FEDERAL GOVERNMENT OF NIGERIA

NATIONAL AIDS SPENDING ASSESSMENT (NASA)

FOR THE PERIOD: 2011-2012

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

NACA National Agency for the Control of AIDS (NACA)
UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK
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2. Dr. Omokhudu Idogho – Programme Director, DFID/ENR Programme
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5. Dr. Kayode Ogungbemi - National Agency for the Control of AIDS
6. Dr. Greg Ashefor - National Agency for the Control of AIDS
7. Mr. David Owolabi - United Nation Development Programme
8. Dr. Gwomson Dauda - Federal Ministry of Health, HIV/AIDS division.
9. Dr. Emmanuel Alhassan - National Agency for the Control of AIDS
10. Mr.Monday Yanet - National Agency for the Control of AIDS

NASA Core Team

1. Dr. Michael Kayode Ogumgbemi –National Agency for the Control of AIDS
2. Dr. Masauso Nzima –UNAIDS Country Office Nigeria
3. Dr. Greg Ashefor –National Agency for the Control Of AIDS
4. Mr. Monday Y. Yanet –National Agency for the Control of AIDS
5. Mrs. Peju Odulami –National Agency for the Control of AIDS
6. Dr. Segun Oyedeji –Technical Lead National
7. Mr. Abubakar Umar Mohammed - Senior National Consultant
8. Mr. Festus Idepefo –Data Manager
9. Miss Lilian Chiedo –Data Manager
10. Mr. Ayorinde .S. Lemah –Data Manager
11. Christian Aran' –UNAIDS Geneva (Technical Support)
12. Dr. Francis Ukwuije –ENR/Population Council

Foreword

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

The country has conducted two national AIDS Spending Assessment (NASA) for 2007 and 2008 in 2009 and 2009 and 2010 in 2011 all in retrospect and this third edition conducted in 2013 for years 2011 and 2012. These efforts are gear towards addressing the challenges of inadequate information on HIV/AIDS expenditure in the country. The gains of the first and second National AIDS Spending Assessments led the National Agency for the Control of AIDS (NACA) in collaboration with UNAIDS, ENR Programme, PEPFAR and other development partners to conduct NASA 2011 and 2012.

The National AIDS Spending Assessment (NASA) document describes the HIV/AIDS financial flow and expenditure for both health and non-health in Nigeria for the period of 2011 and 2012 according to three dimensions and six vectors. The NASA dimensions are: Financing, Provision and Use. Financing has funding sources (FS) and financing agents (FA) as vectors, Provision has providers of HIV/AIDS services (PS) and production factor (PF) while Use has AIDS spending categories (ASC) and intended beneficiary population (BP).

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

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

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

Professor John Idoko
Director General
National Agency for the Control of AIDS (NACA)

Acknowledgement

The National AIDS Spending Assessment (NASA) document is a product of the National Agency For the Control of AIDS in collaboration with the joint United Nation programme on HIV/AIDS (UNAIDS) and Department for International Development (DFID) through Enhancing National Response Programme (ENR) and other partners in the national response.

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

This document gives a description of the HIV/AIDS financial flow and expenditure for both health and non-health interventions and activities in Nigeria for the years of 2011 and 2012 in retrospect, according to three dimension and six vectors. The NASA dimensions are financing, provision and use. Financing has funding sources (FS) and financing agents (FA) as vectors, provision has providers of HIV/AIDS services (PS) and production factor (PF) while use has AIDS spending categories (ASC) and intended beneficiary population (BP).

The NASA methodology is based on the use of a transaction processing tool for each funding source, funding agent and providers of HIV/AIDS services to represent the origin and the destination of resources to avoid double counting of expenditure in addition to a standardised classification that ensure resource tracking of HIV and AIDS and categories used are mutually exclusive and exhaustive , while a resource tracking software is used to generate matrixes for cross information on its dimensions and vectors.

This robust document would not have been possible without the support of the following persons and institutions, which NACA would like to acknowledge: The Director General NACA, UNAIDS/ Nigeria Country Coordinator, Director of Programmes DFID/ENR, PEPFAR Coordinator and UNDP.

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

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My sincere appreciation goes to the NASA core team for their dedication, commitment and technical support they lend to the smooth take off and conclusion of the process, the strategic knowledge management and resource mobilization departments for their immense contributions and support.

