's fight against HIV/AIDS through prevention, treatment and care and system strengthening.

PEPFAR has achieved encouraging results and made significant contributions to Nigeria's HIV response.

As of September 2009, PEPFAR's contributions to Nigeria's HIV response include:

- Reaching more than 39 million people with community outreach programs promoting Abstinence, Being Faithful, Correct and Consistent use of Condoms (ABC), and other related preventive strategies;
- About 4.5 million people have been reached with HIV counseling and testing services;
- Approximately 1.5 million pregnant women have been provided with health services for the prevention of mother-to-child transmission of HIV and;
- About 290,000 men, women and children are currently receiving anti-retroviral therapy via PEPFAR direct support
- Equally important, the program supports Nigeria in the critical areas of human capacity development, policy development, and strengthening health systems' capacity and effectiveness.

WORLD BANK

The World Bank supports comprehensive national HIV/AIDS responses for effective HIV/AIDS related services including impact mitigation. The Bank works closely with client countries and other development partners, including civil society and people living with HIV/AIDS (PLWHA).

In recent years, the Bank has dramatically scaled up its financial support to countries, helping to expand programs in many of the hardest-hit places. Cumulative lending for HIV since the first project in 1988 is now over US$2.5 billion, and commitments in sub-Saharan Africa have grown from $10 million annually ten years ago to $250-300 million annually in the last four years.[10]

[10] World Bank data prepared April 30, 2005 by the Global HIV/AIDS Program, World Bank.

The Bank contribution goes beyond financing global efforts against HIV/AIDS. Through strong economic and policy analysis it has helped countries identify the development implications of the epidemic and the potential high returns to investments in prevention, care and treatment and mitigation programs (and how to choose the best ones). And through policy dialogue it has helped redefine AIDS as a development issue.

The Bank approved a credit of $90 million to the Government of Nigeria in 2001 for the HIV/AIDS Program Development Project (HPDP1). An additional $40 million was made available in May 2007. The objective of this project is to reduce the risk of HIV infections through behavior change, and to improve access to HIV/AIDS counseling, testing and care services. The Bank has subsequently designed a Second HIV/AIDS Program Development Project, which proposes a further credit of $225 million over 5 years. Funds will be made available to the National Agency for Control of AIDS, and to 35 state level bodies. The Objective of this credit is to reduce the risk of HIV infections by scaling up prevention interventions and to increase access to and utilisation of HIV counseling, testing and care services. It is intended that this project will become operational in the first half of 2010.

GLOBAL FUND

The Global Fund is a unique global public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria. This partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing. The Global Fund works in close collaboration with other bilateral and multilateral organizations to supplement existing efforts dealing with the three diseases.

Since its creation in 2002, the Global Fund has become the main source of finance for programs to fight AIDS, tuberculosis and malaria, with approved funding of US$ 18.7 billion for more than 572 programs in 140 countries. It provides a quarter of all international financing for AIDS globally, two-thirds for tuberculosis and three quarters for malaria.

Global Fund financing is enabling countries to strengthen health systems by making improvements to infrastructure and providing training to those who deliver services. The Global Fund remains committed to working in partnership to scale up the fight against the diseases and to realize its vision ï a world free of the burden of AIDS, TB and malaria.

While the majority of Global Fund investments support prevention and treatment efforts in the fight against HIV/AIDS, it has emerged as the predominant funder of tuberculosis and malaria programs, making up two-third of international commitments for these diseases.

As of end of December 2009*, with Global Fund supported-programs and resources in fighting HIV/AIDS in Nigeria

- 107,122 people are receiving antiretroviral treatment
- 1,174,182 HIV counseling and testing sessions were conducted
- 10,560 HIV-positive pregnant women have received PMTCT treatment (Prevention from Mother to Child Transmissions) for 2009 only

DFID

Over the last five years, the UK Governmentôs Department for International Development (DFID) has provided £62 million in support of HIV/AIDS prevention and stigma reduction in Nigeria. Examples of current and recent projects in this sector include a seven-year national programme to improve sexual reproductive health among poor and vulnerable populations through behavior change and making condom use more acceptable, and a five-year programme to strengthen the stewardship role of government at the national level and in six states.

The UK also provides 80% of all ôreproductive health commoditiesô- that is, drugs and supplies for safe motherhood and the prevention and treatment of sexually transmitted diseases, plus contraceptives and condoms.

In 2009, DFID started its £100 million "Enhancing Nigeriaôs Response to HIV and AIDS" programme. This new six-year HIV/AIDS programme will reach 27 million young people with its safer sex message and provide 1.2 billion condoms in order to reduce the number of new infections by 50,000 every year.

UNITED NATIONS

The United Nations system response to HIV and AIDS in Nigeria is coordinated by the UN Joint Team on AIDS and implemented through the Joint Programme of support. The programme of support is based on the United Nations Assistance Framework (UNDAF 2009-2012).[11] The six thematic areas outlined in the UN Joint Programme of support are advocacy, planning and coordination; Intensified prevention interventions; Scaling up universal access to treatment services; universal access to care and support ; the UN learning strategy and UN learning team(UNLT) and programme monitoring and evaluation.

In 2006 to 2008, the UN through the Joint Programme of support had consistently used its comparative advantage to strengthen policy, system, frameworks, planning and budgeting; strengthening and developing capacities of federal and state institutions; strengthening social structures and galvanizing them for action to support the national and state responses in the six UNTG-supported states-Benue, Cross River, Edo, Kaduna, Ondo and Taraba.

The UN will spend USD 11,128,741 within the next two years (2009-2011) to reduce HIV/AIDS incidence and prevalence by 25% in 2011.

[11] *The United Nations Joint Programme of Support on HIV and AIDS in Nigeria,2009*

2 Study Design and Methodology

2.1 Introduction

2.2 Context for the Assessment

Nigeria in its effort to monitor and evaluate the countryøs response to the AIDS pandemic and achieve the financing goals set out in the 2001 UNGASS Declaration seeks to track the flow of financial resources from funding source to expenditure. The data will be used to measure national commitment and action, which is an important component of the UNGASS Declaration.

Nigeria, Africaøs most populous country with a population of 140million has a median HIV prevalence of 4.6%. It is the second largest HIV/AIDS epidemic in the world and the largest in the West African sub-region. State HIV prevalence varies from 1.0% in Ekiti State to as high as 10.6% in Benue State, with higher prevalence among women and girls.[12]

The 2009 sustainability analysis of HIV/AIDS services in Nigeria (HAPSAT) revealed that currently, it is not possible to get a comprehensive picture of how and where resources are being expended as the nation responds to the epidemic. For example, donors often reported total expenditures and budgets broken down by thematic area (treatment, care, prevention, health systems strengthening, etc), and allocations to sub-recipients and/or implementing partners. However, data was not generally provided by donors, sub-recipients, or implementing partners, to indicate how much was spent in specific service delivery points or geographical areas, or on specific activities. Thus, the geographical distribution of expenditures and service delivery outputs are not known. Likewise, the unit costs of service delivery, especially behavior change interventions and support to orphans and vulnerable children, are largely unknown and cannot be calculated readily from available data.[13]

2.3 Objectives and Purpose

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

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

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

- What is actually disbursed and spent in each component of the multisectoral HIV and AIDS response? Are increased allocations of expenditure going to priority HIV and AIDS interventions?
- What is the allocation of AIDS spending in relation to the objectives and targets of the National HIV/AIDS Strategic Plan?

[12] National HIV Sero-Prevalence Sentinel Survey Among the Antenatal Clinic Attendees,2008

[13] sustainability analysis of HIV/AIDS services in Nigeria, 2009

- Where do HIV and AIDS funds go ï Who are the main service providers and beneficiaries of these services?

2.4 Scope of the Assessment

The assessment focused on tracking national level HIV expenditure available at central level for the year 2007 and 2008. Data collection covered domestic and external spending in HIV and AIDS, including funds channeled through the government. The assessment did not include household out-of-pocket expenditure on HIV and AIDS and most private sector funds

2.5 Approach

The National HIV and AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. The tool tracks actual expenditure (public, private and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprises the National Response to HIV and AIDS[14].

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

In addition to establishing a finance tracking system of HIV and AIDS activities, NASA facilitates a standardized approach to reporting of indicators that monitor the progress towards the achievement of the targets of the *Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS)[15].

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

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

As part of its methodology, NASA employs double entry tables or matrices to represent the origin and destination of resources, avoiding double-counting the expenditures by reconstructing the resource flows for every transaction from funding source to service

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

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

provider and beneficiary population, rather than just adding up the expenditures of every agent that commits resources to HIV and AIDS activities.

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

NASA was recommended as a methodology for reporting to UNGASS the No 1 Indicator on in-country spending for the whole set of activities within the national response to HIV and AIDS from different sources. Out of 145 countries that submitted their reports for review at the 2008 High-level Meeting, 107 included information on HIV spending.

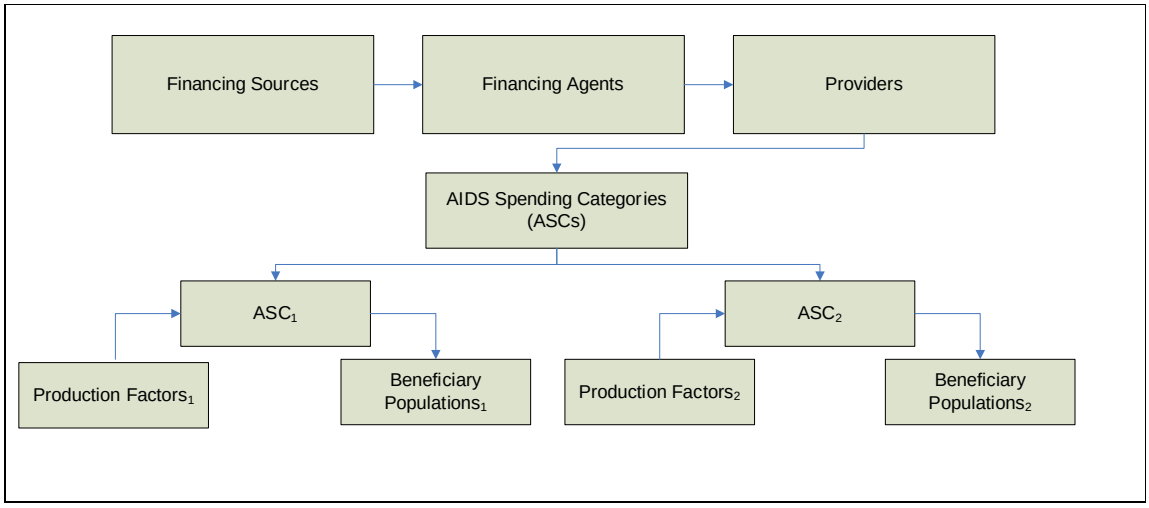
2.6 NASA Methodology

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

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

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

Figure 5 Transactions

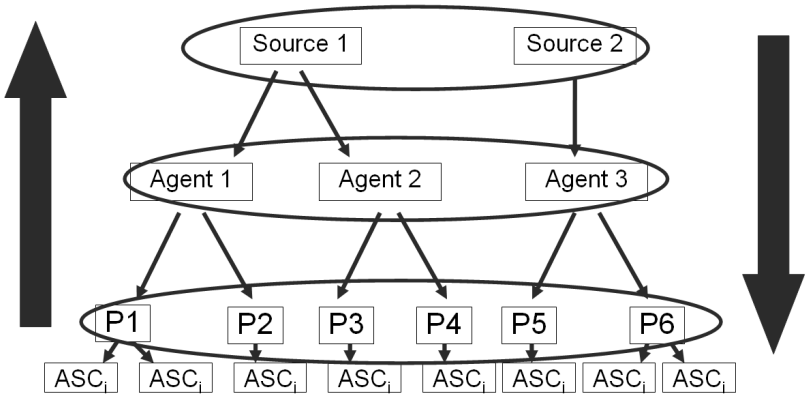


The identification of transactions starts during the planning step with the mapping of the different actors involved in the HIV and AIDS response. The source-agent-provider relation is established here, transfer mechanisms and all kind of activities that are financed this way are

identified. During data collection the transaction is complemented with the amount of the resources implicit on it.

Finally, during data analysis all transactions are completed and crosschecked doing a ñbottom upò and ñtop downò reconciliation to avoid double counting and to ensure that the amounts inputted to the transaction reflect actual spending (Figure 6).

Figure 6 "Bottom up" and "Top down" approach.



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

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

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

Table 1: NASA dimensions and categories.

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

2.7 NASA Preparatory Activities

A first mission of four international experts was carried in September 2008. During this mission, 34 participants were trained on NASA planning and implementation; 21 from the SACAs of seven States (the M&E officers, the programme manager and the finance officer), and 10 from national level (NASCP, NACA, FMoH, NPC), two from the UN system (UNDP and UNAIDS) and 2 national consultants. The workshop strengthened country capacity in resource tracking and analysis by building the capacity of national experts to conduct a NASA exercise and enabling key policy makers to facilitate and support the process. A road map was also developed to roll out NASA at federal and national level.

As a follow up to this training workshop, a mission of UNAIDS/Geneva was organized in August 2009 to prepare and launch the implementation of NASA in Nigeria.

The NASA in Nigeria was conducted by the national technical team under the direct supervision of NACA Director of strategic knowledge management and UNAIDS Nigeria M & E Advisor with the technical support of International NASA experts. The process involved a week mission to the country by an international NASA consultant and the UNAIDS AFE NASA adviser. Two national senior consultants were recruited to support NACA in his task for day-today management of the process. Three national data managers were also recruited and together with the senior consultants, NACA Director Strategic knowledge management, NACA supervisors and UNAIDS monitoring and evaluation advisor constituted the core team for the implementation of NASA in Nigeria. A two day refresher workshop of the core team members was held.

A steering committee made up of officers from different governmental institutions (NACA, Ministry of Health, Ministry of Finance, the Ministry of National Planning and/or other Governmental offices),UNAIDS and ENR was set up to provide supervision on the overall process and to facilitate data collection. The M&E TWG, in its role as an advisory body participated in the process and contributed to the validation of the findings. The timeline of the NASA implementation is presented in Annex 2.

Several advocacy and sensitization meetings were held with partners to facilitate the process. Data collection forms were refined and distributed to key HIV/AIDS national response actors. The NASA team obtained all necessary permissions from the national authorities to access relevant data and conducts the assessment. The letter of support for the mission is presented in Annex 3.

2.8 Data Collection and Processing

2.8.1 Sources of Data

In collaboration with national stakeholders, NASA team identified and mapped HIV financial sources, financial agents, service providers, and AIDS spending categories.
Although a lot of sources of data (detailed expenditure records) were obtained from the primary sources for 2007 and 2008, secondary sources were widely used where primary sources were not available (e.g. expenditure of NGOs who received direct funding from donors which were not captured, donor report or more detailed data on expenditure). In some cases costing techniques were used to estimate some of the expenditures of HIV and AIDS related activities using the best available data and most suitable assumptions.

For the list of institutions visited to collect HIV and AIDS expenditure data and the status of data collected refer to Annex 1.

2.8.2 Data Collection

The initial data collection process involved training. Two focal persons (Finance and Programme Officers) from each of the donor institutions and implementing partners; State Programme Managers and data collectors in ten States of the country comprising Akwa Ibom, Benue, Cross River, Enugu, Imo, Kaduna, Lagos, Nassarawa, Ondo and Taraba were trained for two days. The objective of the training was to acquaint them with the NASA process, enable them to reconstruct all the transactions related to HIV and AIDS activities showing the actual spending, consumption and delivery to the beneficiary population and enable them to completely fill the NASA data forms. The training session was also an opportunity to sensitize and solicit for the release of financial data.

The assessment was undertaken through a desk review of key policy documents, programme documentation and available budgetary and expenditure reports for the period 2007-2008. This review was accompanied by six weeks of data collection in September 2009.

Letters introducing NASA and requesting data were sent out by NACA to the various government ministries, NGOs, bilateral and multilateral organizations in order to formally gain access to the required data. Presentation of NASA objectives, expected outputs and key methodological principles were presented to stakeholders on different meeting and working groups during the preparatory mission and the first week of the main mission.

The standard NASA questionnaires were adjusted to suit the country context. NACA sent the adjusted questionnaires (see Annex 4) to key respondents, and consultants introduced the questionnaires to all donor institutions and agreed on a date for submission of data. Each organization was asked to allocate spending, using various criteria, into different programmes to enable a functional classification of HIV and AIDS expenditures. Funds could be allocated to various HIV service providers (intermediaries) such as NGOs, CBOs, public or private hospitals. NASA consultants were also on hand to support organizations to complete the questionnaires.

2.8.3 Data Processing

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

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

2.8.4 Data validation

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

- The initial stage was by the NASA core team who went through each transaction using the generated RTS beneficiary population and production factor outputs. This was to ensure that the classification of the financing source, financing agent, service providers, AIDS spending categories and the beneficiary populations were consistent with the NASA classification and definitions manual and to ensure the accuracy of the financial data with the submitted one by the various institutions.

- The second stage was carried by the international consultant with technical support from UNAIDS in Geneva. After this stage, all observations and comments were incorporated into the RTS and a new set of outputs were generated.

- The third stage of the validation was by the individual institutions that submitted data. The financial data was sent to the Programme and finance focal persons in the institutions for confirmation. A final set of RTS outputs was generated after including their comments to produce tables and graphs for the final report.

- The final stage of this process was by the national HIV/AIDS Stakeholders. The draft report was shared to all stakeholders for their input. All their comments were captured in the report and a one day validation meeting was held afterwards with all of them in attendance

2.9 Limitations of the Assessment

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

- **Dearth of HIV expenditure data:**
  Data limitations made it difficult to evaluate HIV expenditure in a number of areas including: Opportunistic Infections, Public sector resource envelope (with the exception of FMOH and FMOE), organizational overheads, and production factors (capital and recurrent expenditure). This can be attributed to several reasons including poor record keeping at all levels, lack of unified central data management system by institutions and the inappropriate timing of the NASA process towards the last quarter of the year which coincided with the internal audit activities of various institutions.

- **Missing data:**
  During the NASA mission it was not possible to obtain the necessary information to estimate expenditures on STIs and on OI treatment, cost of supply logistics and the entire ART service delivery, including the cost of HR, cost of breast milk substitute and amount procured for 2007 and 2008, cost of delivery practices and how many of each for 2007 and 2008, cost of postpartum care per patient for 2007 and 2008 disaggregated by state, number of CD4, Viral load and drug resistance tests (aimed to monitor biological response to ART), and the cost of each test in 2007 and 2008. Some institutions did not submit data like ActionAid, Africare, Chemonics, Clinton Foundation, Federal medical store, Harvard University, NELA, NIBUCCA and OSSAP-MDGs.

- **Private funds:**
  The NASA report does not include a full out of pocket expenditures on HIV and AIDS, thus only partial data on private funds is considered

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

3.0 NASA Results and Main Policy Findings

3.1 2007 and 2008 NASA results

3.1.1 Financing Sources

In 2007, direct bilateral contributions (66.0%) were the main source of funding followed by multilateral agencies (19.4%). The expenditure on HIV and AIDS was $**394 million** in 2008. Nigeria HIV response is highly dependant on international funding: public sources financed only 7.6% of the total HIV expenditures while international sources financed 92.3% of total HIV expenditure. Direct bilateral contributions (80.2%) were the main source of funding followed by multilateral agencies (11.5%) (See Table 2 for details).

Table 2: Financing Sources in 2007 and 2008 ï Table (1st and 2nd digits analysis):

Financing Sources	USD 2007	%	USD 2008	%
FS.01 Public Sources	**43,854,033.00**	**14.65**	**30.082,450.00**	**7.6**
FS.02 Private funds	**0**	**0.0**	**300.000.00**	**0.1**
FS.03. International funds	**255,392,257.00**	**85.35**	**364,581,432.00**	**92.3**
FS.03.01 Direct bilateral contributions	197,219,367.00	65.91	319,040,525.00	80.8
FS.03.02 Multilateral Agencies	58,140,411.00	19.2	45,477,907.00	11.5
FS.03.03 International not-for-profit organizations and foundations	32,479.00	0.01	63,000.00	0.0
Total	**299,246,295.00**	**100.0**	**394,963,881.00**	**100.0**

Central Government revenue as shown in figure 7 contributed $42,689,972.00 (14.3%) while the State Governments contributed $1,164,061.00representing 0.4% of the public source of funding in 2007. Financing from the direct bilateral agencies was the main international source of funding in 2007. The Government of United States was the main financing source, contributed $ 185,778,683.00 (62.0%) of the resources spent in Nigeria in 2007. The World Bank was another major source of funds contributing 9.8% of total spending closely followed by the Global Fund to Fight AIDS, Tuberculosis and Malaria with 6.6%.

Figure 8 in 2008 highlights that the Central Government revenue ($27,934,983.00) and State Government revenue ($2,147,465.00) were the public sources of funding in 2008. Financing from the direct bilateral contributions was the main international source of funding in 2008 with the Government of United States as the financing source which contributed 77.7% of the resources spent in Nigeria in 2008. The Global fund was another major source of funds and it contributed 6.9% while the World Bank financed 3.1% of the total spending.

There was a 31.5% increase in the funds spent in 2008 compared to 2007.(See Table 3 and figure 9) However the trend in the funding sources did not change as international funds was still the major financing source in the country. Interestingly, the public sources of fund decreased in 2008

Table 3: Financing Sources 2007 and 2008 – (3rd digit analysis):

Financing sources	2007		2008	
	Amount(USD)	%	Amount (USD)	%
FS.01 Public Sources	**43,854,033.00**	**14.65**	**30,082,450.00**	**7.6**
FS.01.01.01 - Central Government Revenue	42,689,972.00	14.27	27,934,983.00	7.1
FS.01.01.02-State Government Revenue	1,164,061.00	0.39	2,147,465.00	0.5
FS.02. Private funds	**NA**	**NA**	**300,000.00**	**0.1**
FS.03. International funds	**255,392,257.00**	**85.35**	**364,581,432.00**	**92.3**
FS.03.01 Direct bilateral contributions	197,219,367.00	65.91	319,040,527.00	80.8
FS.03.01.12- Government of Japan	141,187.00	0.05	106,090.00	0.0
FS.03.01.21- Government of United Kingdom	11,299,497.00	3.78	12,104,262.00	3.1
FS.03.01.22- Government of United States	185,778,683.00	62.08	306,830,175.00	77.7
FS.03.02 Multilateral Agencies	58,140,411.00	19.43	45,477,907.00	11.5
FS.03.02.07- GFATM	19,626,887.00	6.56	27,270,323.00	6.9
FS.03.02.08- UNAIDS Secretariat	555,365.00	0.19	921,608.00	0.2
FS.03.02.09- United Nations Childrenôs Fund (UNICEF)	6,261,976.00	2.09	3,776,777.00	1.0
FS.03.02.10- United Nations Development Fund for Women (UNIFEM)	45,178.00	0.02	130,838.00	0.0
FS.03.02.11- United Nations Development Programme (UNDP)	394,134.00	0.13	553,468.00	0.1
FS.03.02.12- United Nations Educational, scientific and cultural Organization(UNESCO)	NA	NA	224,212.00	0.1
FS.03.02.16- United Nations Office on Drugs and Crime (UNODC)	15,116.00	0.01	18,882.00	0.0
FS.03.02.17- United Nations Population Fund (UNFPA)	521,543.00	0.17	NA	NA
FS.03.02.18 - World Bank (WB)	29,349,493.00	9.81	12,231,694.00	3.1
FS.03.02.20- World Health Organization (WHO)	1,370,719.00	0.46	314,316.00	0.1
FS.3.3 International not-for-profit organizations and foundations	32,479.00	0.01	63,000.00	0.0
Total	**299,246,295.00**	**100**	**394,963,881.00**	**100.0**

Figure 7: Financing sources in 2007

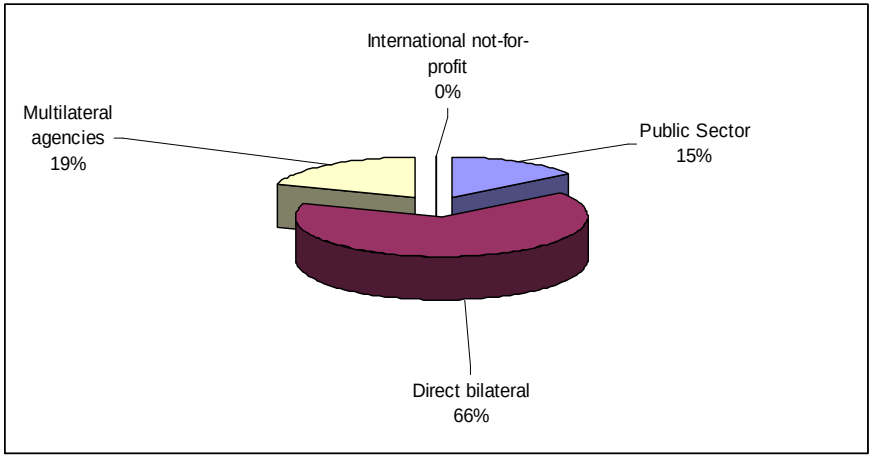


Figure 8: Financing Sources in 2008

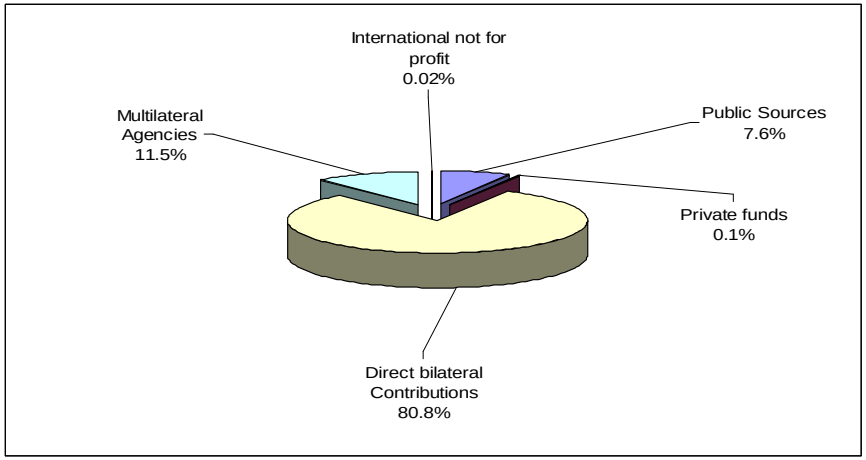
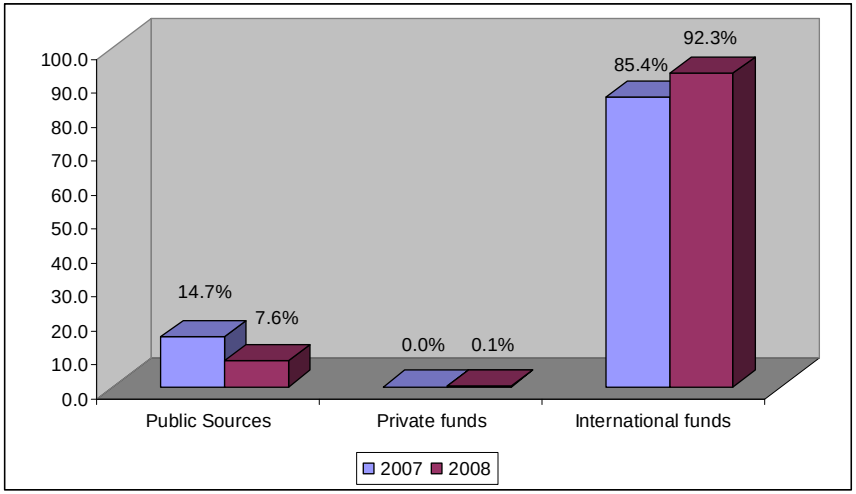


Figure 9: comparison of financing sources in 2007 and 2008



Nigeria spending pattern by financing source-2007 and 2008

The level of details of spending data allows the analysis of the areas of spending by Financing Sources. The comparison of the spending profile of five main financing sources (three ï external, one ï public and one private) are highlighted in Tables 4 and 5 and graphically depicted Figures 10 and 11. As clearly seen in the graph, care and treatment remain the key spending priorities for the public and direct bilateral funds while programme management and administration was the most financed area within multilateral agencies and international non-profit making organizations and foundations.

Table 4: Spending pattern by financing source-2007

AIDS spending categories	FS.01 Public funds	%	FS.03.01 Direct bilateral contributions	%	FS.03.02 Multilateral Agencies	%	FS.03.03 International non-profit funds	%
ASC.01 Prevention	242,530.00	0.6	34,418,758.00	17.5	2,997,206.00	5.2	-	
ASC.02 Care and treatment	32,477,778.00	74.1	99,997,441.00	50.7	2,612,900.00	4.5	-	
ASC.03 Orphans and vulnerable children (OVC)	1,499.00	0.0	5,142,039.00	2.6	571,600.00	1.0	-	
ASC.04 Programme management and administration	9,633,440.00	22.0	49,401,821.00	25.0	43,757,394.00	75.3	32,479.00	100
ASC.05 Human resources	1,296,930.00	3.0	7,808,331.00	4.0	6,085,158.00	10.5	-	
ASC.06 Social protection and social services (excluding OVC)	133,479.00	0.3	2,000.00	0.0	3,331.00	0.0	-	
ASC.07 Enabling environment	-	-	448,984.00	0.2	2,112,821.00	3.6	-	
ASC.08 HIV and AIDS-related research (excluding operations research)	68,376.00	0.2	-	-	-	-	-	
Total	**43,854,032.00**	**100.00**	**197,219,374.00**	**100.00**	**58,140,410.00**	**100.00**	**32,479.00**	**100**

Table 5: Spending categories by financing source-2008

AIDS spending categories	FS.01 Public Sources	%	FS.02 Private funds	%	FS.03.01 Direct bilateral contributions	%	FS.03.02 Multilateral agencies	%	FS.03.03 International non-profit	%
ASC.01 Prevention	6,380,404	21.2	300,000	100.0	48,654,716	15.3	2,913,713	6.4	0	0
ASC.02 Care and treatment	18,806,722	62.5	0	0.0	164,781,352	51.6	2,323,569	5.1	0	0.0
ASC.03 Orphans and vulnerable children	0	0	0	0.0	9,189,292	2.9	782,528	1.7	0	0.0
ASC.04 Programme management and administration	3,937,157	13.1	0	0.0	79,864,570	25.0	33,656,435	74.0	63,000	100.0
ASC.05 Human resources	637,162	2.1	0	0.0	16,168,020	5.1	4,340,351	9.5	0	0.0
ASC.06 Social protection and social services	0	0	0	0.0	25,515	0.0	110,604	0.2	0	0.0
ASC.07 Enabling environment	321,005	1.1	0	0.0	357,060	0.1	1,333,357	2.9	0	0.0
ASC.08 HIV Research	0	0	0	0.0	0	0.0	17,350	0.0	0	0.0
Total	**30,082,450**	**100**	**300,000**	**100**	**319,040,525**	**100**	**45,477,907**	**100**	**63,000**	**100**

Figure 10: Spending by Financing Sources 2007

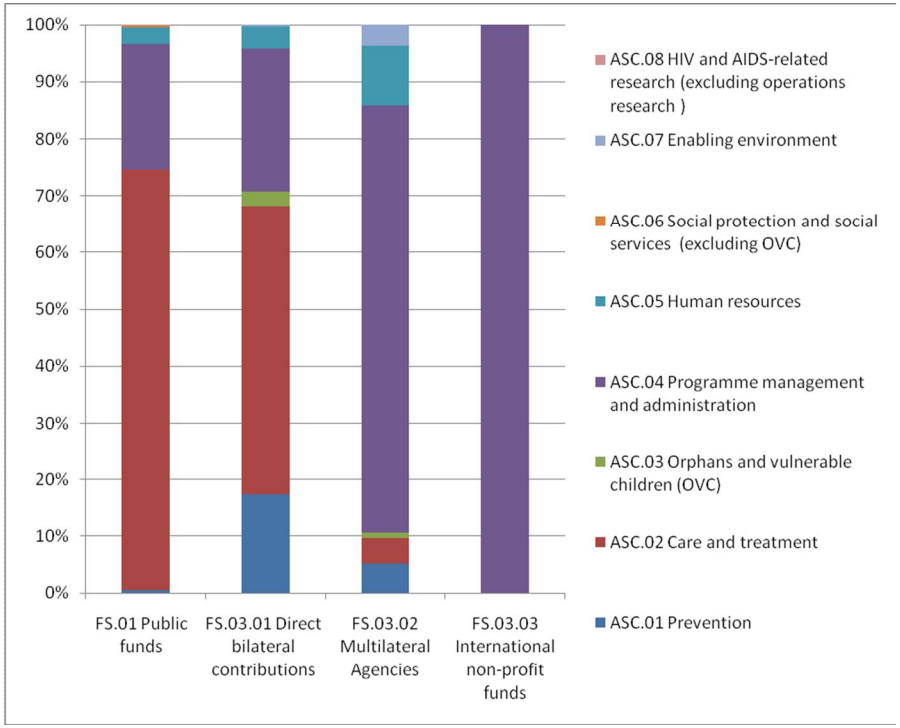
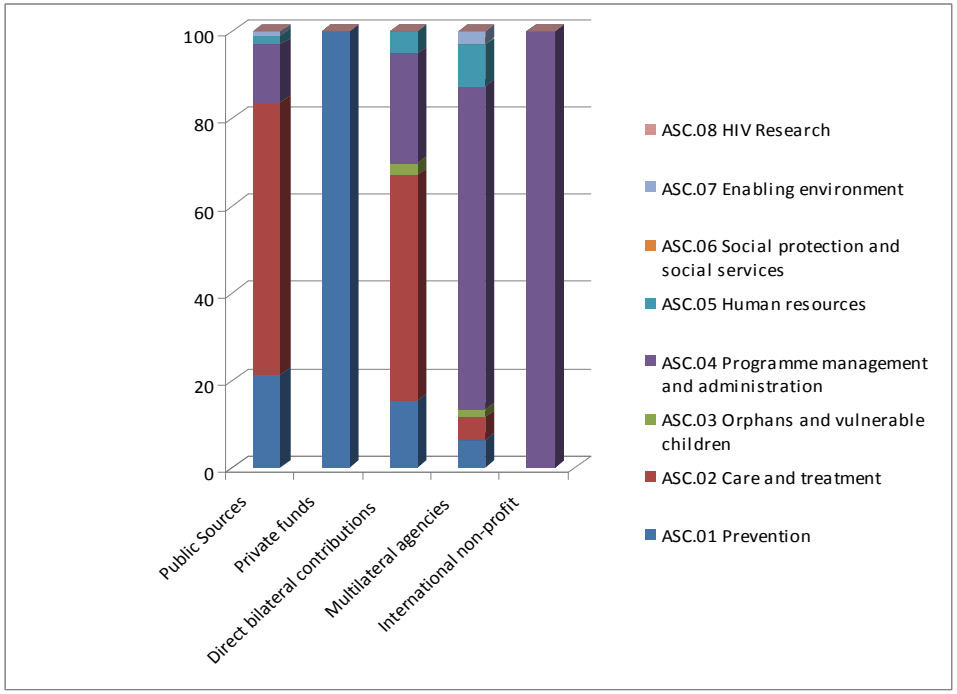


Figure11: Spending by Financing Sources 2008



Figures 12 and 13 shows the origin of funds for selected interventions, all of which are mainly covered by direct bilateral donors. PMTCT, VCT and prevention programme for sex workers and their client rely mainly on direct bilateral and multilateral resources with no public funding.
All the private funds in 2008 were used for blood safety.