Dr. Michael Kayode Ogungbemi
Director, Strategic Knowledge Management

Table of Contents

LIST OF TABLES

LIST OF FIGURES

Appendices

Acronyms

ADB	Asian Development Bank
AfDB	African Development Bank
AIDS	acquired immune deficiency syndrome
ARV	antiretroviral drug
ASC	AIDS spending category
ART	antiretroviral therapy
BCC	behaviour change communication
BP	Beneficiary Population
CDB	Caribbean Development Bank
COFOG	classification of the functions of government
COICOP	classification of individual consumption by purpose
COPNI	classification of the purposes of non-profit institutions serving households
CSO	civil society organization
DAC	Development Assistance Committee (of the OECD)
DFID	Department for International Development (of the United Kingdom)
EBRD	European Bank for Reconstruction and Development
FA	financing agents
FBO	Faith-based organization
FS	financing sources
GDP	gross domestic product
GFS	government finance statistics
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GGE	general government expenditure
GTZ	Gesellschaft für Technische Zusammenarbeit (of Germany)
HIPC	heavily indebted poor countries
HIV	human immunodeficiency virus
IADB	Inter-American Development Bank
ICD	International Classification of Disease (unless otherwise noted, 10th revision)
ICHA	International Classification for Health Accounts
IDU	injecting drug user
IEC	Information, Education and Communication
ILO	International Labour Organization
IMF	International Monetary Fund
ISIC	International Standard Industrial Classification (unless otherwise noted, 3rd (Revision)
MARP	most-at-risk populations
MDG	Millennium Development Goals
MSM	men who have sex with men
NAA	national AIDS accounts

NAC	National AIDS Coordinating Authority
NACP	National AIDS Control Programme
NAP	National AIDS Programme
NASA	National AIDS Spending Assessment
n.e.c.	Not elsewhere classified
NGO	nongovernmental organization
NHA	national health accounts
OECD	Organisation for Economic Cooperation and Development
OI	opportunistic infection
OVC	orphans and vulnerable children
PEP	post-exposure prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PF	production factors/resource costs in HIV
PG	Producers guide (*guide to produce national health accounts*)
PHR*plus*	Partners for Health Reform *plus*
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission
PS	Provider (in the National response to HIV classification)
RTS	Resource Tracking System
SHA	system of health accounts
SIDALAC	Latin American and Caribbean monitoring of HIV
SNA	System of National Accounts (unless otherwise noted 93 revision)
STI	sexually transmitted infections
SW	sex workers
UNAIDS	Joint United Nations Programme on HIV
UNDOC	United Nations Office on Drugs and Crimes
UNGASS	United Nations General Assembly Special Session
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
VCT	Voluntary Counselling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

Definition of terms

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

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

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

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

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

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

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

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

Financing Agent: Institutions that take programmatic decisions on the use of the funds. The programmatic decisions are the goods and services that the fund will be used for, the provider of the goods and services and the beneficiary population of the goods and services.

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

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

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

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

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

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

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

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

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

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

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

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

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

Social Protection and Social Services – functions of government relating to the provision of cash-benefits and benefits-in-kind to categories of individuals defined by needs such as sickness, old age’ disability, unemployment, social exclusion, and so on.

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

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

Table 1 Basic Factsheet on Nigeria HIV and AIDS Expenditure for the Period 2011-2012