Figure 12: *Selected prevention spending areas and their financing sources, 2007*

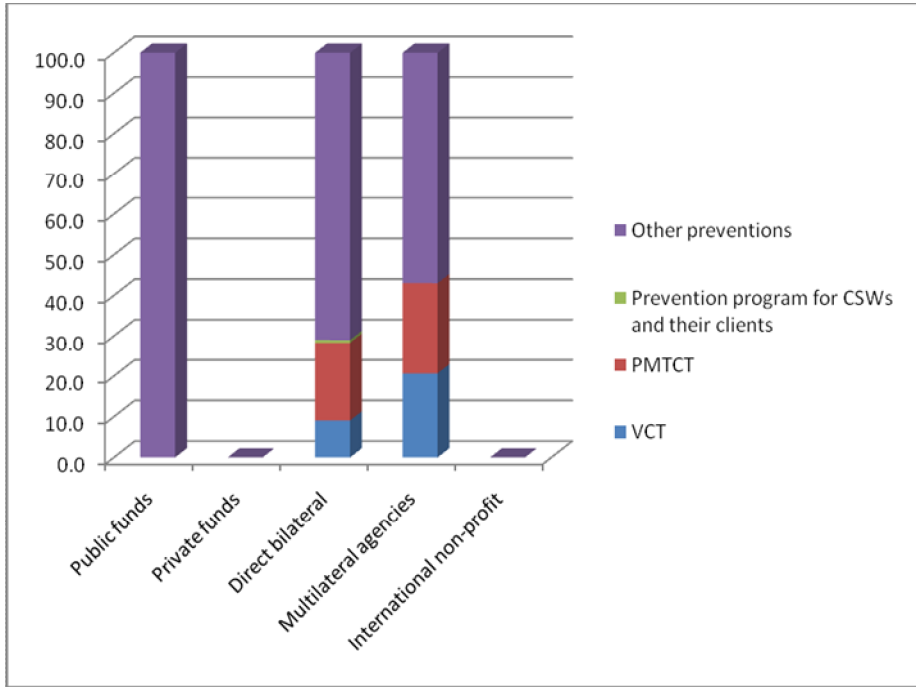
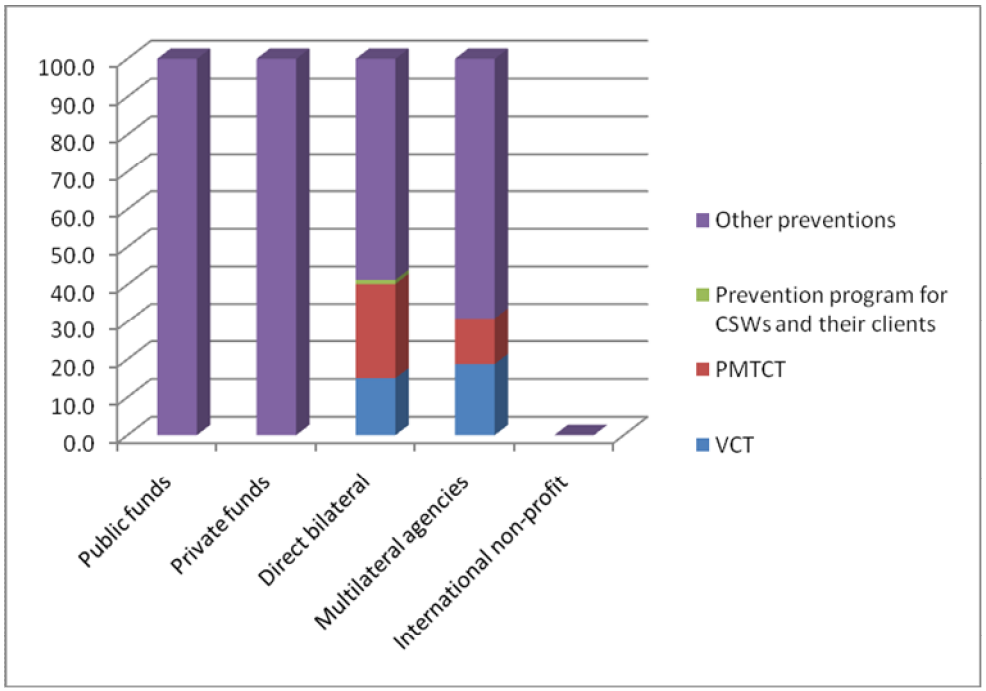


Figure 13: Selected prevention spending areas and their financing sources, 2008



3.1.2 Financing Agents

Table 6 is a first and second digit analysis of the financing agents. In 2007, the Financing agents were mainly the international purchasing Organizations (71.4%) while the public sector (28.4%) closely followed and the private sector spent $ 447,569.00 on HIV goods and services representing 0.15

The International purchasing Organizations were in the majority of the financing agents in 2008 as they spent $331,348,389.00(84.0%) on HIV goods and/or services with the public sector spending $59,070,207.00(15.0%) and the private sector $ 4,545,285.00(1.0%).
%.

Table 6: Financing Agents (1st and 2nd digits analysis)

Financing Agents	USD 2007	%	USD 2008	%
FA.01- Public Sector	**85,080,092.00**	**28.4**	**59,070,207.00**	**15.0**
FA.02- Private Sector	**447,569.00**	**0.1**	**4,545,285.00**	**1.0**
FA.03. International Purchasing Organizations	**213,718,629.00**	**71.4**	**331,348,389.00**	**84.0**
FA.03.01 Country offices of bilateral agencies	121,315,208.00	40.5	161,629,658.00	41.0
FS.03.02 Multilateral Agencies	9,035,686.00	3.0	6,020,125.00	2.0
FA.03.03 International non-for-making organizations and foundations	83,367,735.00	27.9	163,698,606.00	41.0
Total U$S	**299,246,295.00**	**100.0**	**394,963,881.00**	**100.0**

In 2007 as shown in figure 14 below depicts that the Federal Ministry of Health was the main financing agent from the public sector (11.3%) followed by the National agency for the control of AIDS (6.9%). The bilateral agencies made up of the Government of the United States as the major international purchasing organization accounted for 40.5% of purchases of goods and/or services

The National Agency for the control of AIDS topped the list of the public sector financing agents with $22,699,275.00 (6.0%) spent on HIV goods and/or services in 2008.(Figure 15) The Government of United States as a bilateral agency spent $161,629,658.00 (41.0%) followed by other international not-for-profit organizations not elsewhere classified which spent $ 142,471,593.00 (36.0%) .(See Table 7 for details).

Table 7: Financing Agents (3rd digit analysis)

Financing agents	2007		2008	
	Amount (USD)	%	Amount (USD)	%
FA.01 Public sector	**85,080,092.00**	**28.43**	**59,070,207.00**	**14.96**
FA 01.01.01.01 Ministry of Health (or equivalent sector entity)	33,873,519.00	11.32	18,811,283.00	4.76
FA 01.01.01.02 Ministry of Education(or equivalent sector entity)	49,573.00	0.02	21,368.00	0.01
FA 01.01.01.08 Other ministries (or equivalent sector entities)	87,324.00	0.03	161,996.00	0.04
FA 01.01.01.10 National AIDS commission	20,500,668.00	6.85	22,699,275.00	5.75
FA 01.01.01.99 Central or federal authorities' entities n.e.c	3,242,638.00	1.08	5,276,665.00	1.34
FA 01.01.02.06 State/province/department aids commission	27,326,370.00	9.13	12,099,312.00	3.06
FA.01.99 Other public financing agents n.e.c.	NA	NA	308.00	0.00
FA 02 Private sector	**447,569.00**	**0.15**	**4,545,285.00**	**1.15**
FA 02.05 Not-for-profit institutions (other than social insurance)	202,044.00	0.07	4,418,808.00	1.12
FA 02.99 Other private financing agents n.e.c	245,525.00	0.08	126,477.00	0.03
FA 03 International purchasing organizations	**213,718,629.00**	**71.42**	**331,348,389.00**	**83.89**
FA 03.01 Bilateral agencies	121,315,208.00	40.54	NA	NA
FA 03.01.22 Government of United States	121,315,208.00	40.54	161,629,658.00	40.92
FA 03.02 Multilateral agencies managing external resources	9,035,686.00	3.02	5,339,722.00	1.35
FA 03.02.07 UNAIDS Secretariat	555,365.00	0.19	921,608.00	0.23
FA 03.02.08 United Nations Children's fund (UNICEF)	6,123,246.00	2.05	3,714,926.00	0.94
FA 03.02.09 United Nations Development Fund for Women	45,178.00	0.02	130,838.00	0.03
FA 03.02.10 United nations development programme (UNDP)	394,134.00	0.13	553,468.00	0.14
FA 03.02.11 United Nations Educational, Scientific and Cultural organization (UNESCO)	141,187.00	0.05	330,302.00	0.08
FA 03.02.15 United nations office on drugs and crime (UNODC)	15,116.00	0.01	18,882.00	0.00
FA 03.02.16 United nations population fund (UNFPA)	390,741.00	0.13	NA	NA
FA 03.02.19 World health organization (WHO)	1,370,719.00	0.46	350,101.00	0.09
FA 03.03 International non-profit making organizations and foundations	83,367,735.00	27.86	163,698,606.00	41.45
FA 03.03.14 Family Health International	11,005,733.00	3.68	21,177,767.00	5.36
FA.03.03.25 The Clinton Foundation	NA	NA	49,246.00	0.01
FA 03.03.99 Other international non-profit making organization	72,362,002.00	24.18	142,471,593.00	36.07
Total	**299,246,295.00**	**100.0**	**394,963,881.00**	**100.0**

Figure 14: Financing Agents in 2007

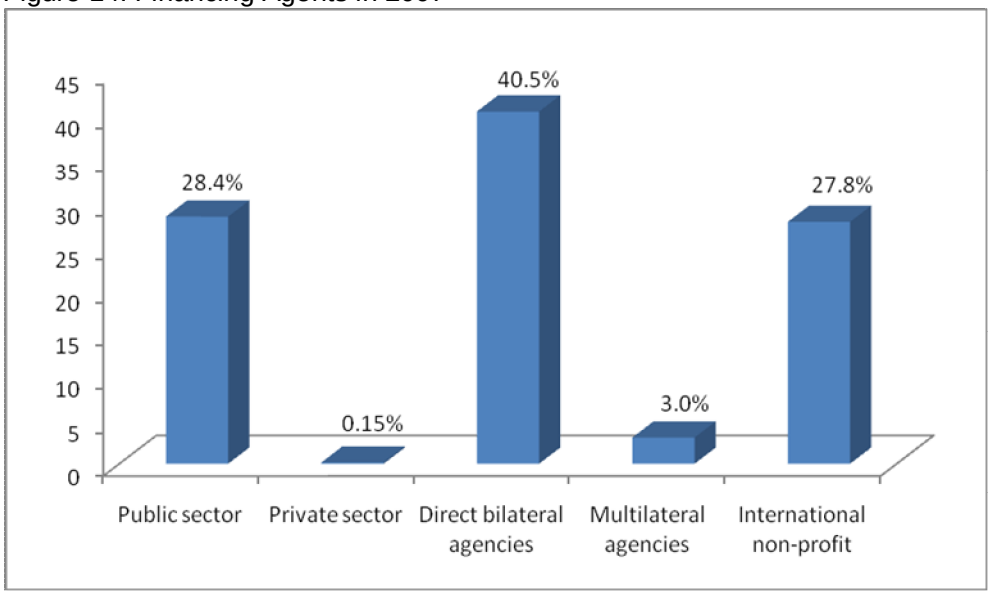


Figure 15: Financing Agents in 2008

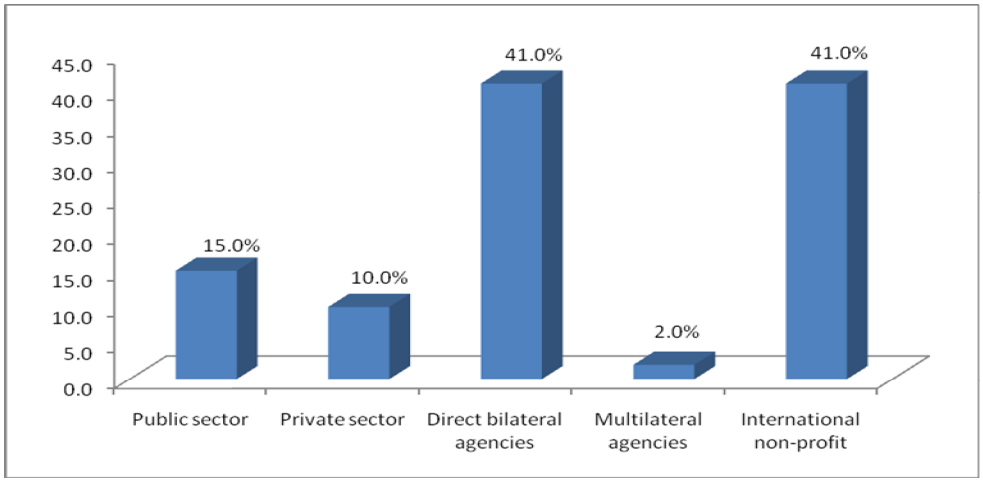
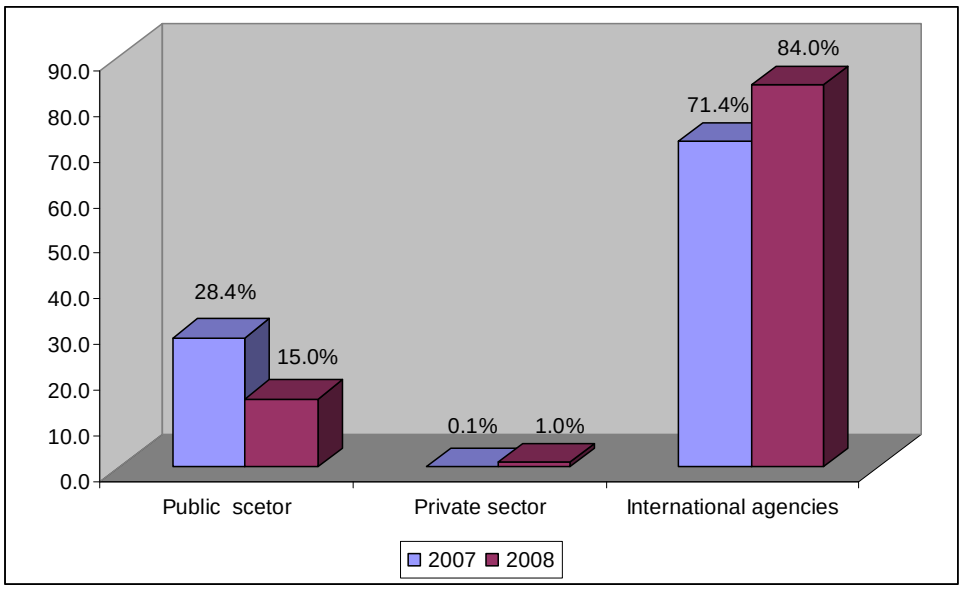


Figure 16: Comparison of financing agents in 2007 and 2008



The financing of HIV response in 2007 comes mainly from international source and the decision on how to use the funds equally relies on international Organizations. Table 8 shows the relation between financing sources; who are the origin of funds and financing agents; institutions making programmatic decisions. Most of the funds in Nigeria in 2007 were managed by international purchasing Organizations.

Even if the financing of the HIV response comes mainly from international sources, the decision on how to use the funds relies on country offices of bilateral agencies, Table 9 shows the relation between financing sources, who are the origin of funds, and financing agents, institutions making programmatic decisions. Most of funds in Nigeria in 2008 were managed by international purchasing organizations sector.

Table 8: Financing Sources to financing agents- 2007

Financing Sources to Financing Agents		Financing Sources				Total
		Central Government Revenue	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	
Financing Agents	**Public Sector**	43,854,033.00	3,024,947.00	38,168,633.00	32,479.00	85,080,092.00
	Private Sector	0	255,087.00	192,482.00	0	447,569.00
	Bilateral agencies	0	121,315,208.00	0	0	121,315,208.00
	Multilateral Agencies	0	141,978.00	8,893,708.00	0	9,035,686.00
	International Non Profit	0	72,482,147.00	10,885,588.00	0	83,367,735.00
Total		43,854,033.00	197,219,367.00	58,140,411.00	32,479.00	299,246,295.00

Table 9: Financing Sources to financing agents-2008

Financing Sources to Financing Agents		Financing Sources					Total
		Central Government Revenue	Private Funds	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	
Financing Agents	**Public Sector**	30,082,450.00	0	1,436,515.00	27,551,242.00	0	59,070,207.00
	Private Sector	0	0	4,418,808.00	126,477.00	0	4,545,285.00
	Country office of Bilateral agencies	0	0	161,629,658.00	0	0	161,629,658.00
	Multilateral Agencies	0	0	106,090.00	5,914,035.00	0	6,020,125.00
	International Non Profit	0	300.000.00	151,449,454.00	11,886,152.00	63,000.00	163,698,606.00
Total		30,082,450.00	300.000.00	319,040,525.00	45,477,906.00	63,000.00	394,963,881.00

3.1.3 HIV Service Providers

The private sector non-profit institutions (47.0%) were the main providers of HIV/AIDS service in 2007 and closely followed by the public sector providers (43.0%).
The public sector providers, private sector non-profit providers, bilateral and multilateral entities provided 39.9%, 53.0% and 7.0% of HIV/AIDS services respectively in 2008 in Nigeria (See table 10 below)

Table 10: HIV Service providers on 2007 and 2008(1st and 2nd digits analysis)

HIV/AIDS Service Providers	2007		2008	
	USD$	%	USD	%
PS.01-Public Sector Providers	127,202,277.00	42.5	157,683,991.00	39.9
PS.02-Private Sector non-profit Providers	143,272,305.00	47.9	209,251,453.00	53.0
PS.03-Bilateral and Multilateral entities	28,771,713.00	9.6	27,572,247.00	7.0
PS.04-Rest of the world providers	0	0.0	456,191.00	0.1
TOTAL	**299,246,295.00**	**100.0**	**394,963,881.00**	**100.0**

The public sector providers spent a higher amount in 2008 compared to 2007 but the proportion of their contribution (42.5% in 2007 compared to 39.9% in 2008 of spending) was not impressive compared to what the private sector non-profit providers spent. (Figures 17-20)

Table 11: HIV/AIDS Service providers in 2007 (3rd digit analysis)

HIV Service Providers	2007		2008	
	Amount (USD)	%	Amount (USD)	%
PS.01-Public sector providers	**127,202,277.00**	**42.5**	**157,683,991.00**	**39.92**
PS.01.01.01-Hospitals (Governmental)	13,175,363.00	4.40	43,229,563.00	10.95
PS.01.01.06-Blood banks (Governmental)	3,009,644.00	1.01	4,616,012.00	1.17
PS.01.01.10.99-Schools and training centres n.e.c. (Governmental)	15,116.00	0.01	18,882.00	0.00
PS.01.01.14.01-National AIDS commission (NACs)	17,703,542.00	5.92	20,375,754.00	5.16
PS.01.01.14.02-Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	33,891,004.00	11.33	18,831,063.00	4.77
PS.01.01.14.03-Departments inside the Ministry of Education or equivalent	420,138.00	0.14	940,421.00	0.24

PS.01.01.14.08-Departments inside the Ministry of Justice or equivalent	4,919.00	0.00	NA	NA
PS.01.01.14.04 Departments inside the Ministry of Social Development or equivalent	NA	NA	4,651.00	0.00
PS.01.01.14.05 Departments inside the Ministry of Defense or equivalent	NA	NA	2,234.00	0.00
PS.01.01.14.06 Departments inside the Ministry of Finance or equivalent	NA	NA	4,659.00	0.00
PS.01.01.14.99-Government entities n.e.c.	7,165,686.00	2.39	10,974,818.00	2.78
PS.01.01.99-Governmental organizations n.e.c.	657,853.00	0.22	656,744.00	0.17
PS.01.02.13-Research institutions (Parastatal)	51,159,012.00	17.10	58,029,190.00	14.69
PS.02-Private sector providers	**143,272,305.00**	**47.9**	**209,251,453.00**	**52.98**
PS.02.01.01.02-Ambulatory care (Non-profit non faith-based)	32,816.00	0.01	NA	NA
PS.02.01.01.10.99-Schools and training centres n.e.c. (Non-profit non faith-based)	2,590.00	0.00	492.00	0.00
PS.02.01.01.14-Self-help and informal community-based organizations (Non-profit non faith-based)	1,096,470.00	0.37	3,824,942.00	0.97
PS.02.01.01.15-Civil society organizations (Non-profit non faith-based)	2,403,605.00	0.80	1,059,270.00	0.27
PS.02.01.01.99-Other non-profit non-faith-based providers n.e.c.	83,558,128.00	27.92	134,548,895.00	34.07
PS.02.01.02.01-Hospitals (Non-profit faith-based)	3,007,695.00	1.01	6,770,775.00	1.71
PS.02.01.02.13-Self-help and informal community-based organizations (Non-profit faith-based)	1,000.00	0.00	1,769,279.00	0.45
PS.02.01.02.14-Civil society organizations (Non-profit faith-based)	192,929.00	0.06	NA	NA
PS.02.01.02.99-Other non-profit faith-based private sector providers n.e.c.	**19,681,802.00**	**6.58**	**35,235,850.00**	**8.92**
PS.02.01.99-Other non-profit private sector providers n.e.c.	6,990,569.00	2.34	8,474,441.00	2.15
PS.02.02.01-Hospitals (For profit)	90,808.00	0.03	123,055.00	0.03
PS.02.02.10.03-Higher education (For profit)	758,222.00	0.25	1,308,762.00	0.33
PS.02.02.14-Consultancy firms (For profit)	613,535.00	0.21	3,604.00	0.00
PS.02.02.15-ñWorkplaceò(For profit)	137,209.00	0.05	135,746.00	0.03
PS.02.02.99-For profit private sector providers n.e.c.	4,863,871.00	1.63	11,109,604.00	2.81
PS.02.99-Private sector providers n.e.c.	19,841,056.00	6.63	4,886,738.00	1.24
PS.03-Bilateral and multilateral entities - in country offices	**28,771,713.00**	**9.6**	**27,572,247.00**	**6.98**
PS.03.01-Bilateral agencies	20,734,947.00	6.93	22,804,874.00	5.77
PS.03.02-Multilateral agencies	8,036,766.00	2.69	4,767,373.00	1.21
PS.99 Providers n.e.c.	**NA**	**NA**	**456191.00**	**0.12**
Total	**299,246,295.00**	**100**	**394,963,881.00**	**100.00**

Figure 17: HIV/AIDS Service Providers in 2007

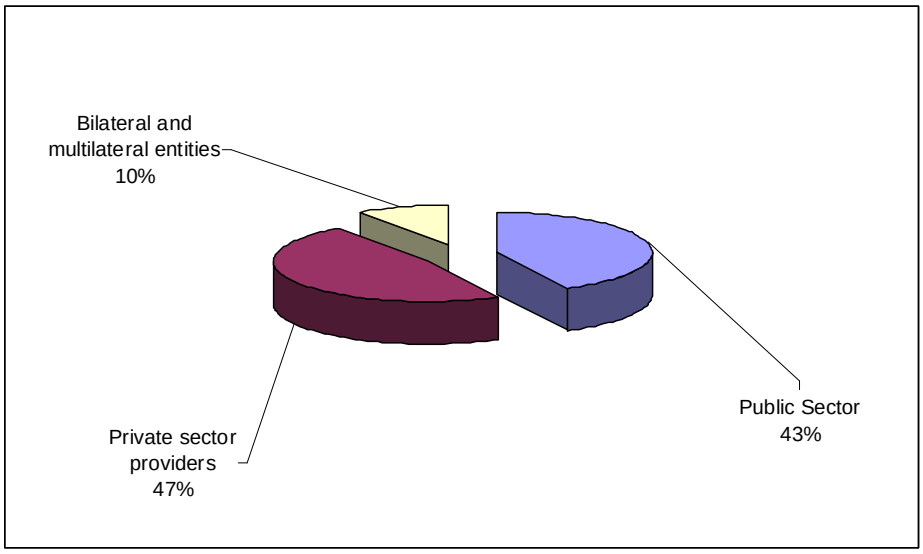


Figure 18: HIV/AIDS Service providers in 2008

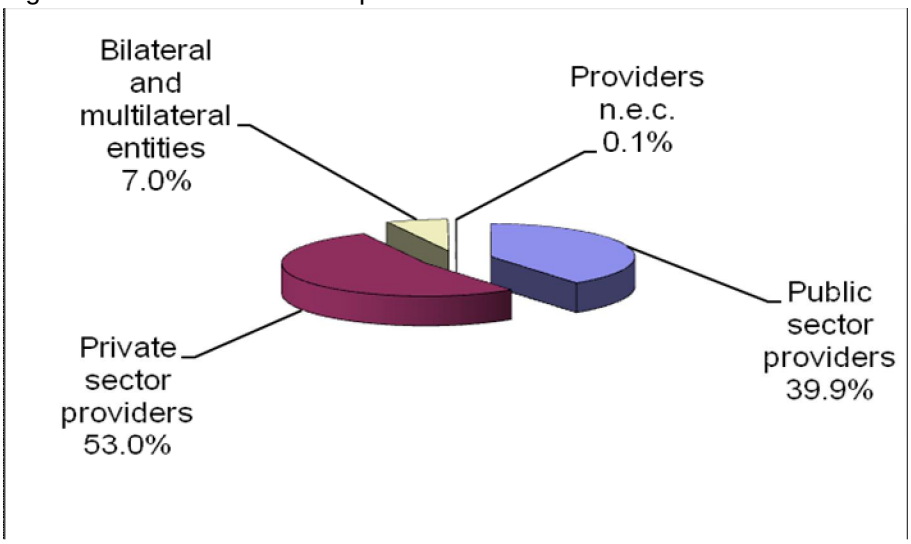
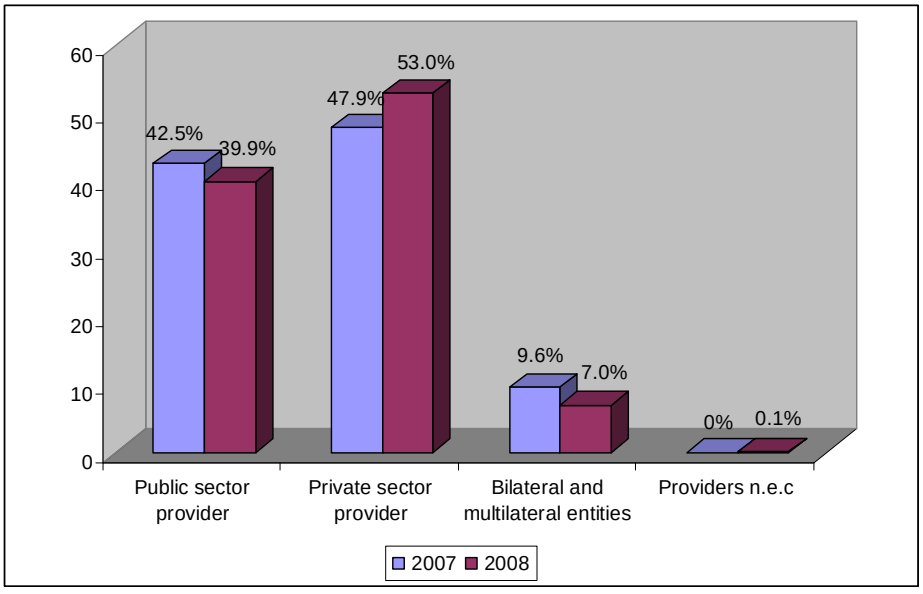


Figure 19: Comparison of HIV Service providers in 2007 and 2008



3.1.4 AIDS Spending Categories

The key spending priorities in 2007 and 2008 as highlighted in tables 12 and 13 was on Care and treatment (44.0% - $135million in 2007 and 47.1%-$185million in 2008). Figures 19 and 20 are graphic representations of the broad AIDS spending categories.

Table 12: AIDS spending categories in 2007 and 2008(1st and 2nd digits analysis)

AIDS spending Categories	2007		2008	
	Amount(USD)	%	Amount(USD)	%
Prevention	37,658,494.00	12.6	58,248,833.00	14.7
Care & treatment	135,088,119.00	45.1	185,911,643.00	47.1
OVC	5,715,138.00	1.9	9,971,820.00	2.5
Program management	102,825,134.00	34.4	117,521,162.00	29.8
Human resources	15,190,419.00	5.1	21,145,533.00	5.4
Social Protection	138,810.00	0.05	136,119.00	0.0
Enabling environment	2,561,805.00	0.9	2,011,422.00	0.5
Research	68,376.00	0.02	17,350.00	0.0
Total	**299,246,295.00**	100.0	**394,963,881.00**	100.0

Table 13: AIDS Spending Categories 2007 and 2008(3rd digit analysis)

AIDS Spending Categories	2007		2008	
	Amount (USD)	%	Amount (USD)	%
ASC 01-Prevention	**37,658,494.00**	12.58	**58,248,833.00**	**14.75**
ASC.01.01.01-Health-related communication for social and behavioural change	1,686,692.00	0.56	3,698,423.00	0.94
ASC.01.01.98-Communication for Social and behavioural change not disaggregated by type	2,918,988.00	0.98	4,344,414.00	1.10
ASC.01.02-Community mobilization	1,193,856.00	0.40	1,776,334.00	0.45
ASC.01.03-Voluntary counselling and testing (VCT)	3,741,497.00	1.25	7,851,726.00	1.99
ASC.01.04 Risk-reduction for vulnerable and accessible populations	241,234.00	0.06	1,117,226.00	0.28
ASC.01.04.02-Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	98,291.00	0.03	NA	NA
ASC.01.04.04-Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	7,966.00	0.00	NA	NA
ASC.01.04.98-Programmatic interventions for vulnerable and accessible population not disaggregated by type	134,977.00	0.05	NA	NA
ASC.01.05-Prevention ï youth in school	457,651.00	0.15	817,224.00	0.21
ASC.01.07.98-Prevention of HIV transmission aimed at PLHIV not disaggregated by type	38,258.00	0.01	NA	NA
ASC.01.06-Prevention ï youth out-of-school	264,987.00	0.09	NA	NA
ASC.01.08 Prevention programmes for sex workers and their clients	228,233.00	0.08	527,289.00	0.13
ASC.01.08.98-Programmatic interventions for sex workers and their clients not disaggregated by type	228,233.00	0.08	NA	NA
ASC.01.11.98-Programmatic interventions in the workplace not disaggregated by type	115,999.00	0.04	751,902.00	0.19
ASC.01.11.99-Other programmatic interventions in the workplace n.e.c.	35,923.00	0.01	NA	NA
ASC.01.12-Condom social marketing	3,000.00	0.00	9,925.00	0.00
ASC.01.13-Public and commercial sector male condom provision	2,333,314.00	0.78	2,014,624.00	0.51
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	NA	NA	7,200.00	0.00
ASC.01.17.01-Pregnant women counseling and testing in PMTCT programmes	270,219.00	0.09	104,439.00	0.03
ASC.01.17.02-Antiretroviral prophylaxis for HIV-infected pregnant women and newborns	706,295.00	0.24	1,015,200.00	0.26
ASC.01.17.03-Safe infant feeding practices (including	273,363.00	0.09	72,921.00	0.02

substitution of breast milk)				
ASC.01.17.98-PMTCT not disaggregated by intervention	6,050,439.00	2.02	10,298,695.00	2.61
ASC.01.17.99-PMTCT activities n.e.c.	201,136.00	0.07	1,108,113.00	0.28
ASC.01.19-Blood safety	4,349,943.00	1.45	6,579,299.00	1.67
ASC.01.20-Safe medical injections	511,492.00	0.17	1,388,770.00	0.35
ASC.01.21-Universal precautions	157,718.00	0.05	13,512.00	0.00
ASC.01.98-Prevention activities not disaggregated by intervention	11,878,257.00	3.97	14,048,408.00	3.56
ASC 02-Care and Treatment	**135,088,119.00**	**45.14**	**185,911,643.00**	**47.07**
ASC.02.01 Outpatient care	97,137,214.00	32.46	123,112,124.00	31.17
ASC.02.01.01-Provider- initiated testing and counseling (PITC)	484,267.00	0.16	NA	NA
ASC.02.01.02-OI outpatient prophylaxis and treatment	26,862,503.00	8.98	NA	NA
ASC.02.01.03-Antiretroviral therapy	67,341,574.00	22.50	NA	NA
ASC.02.01.04-Nutritional support associated to ARV therapy	195,352.00	0.07	NA	NA
ASC.02.01.05-Specific HIV-related laboratory monitoring	2,080,640.00	0.70	NA	NA
ASC.02.01.09-Home-based	42,502.00	0.01	NA	NA
ASC.02.01.98-Outpatient care services not disaggregated by intervention	130,376.00	0.04	NA	NA
ASC.02.98-Care and treatment services not disaggregated by intervention	37,917,567.00	12.67	62,707,519.00	15.88
ASC.02.99-Care and treatment services n.e.c.	33,338.00	0.01	92,000.00	0.02
ASC 03-Orphans and Vulnerable Children	**5,715,138.00**	**1.91**	**9,971,820.00**	**2.52**
ASC.03.01-OVC Education	3,122.00	0.00		
ASC.03.02-OVC Basic health care	2,210.00	0.00	9,817.00	0.00
ASC.03.03-OVC Family/home support	163,009.00	0.05	1,879,567.00	0.48
ASC.03.05-OVC Social Services and Administrative costs	495,439.00	0.17	100,468.00	0.03
ASC.03.06-OVC Institutional care	67,480.00	0.02	254,236.00	0.06
ASC.03.98-OVC Services not disaggregated by intervention	4,983,878.00	1.67	7,727,732.00	1.96
ASC 04-Programme management and administration	**102,825,134.00**	**34.36**	**117,521,162.00**	**29.75**
ASC.04.01-Planning, coordination and programme management	33,919,253.00	11.33	38,548,940.00	9.76
ASC.04.02-Administration and transaction costs associated with managing and disbursing funds	1,423,516.00	0.48	442,572.00	0.11
ASC.04.03-Monitoring and evaluation	11,476,037.00	3.83	13,136,658.00	3.33
ASC.04.04-Operations research	418,456.00	0.14	357,459.00	0.09
ASC.04.05 Serological-surveillance (sero-surveillance)	NA	NA	37,912.00	0.01
ASC.04.07-Drug supply systems	4,289,320.00	1.43	NA	NA
ASC.04.08-Information technology	523,051.00	0.17	NA	NA
ASC.04.09-Patient tracking	13,400.00	0.00	14,339.00	0.00
ASC.04.10.01-Upgrading	6,531,942.00	2.18		3.60

laboratory infrastructure and new equipment			14,221,566.00	
ASC.04.10.98-Upgrading and construction of infrastructure not disaggregated by intervention	2,785,585.00	0.93	4,538,066.00	1.15
ASC.04.10.99-Upgrading and construction of infrastructure n.e.c.	1,345,309.00	0.45	1,176,472.00	0.30
ASC.04.98-Programme management and administration not disaggregated by type	40,099,265.00	13.40	42,117,389.00	10.66
ASC 05-Human Resources	**15,190,419.00**	**5.08**	**21,145,533.00**	**5.35**
ASC.05.01.98-Monetary incentives for human resources not broken down by staff	99,517.00	0.03	162,167.00	0.04
ASC.05.03-Training	10,167,487.00	3.40	14,831,884.00	3.76
ASC.05.98-Human resources not disaggregated by type	4,923,415.00	1.65	6,047,108.00	1.53
ASC.05.99 Human resources n.e.c.	NA	NA	104,374.00	0.03
ASC 06-Social Protection and Social services	**138,810.00**	**0.05**	**136,119.00**	**0.03**
ASC.06.01 Social protection through monetary benefits	NA	NA	99,150.00	0.03
ASC.06.02-Social protection through in-kind benefits	121,679.00	0.04	11,454.00	0.00
ASC.06.03-Social protection through provision of social services	8,521.00	0.00	NA	NA
ASC.06.04-HIV-specific income generation projects	8,610.00	0.00	25,000.00	0.01
ASC.06.98 Social protection services and social services not disaggregated by type	NA	NA	515.00	0.00
ASC 07-Enabling Environment	**2,561,805.00**	**0.86**	**2,011,422.00**	**0.51**
ASC.07.01-Advocacy	1,597,783.00	0.53	1,452,067.00	0.37
ASC.07.02 Human rights programmes	64,712.00	0.02	33,445.00	0.01
ASC.07.02.01-Human rights programmes empowering individuals to claim their rights	9,525.00	0.00	NA	NA
ASC.07.02.98-Human rights programmes not disaggregated by type	55,187.00	0.02	NA	NA
ASC.07.03-AIDS-specific institutional development	894,284.00	0.30	499,635.00	0.13
ASC.07.98-Enabling environment not disaggregated by type	26.00	0.00	21,275.00	0.01
ASC.07.99-Enabling environment n.e.c.	5,000.00	0.00	5,000.00	0.00
ASC 08-HIV-Related Research	**68,376.00**	**0.02**	**17,350.00**	**0.00**
ASC.08.98-HIV and AIDS-related research activities not disaggregated by type	68,376.00	0.02	17,350.00	0.00
TOTAL	**299,246,295.00**	**100.0**	**394,963,881.00**	**100.0**