	2011		2012	
	Amount(USD)	%	Amount(USD)	%
HIV and AIDS Expenditure by Funding Sources				
Total Spending	**501,467,005**		**577,432,903**	
Public	88,875,936	17.72	122,964,880	21.29
Private Funds*:	1,207,840	0.24	9,275,917	1.60
International	411,383,229	82.04	445,192,106	77.10
HIV and AIDS Expenditure by Financing Agent				
Public	89,894,897	17.93	123,800,364	21.44
Private	12,993,176	2.59	11,904,339	2.06
International	398,578,932	79.48	441,728,200	76.50
HIV and AIDS Expenditure by Service Provider				
Public Providers	273,835,863	54.61	326,503,352	56.54
Private Non-Profit	219,760,302	43.82	240,918,309	41.72
Bilateral and Multilaterals	7,870,840	1.57	10,011,242	1.73
Rest of the world providers	0	0	0	0
HIV and AIDS Expenditure by Programmatic Area				
Prevention	63,525,516	12.67	68,879,597	11.93
Care and treatment	171,094,653	34.12	191,463,353	33.16
OVC activities	12,934,848	2.58	14,394,105	2.49
Program management activities	135,085,394	26.94	168,644,890	29.21
Human resources	92,574,388	18.46	103,029,640	17.84
Social protection and social services	7,865,514	1.57	8,786,223	1.52
Enabling environment	13,607,710	2.71	15,168,221	2.63
Research activities	4,778,982	0.95	7,066,874	1.22
HIV and Expenditure by Beneficiary				
People Living with HIV	175,581,071	35.00	209,757,517	36.00
Most at risk populations	10,342,359	2.00	19,855,006	3.00
Other key populations	31,473,398	6.00	35,350,187	6.00
Specific" accessible" populations	2,446,178	0.00	2,056,840	0.00
General Population	36,850,416	7.00	29,521,495	5.00
Non-targeted interventions	244,773,583	49.00	280,891,858	49.00
Specific targeted populations not elsewhere classified	0	0.00	0.00	0.00
Out of Pocket Expenditure				
	$ 228,246,480		$ 259,259,088	

Executive Summary

The funding of HIV and AIDS programmes in Nigeria, is categorized into three main sources: public, external (international) and organized private sources. The National Strategic plan (NSP) 2010-2015 priority is to reposition HIV prevention as the centrepiece of the national HIV/AIDS response. The National Agency for the Control of AIDS (NACA) has as one of its mandates to mobilize resources (local and foreign) and coordinate equitable application for HIV/AIDS activities. Nigeria's national response to HIV and AIDS is still to a large extent sustained by external assistance from international, multilateral and bilateral organizations alongside foundations and NGO's.

In 2009 NACA conducted its first National AIDS Spending Assessment (NASA) which was for 2007 and 2008 HIV and AIDS funding activities. The main objective of NASA is to track the allocation of HIV and AIDS funds, from their origin down to the end point of service delivery, among the different financing sources (public, private or external) and among the different providers and beneficiaries (target groups). NASA was again conducted in 2011 to track HIV/AIDS expenditure for the period 2009/2010.The key question addressed by this NASA study was to determine amounts disbursed and spent in each component of the multi-sectoral HIV and AIDS response and the allocation of AIDS spending in relation to the objectives and targets of the National HIV/AIDS Strategic framework and Plan.

NASA describes the flow of resources from their origin down to the beneficiary populations. The financial flows for the national HIV response are grouped in three dimensions: finance, provision and consumption. Expenditures are reconciled from these three dimensions using data triangulation. A mapping of all institutions involved in the HIV/AIDS response was first carried out followed by a desk review of key National policy documents, programme documentation and available budgetary and expenditure reports for the period 2011-2012. 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 expenditure on HIV and AIDS related activities using best available data and the most suitable assumptions. The data processing was by the resource tracking module of NASA Excel questionnaires which was adjusted to suit the country context and the NASA Resource Tracking Software (RTS) which was used for data analysis and triangulation to establish the level and proportion of funding from different sources. The data validation was done in four stages for accuracy and consistency by the core team, UNAIDS international Technical consultant, individual institutions and the national HIV/AIDS Stakeholders. The limitations of the assessment were limited data from private sector and state level expenditure was available for only 8 States.

Main Findings

Based on available data there has been increased funding for HIV/AIDS national response in Nigeria from $299,246,295 in 2007, $496,917,471 in 2010 to $577,432,903 in 2012. Within the total amount, the HIV expenditure by Government in 2012 ($122,964,880) witnessed a slight decrease of (0.03%) when compared to the expenditure in 2010 ($126,645,333). Conversely, the major part of the funding for the implementation of HIV/AIDS goods and services in Nigeria relied heavily on international funds 82.04% and 77.10% in 2011 and 2012 respectively. Of this amount Direct Bilateral contribution covered more than 50% of the total funding in both years. In the context of programmatic decisions (type of goods and services to purchase, service providers and beneficiary population), the international/purchasing organizations accounted for most of the decisions taken with (79.48 % and 76.5% in 2011 and 2012 respectively).