Figure 20: Broad AIDS Spending Categories in 2007

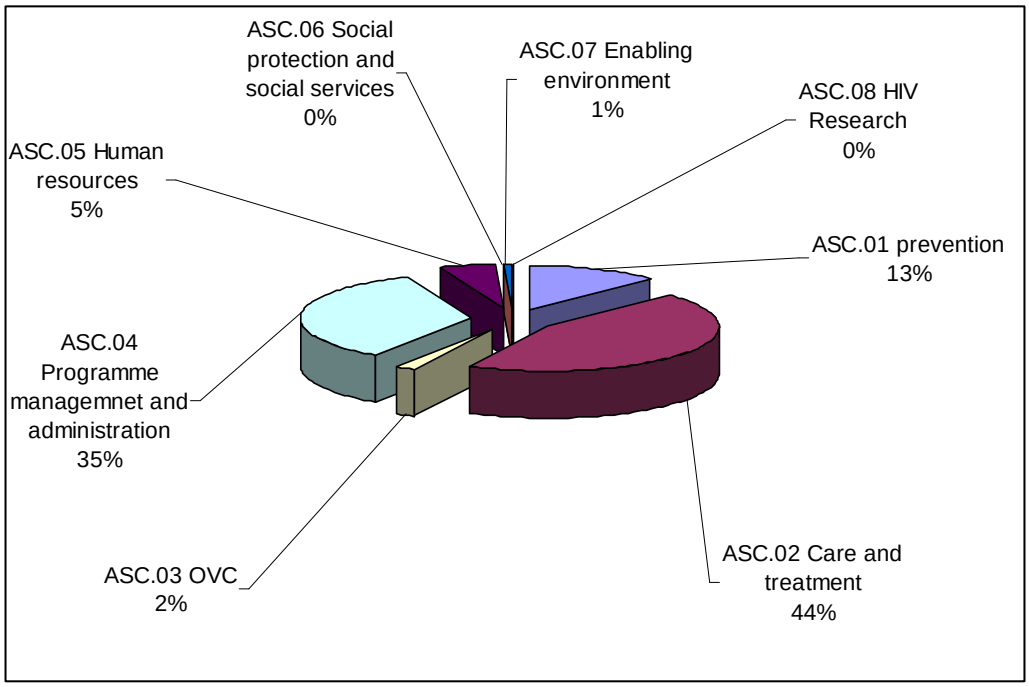
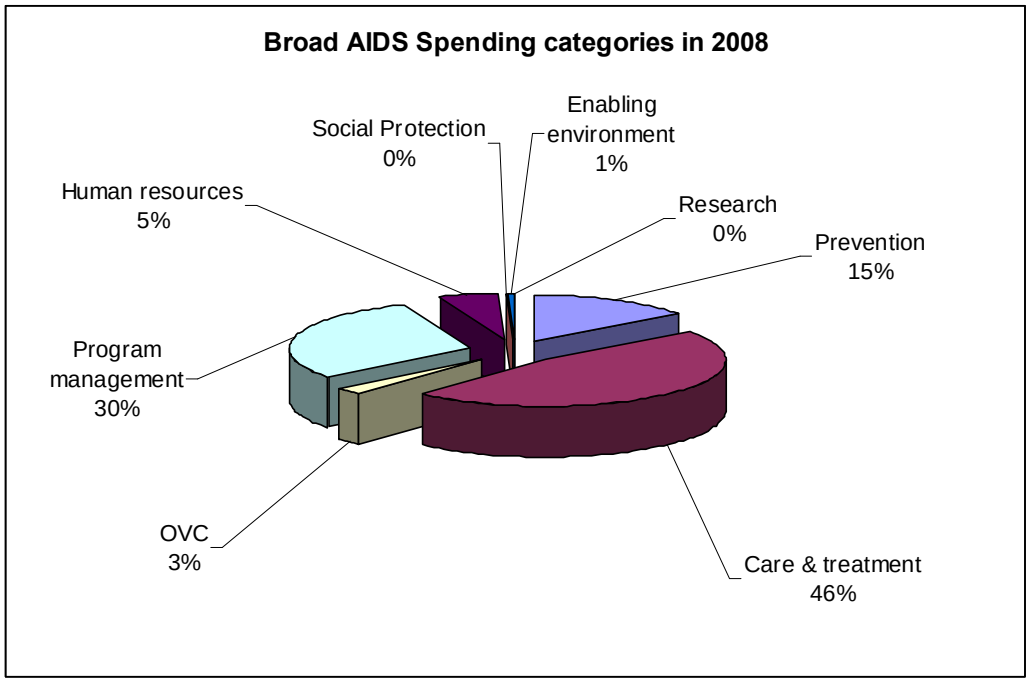


Figure 21: Broad AIDS Spending categories in 2008



3.1.5 Beneficiary populations

People living with HIV/AIDS (45.0% in 2007 and 47.3% in 2008) were the major beneficiaries of the HIV/AIDS response in 2007 in Nigeria with non-targeted intervention of 40.0% and 35.4% in 2007 and 2008 respectively. Table 14 highlights the beneficiary populations in the years under review. These are reinforced in figures 21 and 22.

Table 14: Beneficiary Populations of HIV/AIDS response in 2007 and 2008(1st, 2nd and 3rd digits analysis)

Beneficiary Population	2007		2008	
	Amount(USD)	%	Amount(USD)	%
BP.01-People living with HIV	134,148,875.00	**44.83**	**186,992,485.00**	**47.34**
BP.01.01.98-Adult and young people (15 years and over) living with HIV not disaggregated by gender	1,557,895.00	0.52	475,000.00	0.12
BP.01.02.98-Children (under 15 years) living with HIV not disaggregated by gender	6,828,592.00	2.28	919,691.00	0.23
BP.01.98-People living with HIV not disaggregated by age or gender	125,762,388.00	42.03	185,597,794.00	46.99
BP.02-Most at risk population	228,233.00	**0.08**	**539,220.00**	**0.14**
BP.02.02.98-Sex workers, not disaggregated by gender, and their clients	228,233.00	0.08	527,289.00	0.13
BP.02.98-ñMost at risk populationsò not disaggregated by type	NA	NA	11,931.00	0.00
BP.03-Other key populations	17,228,245.00	**5.76**	**29,693,322.00**	**7.52**
BP.03.01-Orphans and vulnerable children (OVC)	5,715,138.00	1.91	9,971,943.00	2.52
BP.03.02-Children born or to be born of women living with HIV	6,795,157.00	2.27	12,599,368.00	3.19
BP.03.08-Truck drivers/transport workers and commercial drivers	103,020.00	0.03	123,850.00	0.03
BP.03.11-Children and youth out of school	264,987.00	0.09	418,862.00	0.11
BP.03.14-Recipients of blood or blood products	4,349,943.00	1.45	6,579,299.00	1.67
BP.04-Specific "accessible" population	948,240.00	**0.32**	**2,141,459.00**	**0.54**
BP.04.01-People attending STI clinics	NA	NA	7,200.00	0.00
BP.04.03-Junior high/high school students	172,160.00	0.06	659,879.00	0.17
BP.04.04-University students	7,966.00	0.00	23,326.00	0.01
BP.04.05-Health care workers	157,718.00	0.05	17,640.00	0.00
BP.04.10-Factory employees (e.g. for workplace interventions)	151,922.00	0.05	751,902.00	0.19
BP.04.98-Specific ñaccessible ò populations not disaggregated by type	458,474.00	0.15	681,512.00	0.17
BP.05-General population	26,736,563.00	**8.93**	**34,771,728.00**	**8.80**
BP.05.01.98-General adult population (older than 24 years) not disaggregated by gender	1,890,030.00	0.63	171,815.00	0.04
BP.05.03.98-Youth (age 15 to 24 years) not disaggregated by gender	842,400.00	0.28	39,598.00	0.01
BP.05.98-General population not disaggregated by age or gender.	24,004,133.00	8.02	34,560,315.00	8.75
BP.06-Non targeted interventions	119,956,139.00	**40.09**	**139,932,326.00**	**35.43**
BP.99-Specific targeted populations not elsewhere classified (n.e.c.)	NA	**NA**	**893,341.00**	**0.23**
Total	**299,246,295.00**	**100.00**	**394,963,881.00**	**100**

Figure 22: Beneficiary population in 2007

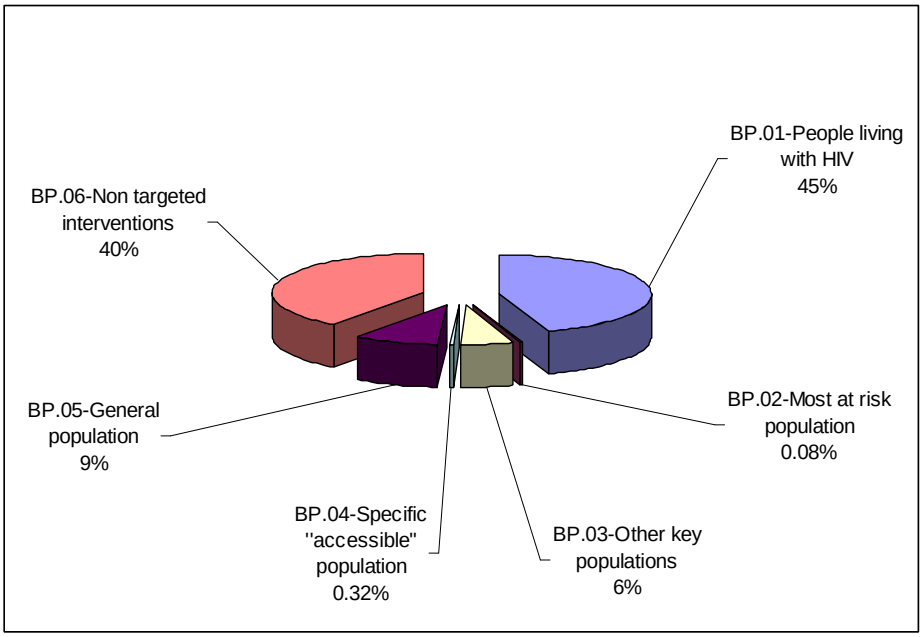


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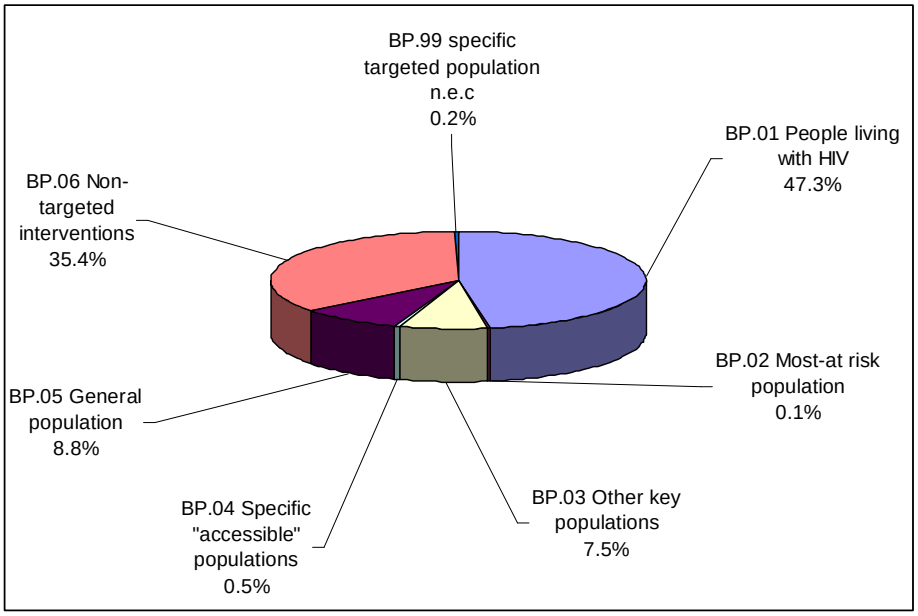
Figure 23: Beneficiary populations in 2008



In 2007, most of the public funds (74.3%) were mainly for the people living with HIV which was spent on care and treatment while the bulk of the multilateral agencies and international non-profit Organizations were for non-targetted interventions. The funding targeting most-at-risk population was mainly from the direct bilateral contributions. The details are shown in figure 23 below.

In 2008, majority of the public funds and direct bilateral contributions were mainly for the people living with HIV/AIDS(Figure 24) while all the private funds was for other key populations which includes populations such as orphans and vulnerable children, children born or to be born to HIV-positive mothers, refugees amongst others. Majority of the multilateral funds and all the international non-profit Organizations funds did not have selected or targetted populations;:these expenditures impact a broader issues mainly related

to a national systemsô strengthening and capacity building ï management, monitoring and evaluation and training

Figure 24: Beneficiary populations by Financing Source-2007

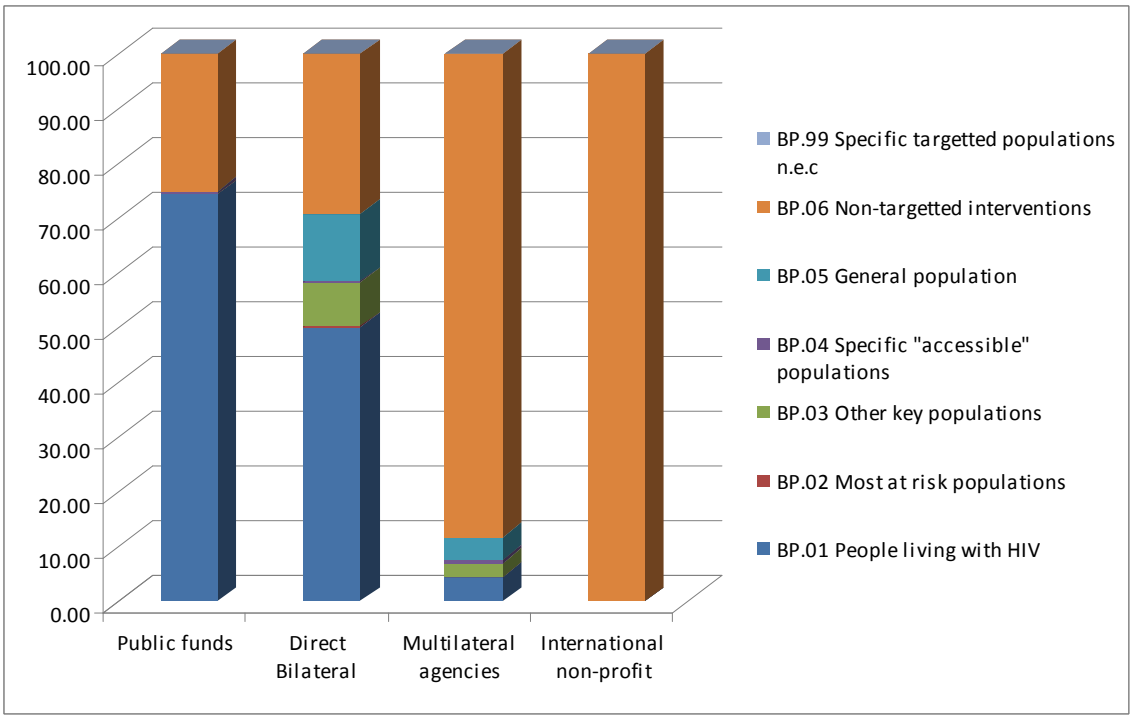
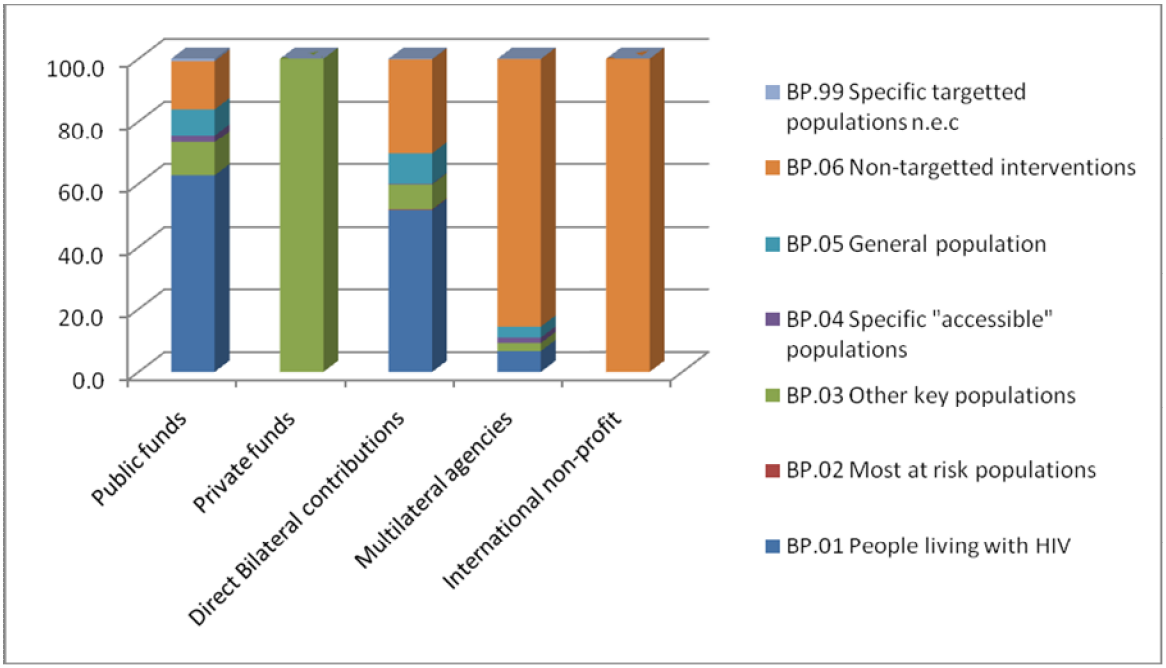


Figure 25: Beneficiary populations by Financing Source-2008



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

Table 15: Reported Official Development assistance for HIV to Nigeria, 2001-2008 (US$ millions)

Donor	2001	2002	2003	2004	2005	2006	2007	2008
Canada	-	6.365	-	2.031	4.434	2.577	1.758	0.882
Finland	-	-	-	-	-	0.027		
France	0.102	0.060	0.071	0.049	-	-		
Germany	-	-	0.017	-	0.266	0.001	0.046	0.018
Greece							0.015	
Ireland	-	-	-	-	0.068	0.124	0.145	0.081
Italy							0.056	
Japan							0.157	
Norway	-	-	-	-	0.006	-	0.035	0.030
Sweden	-	-	-	-	-	0.009	0.010	0.007
United Kingdom	2.388	1.244	1.510	2.890	3.601	25.281	30.076	32.609
United States	-	4.781	33.738	54.962	51.538	95.693	170.503	286.028
IDA	-	1.100	2.000	6.700	55.530	-		4.224
UNICEF	0.980	0.163	0.563	0.175	0.065	1.647	2.291	3.352
UNAIDS	1.103	0.275	0.884	-	1.125	-	1.151	0.988
UNFPA	-	-	0.030	-	-	-	0.279	0.315
GFATM	-	-	2.523	0.303	15.273	19.678	6.675	40.182
EC								0.507
UNDP							1.548	1.138
Total	**4.57**	**13.99**	**41.34**	**67.11**	**131.91**	**145.04**	**214.74**	**370.36**

Source: OECD database

4.0 Discussion of results

4.1 Financing Sources

Nigeria is heavily dependent on donor funding for implementing the vast majority of HIV/AIDS services. The expenditure on HIV and AIDS was $300 million in 2007 of which the majority $255,392,257.00 (85.35%) was from International funds. The breakdown of the international funds were direct bilateral contributions $197,219,367.00 (65.91%), multilateral agencies $58,140,411.00 (19.43%) and the rest were from International not-for-profit organizations and foundations amounted to $32,479 (0.01%) of the total International funds. Public sources contributed the remaining sum of $43,854,033 (14.65%) of the total expenditure for the year. There were no funds from Private sources for the year 2007.

In 2008, the same trend continued with the international funds accounting for the bulk of the expenditure on HIV/AIDS activities for the year. The International funds contributed 92.3% of the $**364,581,432.00** total expenditure while the Public fund was 7.6% of it and Private funds 0.1% of the total expenditure. The international funds was made up of $**364,581,432.00** (**92.3**%), $319,040,525.00, (80.8%) $45,477,907.00 (11.5) and $63,000.00 (0.0%) respectively for the direct bilateral contributions, multilateral agencies and International not-for profit organizations and foundations funds.

In both years under review, Nigeria HIV response was heavily dependent on international funds for implementing the vast majority of HIV/AIDS services for implementing the vast majority of HIV/AIDS services. The contribution from the public sources was minimal. This finding is in sync with the Nigeria HAPSAT which reported that only 8.0% of 2008 funding came from domestic (public) sources PEPFAR and GFATM accounted for 48.0% and 33.0% the total budget, respectively. NASA found out that 7.6% of funds were from the public sector in the same year. The window for sourcing private funds from the organized private sector like NIBUCCA had not been sufficiently explored which is apparent in the amount contributed by them. There was an increase of 32.0% in funds spent in Nigeria from 2007 to 2008.

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4.2 Financing Agents

In 2007, the International/purchasing Organizations served as the major agents for HIV/AIDS activities with $213,718,629.00 (71.42%) spent on goods and/or services out of the total expenditure of $299,246,295.00 for the year. The public sector amounted to 28.43% of the expenditure with the private sector accounting for 0.15%.The international financing agents were made up of; country offices of bilateral agencies $121,315,208 (40.54%), International not-for-profit making organizations and foundations amounted $83,367,735.00 (27.86%) and multilateral agencies $9,035,686.00 (3.02%).

The main financing agents who determined the providers, the AIDS spending categories and the beneficiary populations in 2008 were the International/purchasing Organizations. They accounted for **84.0**% of funds spent or HIV goods and/services. The public sector determined only 15% of the funds for goods and/or services while the private sector contributed 1.0%. The Government of United States was the sole bilateral agency that accounted 41.0% of the International Organizations financing agents.

In both years the same pattern of distribution occurred for the financing agents with the International agents taking majority decision on what the goods and services to be purchased for HIV intervention in Nigeria.

4.3 HIV/AIDS Service Providers

The HIV service providers were mainly from the private sector. This comprise private (nongovernmental) non-profit and profit actors providing goods and services in the response to HIV. These are Organizations in its broadest sense not directly part of the structure of Government. They accounted for 47.9% of the services provided in 2007 and 53.0% in 2008. The private providers who rendered services were the non-profit institutions with 39.3% and 48.5% in 2007 and 2008 respectively. The public sector provided 42.5% of the services which amounted for $127million in 2007 but decreased to 39.9% of the total expenditure in 2008 despite an increase in the funds they spent to $157million. The main public providers were Government Organisations followed by parastatal organizations in both years. The bilateral and multilateral entities provided minimal services in both years.

4.4 AIDS Spending Categories

In 2007 the total spending was $299,246,295.00 and the bulk of it was spent on care and treatment (45.14%), followed by Programme management and administration (34.36%). A negligible amount of $37,658,494.00 was spent on prevention. The other thematic intervention areas for which money was spent was human resources (5.08%), orphans and vulnerable children (1.91%),Enabling environment (0.86%) , Social protection and social services and research (0.05%).

In 2008, the pattern of the AIDS spending was similar to that in 2007. There was a marginal increase in spending on prevention which ought to be core HIV/AIDS intervention area. Prevention is a comprehensive set of activities or programmes to reduce risky behavior. This intervention leads to decrease in HIV infections among the population and improvements in quality and safety in health facilities.[16] However there was an increase in funding for most of the activities from 2007 to 2008 with the exception of social protection, enabling environment and Research with a decrease of 2.0%, 30.0% and 75.0% respectively. Though there was a 13.0% increase in funding for Program management, there was a considerable decrease in the percentage of total expenditure distribution for it from 34.2% in 2007 to 29.8% in 2008.

4.5 Beneficiary Population

The major beneficiaries of the HIV/AIDS response in Nigeria in 2007 and 2008 were the people living with HIV/AIDS of with 45.0% in 2007 and 47.1% in 2008.This is likely to be a morale booster for people living with HIV/AIDS and increase their confidence in Government effort to take care of their health. This was closely followed by the non-targeted interventions who do dond belong to a specific population with 40% and 35.4% in 2007 and 2008 respectively. The most at-risk who should be the priority for the monitoring and evaluation efforts of national programmes only got 0.08% in 2007 and 0.1% in 2008 of all the HIV expenditure in Nigeria. This poses a challenge to all stakeholders in Nigeria HIV response programmes

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

The NASA findings indicate that about 45% of the resources were spent on Care & Treatment, about 32% on Program Management, and about 13% on Prevention.

A situation where HIV infection has been reported from every local government area in Nigeria, where about 95% of Nigerians are HIV negative and where the potential for escalation of the epidemic exists in every community, spending only about 13% of overall program expenditure on Prevention interventions is most certainly inadequate.

HIV prevalence among female sex workers (FSW) is about 10 times that of the general population (34% vs. 3.6%). In the same vein, the HIV prevalence among men who have sex

[16] *National AIDS Spending Assessment classifications and definition,2009*

with men (MSM) and injecting drug users are higher than that of the general population. Therefore MARPS and their sexual partners play a significant role in the spread of HIV infection in Nigeria and alone contribute about one-third of new HIV infections. Against this background, spending only 0.1% of total expenditure on MARPS has been adjudged to be abysmally poor. There is a need to pay more attention to MARPS in order to reach the targets set for the National HIV/AIDS Strategic Plan.

Objective 12 of the NSP which deals with MARPS did not provide any details on the howøs and whatøs to enable its audience to objectively assess the preventive interventions targeted at MARPS both quantitatively and qualitatively. Therefore there is a need to estimate the population sizes of MARPS and the population sizes of their sexual partners. This will help to sharp focus interventions and fund allocation. We need to know what they know about HIV/AIDS/STI especially at community levels ï facts, myths and misconceptions. We need to know how and where they network among themselves and with their partners and the prevalence of specific risk behaviours. We need to understand why they chose to or are forced to become what they are and only then will we be in a better position to tailor preventive interventions to suit them.

As noted about 95% of Nigerians are HIV negative and MOT findings indicate that about two-thirds of new HIV infections are attributable to the general population. However, NASA findings indicate that only about 10% of HIV/AIDS expenditure was spent on the general population during the period under study (2007 & 2008). Program activities targeting the general population which should include behavior change communications, HCT and provision of condoms should attract more than just 10% of a total budget of USD 1,188.7 million.

It is important to strengthen strategies for targeting members of the general population especially among those who have been classified as low risk (those who have had sex with only one cohabiting partner in the last twelve months preceding the MOT study). The low risk population group contributes as much as 40% of new adult HIV infections and should be reached through programs targeted at the general population. Such programs should include couple testing and counseling and consistent use of condoms.

It is encouraging to note that the current NSP allocated about a quarter (23.5%) of the Planøs overall budget to prevention. It is hoped that this budgetary increase of almost 100% for prevention expenditures of 2007/2008 will go a long way to address previous budgetary constraints.

PMTCT had been poorly implemented in the past (captured by NASA as 2.51% and 3.2% of the overall HIV/AIDS expenditure respectively for 2007 and 2008). However, the current NSP has strengthened the national PMTCT sub-plan from both budgetary and programmatic standpoints.

NASA reveals that about 45% of the resources were spent to treat and care for PLWHA. This figure is consistent with budgetary allocations to care and treatment in various planning documents. However, this figure if maintained will only ensure that the present number of PLWHA (300,000) will be maintained. The situation will not allow for new ART-eligible cases to be put on ART even if many of those who are on first line ART ñgraduateò more expensive second line ART.

Therefore increase of budgetary allocation to almost 50% for treatment (ART and OI including TB) in the current NSP is a welcome development as this may provide the latitude to put more patients on ART.

Biomedical and operations research serve to provide answers to research questions and provide evidence-based data and information for informed policy formulation and program planning. NASA findings indicate that expenditure on research was 0.02% in 2007 and just above 0% in 2008.

The current NSP has again failed to give prominence to research. Rather, as has been the case in the past, research is subsumed under M&E and as such, does not have a dedicated budget line item. It is therefore very likely that expenditure on research may remain 0% in the coming five to six years of the life of the NSP if the situation is not properly and adequately addressed. It is therefore recommended the planed research policy/agenda should be implemented vigorously.

In the current NSP, NACA noted that ñin general, government entities at all levels appear reluctant to implement 1% budget allocation to HIV/AIDS approved nationallyò. This situation calls for increased and intensified advocacy to political leaders. However, only about 1% of the 2007 and 2008 HIV/AIDS expenditure was spent on Enabling Environment (mainly advocacy).

Advocacy to political office holders and policy makers should be intensified to secure more commitment and support in the hope that sooner than later government at all levels will begin to dedicate up to 1% of their entire budget to fight the HIV/AIDS epidemic.

It is interesting to note that about 32% of the total expenditure was spent on Program Management and Administration. This may indeed be reflective of Donors overhead costs and those of their Implementing Partners. It is important to take this expenditure item into consideration when costing national HIV/AIDS plans since donors provide funds for over 85% of HIV/AIDS program activities in Nigeria.

5.0 Conclusion and Recommendations

5.1 Conclusion

#	Key Message	Details
1.	**HIV spending:**	HIV spending increased from $ 299 million in 2007 to almost $400 million in 2008
2.	**Increased spending:**	HIV spending increased by 14.0% from 2007 to 2008.
3.	**Financing of the HIV response:**	The HIV response in Nigeria is highly dependant on international funds. 85.3% of the funds in 2007 and 92.3% of funds in 2008 came from international sources. Bilateral agencies were the main source of funding in Nigeria in the period of analysis.
4.	**Financial decision making for the HIV response:**	Most of the funds are coming from international sources and only 28.4% and 15.0% of the funds were managed by public institutions in 2007 and 2008 respectively (mainly Federal Ministry of Health in 2007 and NACA in 2008).
5.	**Profile of Spending:**	Care and treatment was the programmatic area which captured most of the spending, accounting for 45.1% and 47.1% of total HIV spending in 2007 and 2008 respectively. Programme management captured a significant share of HIV spending in Nigeria (34.4% and 29.8% in 2007 and 2008 respectively).
6.	**Funding for Prevention programmes has increased:**	Overall total expenditure on prevention showed a dismal increase from 12.6% of 2007 total spending to 14.7% in 2008.
7.	**Programme management relative weight increased in the period of analysis:**	The spending on programme management and administration strengthening was $102million in 2007 and $117million in 2008.
8.	**People living with HIV/AIDS was the main beneficiary population:**	In 2007 and 2008 close to half of the spending ($ 134 million in 2007 and $187million in 2008) was addressed to the people living with HIV/AIDs, 40.0% and 35.4% in 2007 and 2008 respectively to non targeted interventions and 9.0% of the spending in 2007 and 2008 was addressed to the general population.
9.	**Relatively low spending on MARPS.**	Spending addressed to the most at risk populations captured 0.08% of total spending in 2007 and 0.14% in 2008.