The provision of goods and services to the national response was majorly through the public sector which accounted for 54.61% in 2011 and 56.54% in 2012 with the bilateral and multilateral entities providing the least services in both years. The AIDS Spending Categories (HIV goods and services) in 2011 and 2012 was primarily on Care and Treatment followed closely by Program management. Prevention accounted for 12.67% and 11.93% in 2011 and 2012 respectively which is a significant improvement in 2011 though a slight decrease in 2012. The chief beneficiaries of the expenditure for both years were People Living with HIV/AIDS (35.01% in 2011 and 36.33% in 2012)

Conclusions and Recommendations

Public sector contribution witnessed a slight decrease in both years when compared to 2009 and 2010. International contribution still remains the major source of fund for the HIV/AIDS national response. The private sector needs a strong coordination mechanism between it and the National Coordinating body (NACA) to be able to fully capture private sector expenditure on HIV. From the current NASA, the HIV/AIDS funding was primarily directed to Care and Treatment at the expense of other interventions.

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

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

1.0 Introduction

1.1 HIV and AIDS Epidemic

Nigeria, with a population estimated at 166.2 million people in 2012, is home to more people living with HIV than any other country in the world, except South Africa and India. An estimated 3.4 million Nigerians are living with HIV as at 2011, the second highest figure in Africa.

The country reported her first case of AIDS in 1986 and since then has committed resources to stem the tide of the infection. Initially through a health sector approach, but more recently by multi-sectoral paradigm which seemed to have positively affected the prevalence. Within the last decade, the Federal Government of Nigeria in collaboration with her international partners have committed huge political capital, human and financial resources towards the multi-sectoral response programs aimed at preventing the spread of the virus, and mitigating its impact on Nigerians.

With the valuable support of local and international partners, the country has seen the epidemic profile change significantly from a HIV prevalence rate of 5.8% (in 2001) to 4.1% in 2010. Attaining the status of a country with stable change in the incidence rate of HIV infection among adults 15-49 years old between 2001 and 2011 is a significant achievement but the overall gaps in access to HIV/AIDS service remains a great challenge. This becomes all the more important with wider implications when put within the context that Nigeria has the second highest HIV burden in the world with 3.4 million people estimated to be living with HIV in 2012. At the end of December 2012, only 491,021 HIV positive persons out of an eligible population of 1.6 million were accessing ART (30% of national need). This exemplifies the scale of the service gaps and the urgent need to address them. Systematic reviews of the national response has identified key challenges which revolve around limited domestic financing of the response, weak coordination at national and state levels, inadequate state government contribution to resourcing the response; challenges with human resources for health, weak supply chain management systems; limited service delivery capacity and limited access to HIV (NACA, 2010)