5.2 Recommendations

#	Key Message	Details
1.	**Institutionalize NASA**	Institutionalize the NASA process in Nigeria for ease of data collection and also reporting on HIV and AIDS spending. The key issues that need to be addressed are a) greater advocacy to all stake holders, b) streamlining of financial disbursement and reporting mechanisms; c) the NACA coordinating mandate has to be enforced - that is a suitable mechanism has to be introduced that will track HIV and AIDS from source to provider in Nigeria and d) institutions should be more open in their disclosure of their financial records on HIV to allow a more robust categorization of the expenditure
2.	**Involve NASA spending estimates in Nigeria in a continuum improvement cycle:**	Spending on STIs and OI was underestimated in this first exercise. It is recommended that a more detailed and parsimonious analysis is done on the future NASA excursive.
3.	**Use NASA for National planning**	Use NASA data to determine the comprehensiveness and robustness of the national HIV/AIDS strategic plan and/or sub-plans. Use NASA data for priority setting in HIV/AIDS planning processes.
4.	**Increase level of spending on MARPS:**	Programmes targeting MARPS should be strengthened and expanded to include studies on the characteristics and behaviours of this sub-population and their sexual partners..
5.	**Improve PMTCT**	PMTCT programming should be cyclical and funding at all levels should reflect this. Targets should be set on annual basis as well as budgetary

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Appendices

Annex 1 – Contacted Institutions and data collectors

S/N	Institution	Contact person
1	Action Aid	Nkiru Maduekesi
2	Africare	Doherty Orode
3	AIDS Prevention Initiative in Nigeria/Harvard University (APIN)	Nanlop Ogbureke
4	AIDS relief/Catholic Relief Services	Andrea Rogers
5	Association of Reproductive and family health(ARFH)	Dr Joseph Majiyagbe
6	Benue State AIDS Control Agency	Mr.Joseph Tyovenda
7	Center for Development and population activities(CEDPA)	Leila Madueke
8	Centers for Disease Control and Prevention	Stanley Amadiagwu
9	CHAN	Jennifer Brinkerhoff
10	Chemonics	Alan Bright
11	Christian AID	Olusola Onifade
12	Clinton Foundation	Hajara Santali
13	Cross River State AIDS Control Agency	Rosemary Akpagu
14	Department for International Development(DFID)/ENR	Dr.Omokhudu Idogho
15	Department of Defense(DOD)	Funke Ladipo
16	Ebonyi State AIDS Control Agency	U.K.Anya
17	Enugu State AIDS Control Agency	DR.C.C.Ani
18	Excellence Community Educational Welfare Scheme (ECEWS)	Gloria Morah
19	Family Health International	Tim Lockhart
20	Federal Government of Nigeria	Femi Akinmade
21	Federal Medical Store	Mr.Linus
22	Federal Ministry of Education	Mr.J.T.Akinfola
23	Federal Ministry of Health (NASCP)	Segilola Araoye
24	Federal Ministry of Women affairs and Social Development	Odo.T.I.
25	Food and Agriculture Organization	Offiaukwu Florence
26	Global fund	Louis Edema

27	Hope Worldwide	Ebunoluwa Jayesimi
28	Imo State AIDS Control Agency	Okonkwo Paul
29	Institute of Human Virology of Nigeria	Debo Olateju / ObilikiruJohnson
30	International Center for AIDS Care and treatment Program/Columbia University (ICAP)	Funmi Adegbesan
31	International foundation for Education and self help(IFRESH)	Tari M. Lawson
32	John Snow /AIDSTAR-one	Funke Jibowu
33	John Snow Inc /Measure Evaluation	Kola Oyediran
34	John Snow Inc./ SCMS-Partnership for supply chain management Inc	Johnnie Ameneyah
35	Joint United Nations Programme on HIV/AIDS (UNAIDS)	Bisi Ajayi
36	Kaduna State AIDS Control Agency	Dr. Mark Anthony
37	Lagos State AIDS Control Agency	Dr.Olusegun Ogboye
38	Management Sciences for Health	Donna coulibaly
39	Nassarawa State AIDS Control Agency	Ibrahim A.Azara
40	National Agency for the Control of HIV/AIDS	Femi Akinmade
41	National Blood Transfusion Safety	Zakari Mohammed
42	NELA	Prof.Femi Soyinka
43	Nigeria Labour Congress	Maureen Onyia
44	Nigerian Business Coalition Against AIDS (NIBUCCA)	Olusina O. Falana
45	Ondo State AIDS Control Agency	Kehinde O.Adebayo
46	OSSAP-MDGs	Barth Feese
47	Partners For Development	Fatiya Askederin
48	Population Council	Andrew Karlyn
49	Safe Blood for Africa Foundation	Asmau Aminu
50	Society for Family Health	Joy Ikede
51	Taraba State AIDS Control Agency	Phillips Sunsuwa
52	United Nations Children Fund (UNICEF)	Mrs. Ibilola Olayinka
53	United Nations Development fund for women (UNIFEM)	Yemi Jaji
54	United Nations Development Programme(UNDP)	Nicole K
55	United Nations Educational, Scientific and Cultural Organization (UNESCO)	Macaulay Olusola

56	United Nations High Commission for Refugees(UNHCR)	Terna Abbo
57	United Nations office for Drug and Crime(UNODC)	Ukamaka Osigwe
58	United Nations population Fund (UNFPA)	Mr. Abolade Sobola
59	United States Agency for International Development (USAID)	Christina Lau
60	Vanderbilt University	Robb Reeds
61	Winrock International/AIDS impact mitigation project	Justina Alamba
62	World Bank	Cisse Boubou
63	World Health Organization (WHO)	Ibrahim A.A

Data collectors

S/N	Name
1	Emmanuel Ogidan
2	Kenneth Anosike
3	Ofonekem Offong
4	Christy Ashefor
5	Kelechi Onyebuchi
6	Gbenga Orukosan
7	Babajide Agbaje
8	Ifanayajo Vincent
9	Bukky Ayanwuyi
10	Sylvester Zaniye

Annex 2-Time line for NASA implementation

Activities	9-Aug		Sep-09				Oct-09				Nov-09				Dec-09				Jan-10						
	W3	W 4	W 1	W2	W 3	W4	W 1	W2	W 3	W4	W 1	W 2	W 3	W4	W 1	W2	W 3	W 4	W1	W 2	W3	W4	W 1	W2	W3
Recruitment of consultants																									
Preparatory activities																									
Training of NASA core team																									
Advocacy meetings																									
Data collection																									
Data analysis																									
Data validation																									
Preliminary outputs																									
NASA outputs triangulation																									
Report writing																									
Report validation																									
Report printing and dissemination																									

Assumption on Exchange rate

The Naira to US dollars exchange fluctuated tremendously in 2007 and 2008.An average exchange rate of N115 to 1 USD was assumed for all the public funds, GFTAM and World Bank transactions. The other institutions reported all their expenditure in US dollars.

Estimation of ART drug consumption and costs

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

- STI drugs distributed
- Antiretroviral distributed for treatment and prevention
- The first and second line ARVs distributed in 2007 and 2008
- Disaggregation of the first and second line ARVs distributed by adult and pediatrics

Assumptions for ART laboratory monitoring and OI diagnostics estimations

No data on the exact amount of tests done in 2007 and 2008 is available. National ART guideline was used to estimate number of tests. The following information regarding different types of tests was used.

	2007	2008
Number of patients on ART	2,900,000	2,952.000
Male patients on ART	N/A	N/A
Female patients on ART	N/A	N/A

Source: Federal Ministry of Health

Assumptions regarding laboratory monitoring of ART and OI diagnostics are accepted by National ART coordinator as relevant.

Type of test	Number of tests per patient per year	2007	2008
HIV Serology	1	2900000	2952000
CD4	2	5800000	5904000
Hib	3	8700000	8856000
Liver function test	2	5800000	5904000
Renal function test	2	5800000	5904000
HB2Aq	1	2900000	2952000
UDRL and TPHA (STI tests)	1	2900000	2952000
Chest testing	1	2900000	2952000
sputum test	1	2900000	2952000

No information regarding cost of each of the tests was available. Estimations were done based on the data in 2007/2008 procurement lists and from the interview with lab specialists.

STI treatment estimations

STIs

In Nigeria, there are about 3 million reported annual cases of STIs mainly caused by Chlamydia, N. Gonorrhoeae and trichomonas vaginalis. There are also increasing reports of genital ulcer disease (GUD) due to chancroid, herpes, and primary syphilis.[17]. It was difficult to measure STI-related spending as the team did not have access to information on procured drugs for STI treatment projected in the GFATM proposal for 2007 and 2008.

[17] FMoH, National Guidelines on Syndromic Management of Sexually Transmitted Infections (STIs) and other Reproductive Tract Infections (RTIs

OI prophylaxis and treatment estimations

O.I TREATMENT COSTS

OI s		Drug to be used (OIs)	Treatment Regimen	Number of tabs/ regimen	Number of episodes /patient	Unit Cost ($)	Year 1 (2007)		Year 2 (2008)	
Candidiasis							Patient Population			
							Number of tabs/pop	Total Cost	Number of tabs/pop	Total Cost
	Oral	Nystatin- 500,000 IU	4x/day for 5 days	20	1	0.0461	654,080.00	30,153.09	1,000,160.00	46,107.38
	Oesophagitis	Fluconazole- 200 mg	1/day for 105 days	105	1	0.0416	1,471,680.00	61,221.89	2,250,360.00	93,614.98
	Vulvo-vaginal	Clotrimazole- 500 mg	1/day	1	6	1.1232	140,160.00	157,427.71	214,320.00	240,724.22
Herpes										
	Oral and genital	Acyclovir 200 mg	5/day for 10 days	50	1	0.083	700,800.00	58,166.40	1,071,600.00	88,942.80
	Herpes zoster	Acyclovir 200 mg	20/day for 10 days	200	1	0.083	1,868,800.00	155,110.40	2,857,600.00	237,180.80
Diarrhea										
	Bacterial	Metronidazole 400 mg	2x/day for 10 days	20	2	0.0039	280,320.00	1,093.25	428,640.00	1,671.70
		Cotrimoxazole 960 mg	2x/day for 10 days	20	2	0.013	280,320.00	3,644.16	428,640.00	5,572.32
		Ciprofloxacin 500 mg	1x/day for 10 days	10	2	0.0253	140,160.00	3,546.05	214,320.00	5,422.30
Pneumonia										
	Bacterial	Amoxycillin 500 mg	4x/day for 10 days	40	1	0.0352	467,200.00	16,445.44	714,400.00	25,146.88
	PCP prophylaxis	Cotrimoxazole 960 mg	1x/day for 360 days	360	1	0.013	300,000.00	3,900.00	500,000.00	6,500.00
	PCP	Cotrimoxazole 960 mg	8x/day for 21 days	168	1	0.013	1,962,240.00	25,509.12	3,000,480.00	39,006.24

Crypcococal Mengitis										
		Amphotericin B 50 mg (INJ)	1 (0.7 mg/kg) x/day for 14 days	14	1	7.1837	6,540.80	46,987.14	10,001.60	71,848.49
		Flucytosine 100 mg	1x/day for 14 days	14	1		6,540.80	0.00	10,001.60	0.00
		Fluconazole- 200 mg	2x/day for 56 days	56	1	0.1125	26,163.20	2,943.36	40,006.40	4,500.72
Toxoplasmosis										
	<60 kg	Pyrimethamine-25 mg	2x/day for 42 days	42	1	0.0055	9,811.20	53.96	15,002.40	82.51
	>60 kg	Pyrimethamine-25 mg	3x/day for 42 days	42	1	0.0055	9,811.20	53.96	15,002.40	82.51
		Clotrimoxazole 960 mg	2x/day for 42 days	84	1	0.013	19,622.40	255.09	30,004.80	390.06
Fungal Skin Infections		Miconazole, 2% in 30 mg	2 tube/patient	2	2	0.333	74,752.00	24,892.42	114,304.00	38,063.23
Scabies		Benzyl Benzoate, 25 %, 100ml	1bottle/patient	1	1	0.0025	467.20	1.17	714.40	1.79
Bacterial Skin Infections		Amoxycillin 500 mg	4x/day for 5 days	20	1	0.0352	467,200.00	16,445.44	714,400.00	25,146.88
TOTAL								607,850.05		930,005.81

Source: NACA

Appendix 4 – PEPFAR-NASA categories Crosswalk for Nigeria

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

Appendix 5 – Letter used for data collection

Letter to Donors and Government Ministries

8th September 2009

To: IPs

Sir/Ma,

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

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

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

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

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

The Objectives of this training are:

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

The detail for this meeting is as follows:

Venue: Vine Hotel, Abuja

Date: Thursday 17th September and Friday 18th September 2009

Thank you.

Dr. Greg Ashefor

For Director

Strategic Knowledge Management Department

National Agency for the Control of AIDS

FORM [1] – Year:_____ (2007 or 2008)

HIV RESPONSE INSTITUTIONS

This information is confidential

Year under study: ***Date:*** ***/ / 09***

1. - Identification of the Institution

[ ]

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

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

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

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

Select with an x if values are in local currency:
Select with an x if values are in USD (***Recommended***):
Other (Euro, etc), please specify:

		Exchange rate
Nigerian naira		
USD		
_____		

2. Origin of funds (OF)

Indicate:

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

Name of the Institution	**Amount received in 2007**	**Amount received in 2008**	***Amount spent in 2007***	***Amount spent in 2008***	***Amount transferred to other Institutions in 2007***	***Amount transferred to other Institutions in 2008***
OF [1]						
OF [2]						
OF [3]						
OF [4]						
OF [5]						
OF [6]						
OF [7]						
OF [8]						
OF [9] Personal Donation						
OF [10] Own funds						
TOTAL						

-If the institution utilized funds, procede to fill in section 4 for each of the amount utilized.
-Personal Donations: cash gifts from individuals (Note: Corporations or other institutions should be captured on OF [1] to OF [8]).
-Own funds: funds generated by the institution (e.g.: income generation activities such as: lottery, raffle draws, etc)

3. Use of Funds:

Indicate in the next 10 tables how the funds from each origin of funds was spent:
Describe the categories conducted
If one activity is targeting more than one beneficiary populations, please fill in the next row

OF [1] Funds				
Activity (Description)	NASA Code for the Activity (please refer to NASA Catalogues code and name)	Beneficiary population (Description)	2007	2008

Funds-Production Factors

Funds - Production Factors 2007										
Salaries	**Antiretrovirals**	**Condoms**	**Other material and supplies**	**Services**	**Buildings (constructions, renovations)**	**Laboratory upgrading**	**Equipment**	**Other capital expenditures**	**No information on PF**	**Total**
Funds - Production Factors 2008										
Salaries	**Antiretrovirals**	**Condoms**	**Other material and supplies**	**Services**	**Buildings (constructions, renovations)**	**Laboratory upgrading**	**Equipment**	**Other capital expenditures**	**No information on PF**	**Total**

4. Funds transferred:

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

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

Name of the institution which received the fund coming from source OF [1]	**Amount transferred in 2007**	**Amount transferred in 2008**	***Amount reported as spent in 2007***	***Amount reported as spent in 2008***
DF [1]				
DF [2]				
DF [3]				
DF [4]				
DF [5]				
DF [6]				
DF [7]				
DF [8]				
DF [9]				
DF [10]				
TOTAL				

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

5. Condom distribution:

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

Name of the Institution from which the condoms were received	**Description of the condom distribution**	**Beneficiary population receiving the condoms. (e.g.: general population). Please use NASA catalogue to identify the Beneficiary**	**Quantity received in 2007 (units)**	**Quantity received in 2008 (units)**	**Quantity distributed in 2007 (units)**	**Quantity distributed in 2008 (units)**

6. In-kind donations:

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

Name of the Institution from which the donation was received	Description of items receiced (type and quantity)	Description of the use of the items received	Quantity received in 2007 (units)	Quantity received in 2008 (units)	Quantity distributed in 2007 (units)	Quantity distributed in 2008 (units)

Annex 7 – Status on data collected

Institution	2007		2008	
	Transaction	Type of Data	Transaction	Type of Data
AIDS Prevention Initiative in Nigeria/Harvard University (APIN)	↓	RE, B	↓	RE, B
AIDS relief/Catholic Relief Services	↓	RE, B	↓	RE, B
Association of Reproductive and family health(ARFH)	↓↑	RE, B	↓↑	RE, B
Benue State AIDS Control Agency	↓	RE	↓	RE
Center for Development and population activities(CEDPA)	↓	RE, B	↓	RE, B
Centers for Disease Control and Prevention	↓↓↑	RE, B	↓↓↑	RE, B
Christian AID	↓	RE, B	↓	RE, B
Clinton Foundation	↑	E	↑	E
Cross River State AIDS Control Agency	↓	RE	↓	RE
Department for International Development(DFID)/ENR	↓	RE	↓	RE
Department of Defense(DOD)	↓↓↑	RE, B	↓↓↑	RE, B
Ebonyi State AIDS Control Agency	↓	RE	↓	RE
Enugu State AIDS Control Agency	↓	RE	↓	RE
Excellence Community Educational Welfare Scheme (ECEWS)	↓	RE, B	↓	RE, B
Family Health International	↓↑	RE, B	↓↑	RE, B
Federal Government of Nigeria	↓	RE, B	↓	RE, B
Federal Ministry of Education	↓	RE, B	↓	RE, B
Federal Ministry of Health (NASCP)	↓	RE, B	↓	RE, B
Global fund	↓,↓↑	RE	↓,↓↑	RE
Imo State AIDS Control Agency	↓	RE	↓	RE
Institute of Human Virology of Nigeria	↓	RE, B	↓	RE, B

International Center for AIDS Care and treatment Program/Columbia University (ICAP)	🡻,↓↑	**RE, B**	🡻,↓↑	**RE, B**
International foundation for Education and self help(IFRESH)	🡻	**RE, B**	🡻	**RE, B**
John Snow /AIDSTAR-one	↓↑	**RE, B**	↓↑	**RE, B**
John Snow Inc /Measure Evaluation	🡻	**RE, B**	🡻	**RE, B**
John Snow Inc./ SCMS-Partnership for supply chain management Inc	🡻,↓↑	**RE, B**	🡻,↓↑	**RE, B**
Joint United Nations Programme on HIV/AIDS (UNAIDS)	🡻	**RE, B**	🡻	**RE, B**
Kaduna State AIDS Control Agency	🡻	**RE**	🡻	**RE**
Lagos State AIDS Control Agency	🡻	**RE**	🡻	**RE**
Management Sciences for Health	🡻	**RE, B**	🡻	**RE, B**
Nassarawa State AIDS Control Agency	🡻	**RE**	🡻	**RE**
National Agency for the Control of HIV/AIDS	🡻,↓↑	**RE, B**	🡻,↓↑	**RE, B**
National Blood Transfusion Safety	🡻	**RE, B**	🡻	**RE, B**
Nigeria Labour Congress	🡻	**RE, B**	🡻	**RE, B**
Ondo State AIDS Control Agency	🡻	**RE, B**	🡻	**RE, B**
Partners For Development	🡻	**RE, B**	🡻	**RE, B**
Population Council	🡻	**RE, B**	🡻	**RE, B**
Safe Blood for Africa Foundation	🡻,↓↑	**RE, B**	🡻,↓↑	**RE, B**
Society for Family Health	🡻,↓↑	**RE, B**	🡻,↓↑	**RE, B**
Taraba State AIDS Control Agency	🡻,↓↑	**RE, B**	🡻,↓↑	**RE, B**
United Nations Children Fund (UNICEF)	🡻	**RE, B**	🡻	**RE, B**
United Nations Development fund for women (UNIFEM)	🡻	**RE, B**	🡻	**RE, B**
United Nations Development Programme(UNDP)	🡻	**RE, B**	🡻	**RE, B**
United Nations Educational, Scientific and Cultural Organization (UNESCO)	🡻	**RE, B**	🡻	**RE, B**
United Nations High Commission for Refugees(UNHCR)	🡻	**RE, B**	🡻	**RE, B**
United Nations office for Drug and Crime(UNODC)	🡻	**RE, B**	🡻	**RE, B**
United Nations population Fund (UNFPA)	🡻	**RE, B**	🡻	**RE, B**