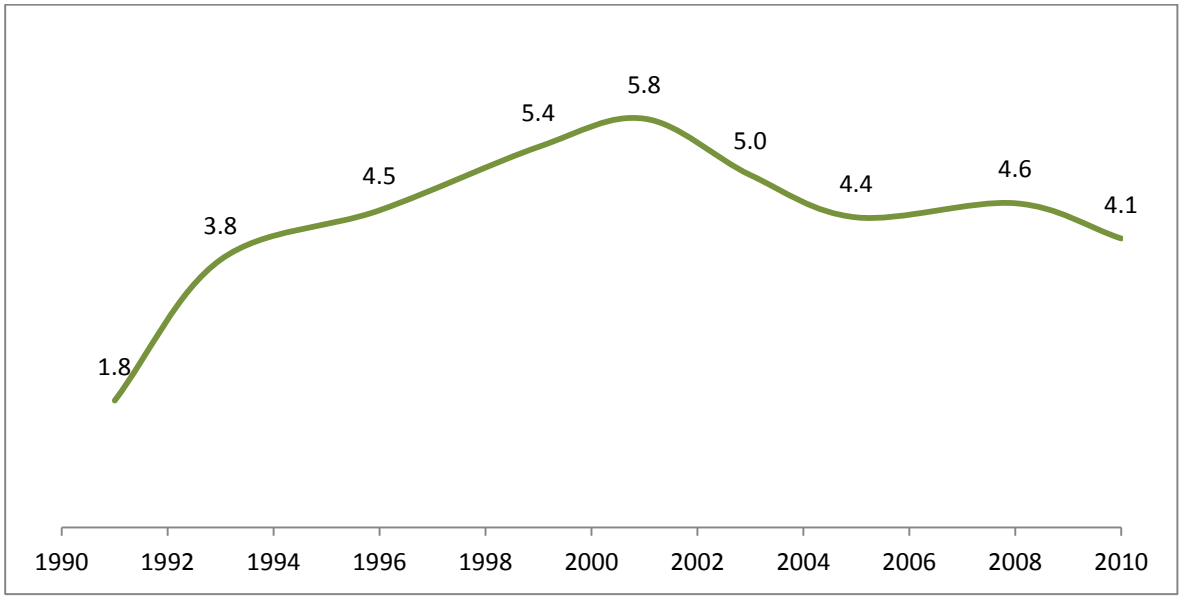


Figure 1 HIV Prevalence Trend in Nigeria 1991-2010

A comparison of HIV prevalence by geopolitical zone in Nigeria between 2008 and 2010 showed that prevalence in the north-west and south-south zones reduced while it increased in the north central, south-east and south-west zones. The HIV prevalence in the north-east zone has remained stable. Twelve (12) states and the Federal Capital Territory (FCT) that have high prevalence have been shown to be responsible for about 70% of the HIV burden in Nigeria. These states which are referred to as '12 plus one states' are: Benue, Akwa-Ibom,

Bayelsa, Anambra, FCT, Plateau, Nasarawa, Abia, Cross-river, Rivers, Kano and Kaduna. The lowest prevalence of 0% was reported in four locations in the country: Kwami in Gombe state, Rano in Kano state, Owhelogbo in Delta state and Ganawuri in Plateau state. The highest prevalence of 21.3% was reported for Wannune in Benue state.

1.1.1 Socioeconomic Impact

Beyond its health impact, HIV has severe socioeconomic implications. Children are exposed to their share of the HIV/AIDS burden either by being affected through mother to child transmission infection or through the loss of one or both parents from AIDS,of the 17.5 million vulnerable children, an estimated 7.3 million have lost one or both parents due to various causes, Of these, 2.23 million were orphaned by HIV/AIDS, while about 260,000 children are living with HIV/AIDS. The 2008 National Situation Assessment and Analysis (SAA) on OVC (FMWASD, 2008) showed that HIV and AIDS has not only been a major cause of death of parents, especially in households where both parents have died, but has also exacerbated the social and economic vulnerability occasioned by serious illness of a parent or other adult member of the household. Within communities, families with HIV/AIDS infected persons are stigmatized. A stigma survey among HIV positive persons in Nigeria showed that 34% of affected persons were excluded from family events, 35% were verbally assaulted, 28% were physically assaulted and 29% suffered a loss of job or income. Beyond their immediate communities, 21% reported being denied health services generally and 8% SRH services specifically[1].

A large proportion of Nigerians live below the poverty line. In this context, HIV infection within the family or household does have implications. The average annual out-of-pocket expenditure for direct HIV services was N84,480. The proportion of household income spent on HIV care was 14.5%[2]. There is an indication that HIV infection within the household is related to higher unemployment, increased time off work, and challenges meeting financial obligations requiring sourcing for additional financial support outside of their income[3]. The death of family members have effect on dependency pattern, changes in household livelihood and coping mechanism especially child labour and prostitution is very prominent.

The impact of the HIV/AIDS epidemic on the health, education and transportation sectors (just to mention some of the sectors) and the uniformed men in terms of susceptibility to new infections and vulnerability cannot be underestimated. In the education sector, the epidemic weakens staffing levels, increase sickness absence levels. Teachers and support staff who are HIV infected or affected are likely to spend less time on work because of stigma, intermittent illness and caring for the sick. With a reported 10-15% infection rate in the Nigerian public sector HIV/AIDS, this can affect social and economic development. Amongst the uniformed forces, the highest prevalence was seen in Benue state (army) with 4.4% and 4.5% in Kano state (police)[4]. The emerging issue of vulnerabilities to HIV transmission among communities in conflict and service personnel engaged in addressing internal conflicts, disasters and terrorism need to be addressed.