United States Agency for International Development (USAID)	↓,↓↑	**RE, B**	↓,↓↑	**RE, B**
Vanderbilt University	↓	**RE, B**	↓	**RE, B**
Winrock International/AIDS impact mitigation project	↓	**RE, B**	↓	**RE, B**
World Bank	↓,↓↑	**RE, B**	↓,↓↑	**RE, B**
World Health Organization (WHO)	↓	**RE, B**	↓	**RE, B**

"Transaction":	
↓Top down	↑Bottom up
↓↑Top down and Bottom up	
"Type of Data":	
RE Reported Expenditures	
E Estimated based on the production of good and services using P*Q approach	
B Budget figures	

2007ï Financing Sources to AIDS Spending Categories ï USD

ASC level 1	ASC level 2	FS.01 Public funds Total	FS.03.01 Direct bilateral contributions	FS.03.02 Multilateral Agencies (ii)	FS.03.03 International not-for-profit organizations and foundations	FS.03 International funds Total	Grand Total
ASC.01 Prevention	ASC.01.01 Communication for social and behavioural change	47,998.00	4,189,083.00	368,599.00		4,557,682.00	4,605,680.00
ASC.01 Prevention	ASC.01.02 Community mobilization		967,924.00	225,932.00		1,193,856.00	1,193,856.00
	ASC.01.03 Voluntary counselling and testing (VCT)		3,122,260.00	619,237.00		3,741,497.00	3,741,497.00
	ASC.01.04 Risk-reduction for vulnerable and accessible populations		103,020.00	138,214.00		241,234.00	241,234.00
	ASC.01.05 Prevention ï youth in school	190,258.00	141,010.00	126,383.00		267,393.00	457,651.00
	ASC.01.06 Prevention ï youth out-of-school		264,987.00			264,987.00	264,987.00
	ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)		33,971.00	4,287.00		38,258.00	38,258.00
	ASC.01.08 Prevention programmes for sex workers and their clients		228,233.00			228,233.00	228,233.00
	ASC.01.11 Prevention programmes in the workplace	4,274.00		147,648.00		147,648.00	151,922.00
	ASC.01.12 Condom social marketing			3,000.00		3,000.00	3,000.00
	ASC.01.13 Public and commercial sector male condom provision		2,304,586.00	28,728.00		2,333,314.00	2,333,314.00
	ASC.01.17 Prevention of mother-to-child transmission (PMTCT)		6,630,475.00	870,977.00		7,501,452.00	7,501,452.00
	ASC.01.19 Blood safety		4,349,943.00			4,349,943.00	4,349,943.00
	ASC.01.20 Safe medical injections		511,492.00			511,492.00	511,492.00
	ASC.01.21 Universal precautions		157,718.00			157,718.00	157,718.00
	ASC.01.98 Prevention activities not disaggregated by intervention		11,414,056.00	464,201.00		11,878,257.00	11,878,257.00
ASC.01 Prevention		242,530.00	34,418,758.00	2,997,206.00		37,415,964.00	37,658,494.00

Total							
ASC.02 Care and treatment	ASC.02.01 Outpatient care	32,477,778.00	64,508,692.00	150,744.00		64,659,436.00	97,137,214.00
	ASC.02.98 Care and treatment services not disaggregated by intervention		35,455,411.00	2,462,156.00		37,917,567.00	37,917,567.00
	ASC.02.99 Care and treatment services n.e.c.		33,338.00			33,338.00	33,338.00
ASC.02 Care and treatment Total		32,477,778.00	99,997,441.00	2,612,900.00		102,610,341.00	135,088,119.00
ASC.03 Orphans and vulnerable children (OVC	ASC.03.01 OVC Education	1,499.00		1,623.00		1,623.00	3,122.00
	ASC.03.02 OVC Basic health care			2,210.00		2,210.00	2,210.00
	ASC.03.03 OVC Family/home support		158,752.00	4,257.00		163,009.00	163,009.00
	ASC.03.05 OVC Social Services and Administrative costs			495,439.00		495,439.00	495,439.00
	ASC.03.06 OVC Institutional care			67,480.00		67,480.00	67,480.00
	ASC.03.98 OVC Services not disaggregated by intervention		4,983,287.00	591.00		4,983,878.00	4,983,878.00
ASC.03 OVC Total		1,499.00	5,142,039.00	571,600.00		5,713,639.00	5,715,138.00
ASC.04 Programme management and administration	ASC.04.01 Planning, coordination and programme management	8,513,914.00	18,249,082.00	7,156,257.00		25,405,339.00	33,919,253.00
	ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	403,320.00	13,080.00	1,007,116.00		1,020,196.00	1,423,516.00
	ASC.04.03 Monitoring and evaluation	220,223.00	5,908,020.00	5,315,315.00	32479	11,255,814.00	11,476,037.00
	ASC.04.04 Operations research		143,910.00	274,546.00		418,456.00	418,456.00
	ASC.04.07 Drug supply systems		1,484,750.00	2,804,570.00		4,289,320.00	4,289,320.00
	ASC.04.08 Information technology	49,786.00		473,265.00		473,265.00	523,051.00
	ASC.04.09 Patient tracking		13,400.00			13,400.00	13,400.00
	ASC.04.10 Upgrading and construction of infrastructure	17,653.00	9,194,858.00	1,450,325.00		10,645,183.00	10,662,836.00
	ASC.04.98 Programme management and administration not disaggregated by type	428,544.00	14,394,721.00	25,276,000.00		39,670,721.00	40,099,265.00
ASC.04 Programme management Total		9,633,440.00	49,401,821.00	43,757,394.00	32479	93,191,694.00	102,825,134.00
ASC.05 Human	ASC.05.01 Monetary incentives for human		59,721.00	39,796.00		99,517.00	

resources	resources						99,517.00
	ASC.05.03 Training	1,296,930.00	3,307,190.00	5,563,367.00		8,870,557.00	10,167,487.00
	ASC.05.98 Human resources not disaggregated by type		4,441,420.00	481,995.00		4,923,415.00	4,923,415.00
ASC.05 Human resources Total		1,296,930.00	7,808,331.00	6,085,158.00		13,893,489.00	15,190,419.00
ASC.06 Social protection and social services (excluding OVC)	ASC.06.02 Social protection through in-kind benefits	121,679.00					121,679.00
	ASC.06.03 Social protection through provision of social services	8,521.00					8,521.00
	ASC.06.04 HIV-specific income generation projects	3,279.00	2,000.00	3,331.00		5,331.00	8,610.00
ASC.06 Social protection and social services (excluding OVC) Total		133,479.00	2,000.00	3,331.00		5,331.00	138,810.00
ASC.07 Enabling environment	ASC.07.01 Advocacy		388,771.00	1,209,012.00		1,597,783.00	1,597,783.00
	ASC.07.02 Human rights programmes		55,187.00	9,525.00		64,712.00	64,712.00
	ASC.07.03 AIDS-specific institutional development			894,284.00		894,284.00	894,284.00
	ASC.07.98 Enabling environment not disaggregated by type		26.00			26.00	26.00
	ASC.07.99 Enabling environment n.e.c.		5,000.00			5,000.00	5,000.00
ASC.07 Enabling environment Total			448,984.00	2,112,821.00		2,561,805.00	2,561,805.00
ASC.08 HIV and AIDS-related research (excluding operations research)	ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	68,376.00					68,376.00
ASC.08 HIV and AIDS-related research Total		68,376.00					68,376.00
Grand Total		**43,854,032.00**	**197,219,374.00**	**58,140,410.00**	**32479**	**255,392,263.00**	**299,246,295.00**

2008-Financing sources to AIDS Spending categories

ASC level 1	ASC level 2	FS.01 Public funds Total	FS.02 Private Funds Total	FS.03.01 Direct bilateral contributions	FS.03.02 Multilateral Agencies (ii)	FS.03.03 International not-for-profit organizations and foundations	FS.03 International funds Total	Grand Total
ASC.01 Prevention	ASC.01.01 Communication for social and behavioural change	2109841		5330396	602600		5932996	8042837
	ASC.01.02 Community mobilization	402584		1337257	36493		1373750	1776334
	ASC.01.03 Voluntary counselling and testing (VCT)			7305312	546414		7851726	7851726
	ASC.01.04 Risk-reduction for vulnerable and accessible populations	60515		579740	476971		1056711	1117226
	ASC.01.05 Prevention ï youth in school	623046		161845	32333		194178	817224
	ASC.01.06 Prevention ï youth out-of-school			418862			418862	418862
	ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)			284327			284327	284327
	ASC.01.08 Prevention programmes for sex workers and their clients			527289			527289	527289
	ASC.01.11 Prevention programmes in the workplace				751902		751902	751902
	ASC.01.12 Condom social marketing			9925			9925	9925
	ASC.01.13 Public and commercial sector male condom provision			2014624			2014624	2014624
	ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)			7200			7200	7200
	ASC.01.17 Prevention of mother-to-child transmission (PMTCT)			12243696	355672		12599368	12599368
	ASC.01.19 Blood safety	3184418	300000	3094881			3094881	6579299
	ASC.01.20 Safe medical injections			1388770			1388770	1388770
	ASC.01.21 Universal precautions			13512			13512	13512
	ASC.01.98 Prevention activities not disaggregated by intervention			13937080	111328		14048408	14048408

ASC.01 Prevention Total		6380404	300000	48654716	2913713		51568429	58248833
ASC.02 Care and treatment	ASC.02.01 Outpatient care	18806722		104271166	34236		104305402	123112124
	ASC.02.98 Care and treatment services not disaggregated by intervention			60418186	2289333		62707519	62707519
	ASC.02.99 Care and treatment services n.e.c.			92000			92000	92000
ASC.02 Care and treatment Total		18806722		164781352	2323569		167104921	185911643
ASC.03 Orphans and vulnerable children (OVC)	ASC.03.02 OVC Basic health care			9817			9817	9817
	ASC.03.03 OVC Family/home support			1879567			1879567	1879567
	ASC.03.05 OVC Social Services and Administrative costs			1500	98968		100468	100468
	ASC.03.06 OVC Institutional care				254236		254236	254236
	ASC.03.98 OVC Services not disaggregated by intervention			7298408	429324		7727732	7727732
ASC.03 OVC Total				9189292	782528		9971820	9971820
ASC.04 Programme management and administration	ASC.04.01 Planning, coordination and programme management	2999354		30064762	5421824	63000	35549586	38548940
	ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	4274		5105	433193		438298	442572
	ASC.04.03 Monitoring and evaluation	70936		7389524	5676198		13065722	13136658
	ASC.04.04 Operations research			260417	97042		357459	357459
	ASC.04.05 Serological-surveillance (serosurveillance)				37912		37912	37912
	ASC.04.07 Drug supply systems			1084990	1759069		2844059	2844059
	ASC.04.08 Information technology	9244		13019	63467		76486	85730
	ASC.04.09 Patient tracking			14339			14339	14339
	ASC.04.10 Upgrading and construction of infrastructure	86292		19222390	627422		19849812	19936104
	ASC.04.98 Programme management and administration not disaggregated by type	767057		21810024	19540308		41350332	42117389
ASC.04 Programme management Total		3937157		79864570	33656435	63000	113584005	117521162

ASC.05 Human resources	ASC.05.01 Monetary incentives for human resources			45523	116644		162167	162167
	ASC.05.03 Training	637162		10871644	3323078		14194722	14831884
	ASC.05.98 Human resources not disaggregated by type			5250853	796255		6047108	6047108
	ASC.05.99 Human resources n.e.c.				104374		104374	104374
ASC.05 Human resources Total		637162		16168020	4340351		20508371	21145533
ASC.06 Social protection and social services (excluding OVC)	ASC.06.01 Social protection through monetary benefits				99150		99150	99150
	ASC.06.02 Social protection through in-kind benefits				11454		11454	11454
	ASC.06.04 HIV-specific income generation projects			25000			25000	25000
	ASC.06.98 Social protection services and social services not disaggregated by type			515			515	515
ASC.06 Social protection and social services (excluding OVC) Total				25515	110604		136119	136119
ASC.07 Enabling environment	ASC.07.01 Advocacy	300544		311315	840208		1151523	1452067
	ASC.07.02 Human rights programmes			33445			33445	33445
	ASC.07.03 AIDS-specific institutional development	20461		7300	471874		479174	499635
	ASC.07.98 Enabling environment not disaggregated by type				21275		21275	21275
	ASC.07.99 Enabling environment n.e.c.			5000			5000	5000
ASC.07 Enabling environment Total		321005		357060	1333357		1690417	2011422
ASC.08 HIV and AIDS-related research (excluding operations research)	ASC.08.99 HIV and AIDS-related research activities n.e.c.				17350		17350	17350
ASC.08 HIV and AIDS-related research (excluding operations research) Total					17350		17350	17350
Grand Total		**30082450**	**300000**	**319040525**	**45477907**	**63000**	**364581432**	**394963882**

Annex 9 – Definition of terms

Beneficiary Population: The beneficiary population is not an expected target ð as accountants and model builders have used in projecting resource needs ð but people that actually have benefited or served from the spending on HIV and AIDS goods and services. Beneficiaries are the actual number of people covered representing an outcome from the resources spent, regardless of the effectiveness of the use of resources (effective coverage).

Capital expenditure: Records the value of non-financial assets that are acquired, disposed of or have experienced a change in value during the period under study. The assets held by the health system include new acquisitions, and major renovation and maintenance of tangible and intangible assets that are used repeatedly or continuously in production processes of health care, over periods of time longer than one year. The main categories of the classification features are buildings, capital equipment and capital transfers. These categories may include major renovation, reconstruction or enlargement of existing fixed assets, as these interventions can improve and extend the previously expected service life of the asset.

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

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

Consumption of fixed capital. The consumption of fixed capital represents the reduction in the value of the fixed assets used in the production process during the accounting period, resulting from physical deterioration, normal obsolescence or damage. It measures the decline in the usefulness of a fixed asset for purposes of production. Measurement is frequently an assumed regular rate of decline of their efficiency in production over time, based on an average service life of the asset.

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

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

Fiduciary Risk: are the risks that public resources are not used for the intended purposes, are not properly accounted for or do not achieve value for money

Financing Agent: entities that pool financial resources collected from different financing sources and transfer them to pay for or to purchase health care or other services or goods. These entities finance programmes or provision of services and goods used in the satisfaction of a need. Financing agents may pool resources that pay directly for resources they consume (principally households) and comprise entities that buy on behalf of specific beneficiaries (mainly intermediaries such as insurers or donors).

Financing Sources: entities that provide money to financing agents to be pooled and distributed. An analysis of financing sources may be of particular interest in countries where funding for the HIV and AIDS response is heavily dependant on international sources of financing or when there are pooled sources through few management entities.

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

Interest: Interest payments accruing to loans made by different entities are not negligible. Interest is defined as payment on top of the amount of the principal borrowed, that has to be paid to the creditor by the debtor over a given period of time without reducing the outstanding amount. Interest may be a predetermined sum of money or a percentage of the outstanding principal. Interest is added to the principal. When government units pay interest on debts on behalf of another unit, as the government incurring the debt as the primary obligor (debtor), the existing debt of another unit should be recorded as a subsidy (when the other unit is an enterprise), or transfer (if it is a government unit).

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

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

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

Non-wage labour income: Includes honoraria towards self-employed providers of care and other services contributing to the *National Response to HIV and AIDS*, gratuities, and diverse forms of compensating services rendered

Provider: Entities or persons that engage directly in the production or provision of services and are responsible for a final product or the subcontracting of a complex process involving several units of production that may require the hiring of personnel and the acquisition of inputs, materials and services towards the final object sought. A provider is usually accountable to the beneficiary for the delivery and the quality of the service rendered though the provision does not entail a positive or desirable outcome. Providers include government and other public entities, private for-profit and non-profit organizations, corporate and non-corporate enterprises.

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

Sector Budget Support: Earmarked support to a particular sector within the government budget

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

Subsidies: Subsidies to medical producers are current unrequited payments that government units make to health services producers on the basis of the level of their production activities or the values of the goods or services that they produce, sell or import. Subsidies are payable per unit of good or service specific products or on production in general to producers only and not to final consumers. They constitute current transfers and not capital transfers. The payment may involve an amount by each unit of product or be calculated as the difference between a specific target price and the market price actually paid by a buyer. Subsidies may cover losses when they are a result of a deliberate government policy, as in the case of health services provided in prices under the average production cost. That an entity engages in these transfers or subsidies is an indication that it should be treated as a financing agent (perhaps in addition to its activity as a provider).

Supplies and services: Consists of all goods and subcontracted services used as inputs in production of health services. This category includes goods that are entirely used up when they are fed into the production process, during which they deteriorate or are lost, accidentally damaged or pilfered. Such goods include inexpensive durable goods, for example hand tools, and goods that are cheaper than machinery and equipment. The category also includes tools used exclusively or mainly at work, for example clothing or footwear worn exclusively or mainly at work (such as protective clothes and uniforms). One of the most important types of supplies is pharmaceuticals. Donations of materials and supplies should be treated to reflect real values, so the amounts recorded should be at market prices and net of subsidies minus indirect taxes.

Transfers: Transfers to households are transactions by which government units reimburse households all or part of the cost of purchasing goods, services or durables without counterpart. These are mostly cash transfers related to health care goods and services, the bulk of the services and goods dispensed without payment being accounted for through the entries above.

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

NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA)

Joint United Nations Programme on HIV/AIDS

Enhancing Nigeria Response to HIV & AIDS Programme