1.1.2 Nigeria National Strategic plan 2010-2015

The NSP 2010-15 is the third in a series of national HIV/AIDS strategic plans which started with the HIV/AIDS Emergency Action Plan (HEAP) 2001-04. Gains from the Emergency Plan informed the development of the second HIV/AIDS Strategic Plan, the National Strategic Framework (NSF) 2005-09, which ushered in a period of significant scale-up of HIV/AIDS services especially access to HIV treatment. This NSP 2010-2015 is six years long and is coterminous with two important international commitments that Nigeria has signed on

[1] UNAIDS HIV Epidemic Update 2012
[2] NACA 2011. Assessment of out-of pocket expenditure for HIV/AIDs services in Nigeria
[3] ODSACA (2012) Socioeconomic Impact of HIV in selected LGAs in Ondo state
[4] IBBSS 2010

especially the Millennium Development Goals and the Universal Access (UA) to HIV/AIDS prevention and care and treatment services. The overarching priority of the NSP 2010-15 is to reposition HIV prevention as the centrepiece of the national HIV/AIDS response.[5] Thus greater focus will be placed on scaling-up HIV prevention services that enable individuals to maintain their HIV negative status as well as improve access to quality treatment and care services for PLHIV including positive health, dignity and prevention (PHDP) interventions that reduce their transmitting HIV to others

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

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

1. Promotion of Behavior Change and Prevention of New HIV Infections

2. Treatment of HIV/AIDS and Related Health Conditions

3. Care and Support of PLHIV, PABA, and OVC

4. Policy, Advocacy, Human Rights, and Legal Issues

5. Institutional Architecture, Systems, Coordination, and Resourcing

6. Monitoring and Evaluation Systems comprising M&E, Research, and Knowledge Management

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

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

1.1.3 Nigeria's Response to the HIV Epidemic

Policy

Over the years the Nigerian response to HIV and AIDS has increased in scope and quality, encompassing many sectors and stakeholders. The coordination and standardization challenges posed by this were addressed through policies and guidelines which have guided Nigeria's response to HIV/AIDS. Whilst the policies have provided enabling environment for coordination and planning, the guidelines ensured effective and quality implementation in line with global best practices. These have contributed immensely to the achievements recorded thus far in the response in the areas of policy, planning and implementation.

[5] NACA(2010):Nigeria National strategic plan 2010-2015

The country's HIV policy and programming frameworks have witnessed remarkable development in the last decade. Key outputs in this regard include: National HIV/AIDS Policy (2005 and 2010); National Strategic Framework (2005-2009 & 2010-2015); National HIV/AIDS Strategic Plan (2010-2015); National HIV/AIDS Workplace Policy; National HIV/AIDS Prevention Plan (2007-2009 & 2010-2012) and the National Behaviour Change Communication Strategy etc. Drawing from these, several sub-national and sectoral policies and plans have been developed and are currently being implemented across sectors and at all levels. All the states, FCT and line ministries currently have developed their 4 year strategic plans and 2 year operational plans. In addition, a monitoring and evaluation plan known as the NNRIMS Operational plan II (NOP2 2011-2016) was developed to support effective tracking of the national response as well as inform future policies and programmes development and reviews

Coordination

The national response in Nigeria is coordinated through a system involving state and non-state sectors. NACA leads the coordination at national level, with the FMoH responsible for coordinating the health sector component of the response while other line ministries are responsible for coordinating other inter-related thematic areas. Non-state actors are involved in key aspects of the response including resource mobilization, advocacy, demand creation and equity. NACA interfaces with representation from key stakeholders to broaden the coordination reach and effectiveness. These include NACA-SACA, NACA-Civil Society organizations (CSO's), NACA-private sector, NACA-public sector and NACA-development partner and NACA-TWG interactions. In line with the tenets of the PCRP, this coordination mechanism while being utilized for implementation of the PCRP will be strengthened with the introduction of a management and funding model that encourages greater state level involvement, transparency and accountability.

Service Delivery

There are several challenges with service delivery: inadequate numbers of service delivery points, equity issues and quality of service. Universal access is hinged on radically increasing the demand and supply aspects of the HIV care continuum. Therefore, rapid investments towards increasing the number of service delivery points, the scope and quality of services and innovative approaches to increasing demand for HIV services are vital for achieving universal access; and retention within the service continuum.

Monitoring and Evaluation

National HIV M&E systems require strong leadership and coordination mechanisms at the national and sub-national levels to generate the requisite information for decision making and tracking progress. From the 2011 JAR report[6], the current system is considered strong at the national level while those at the state, LGA and community levels need to be strengthened. The 2011 JAR report also recommends strengthening of coordination and advisory bodies such as M&E TWG.

[6] Joint Annual Review of the National Response to HIV/AIDS 2011

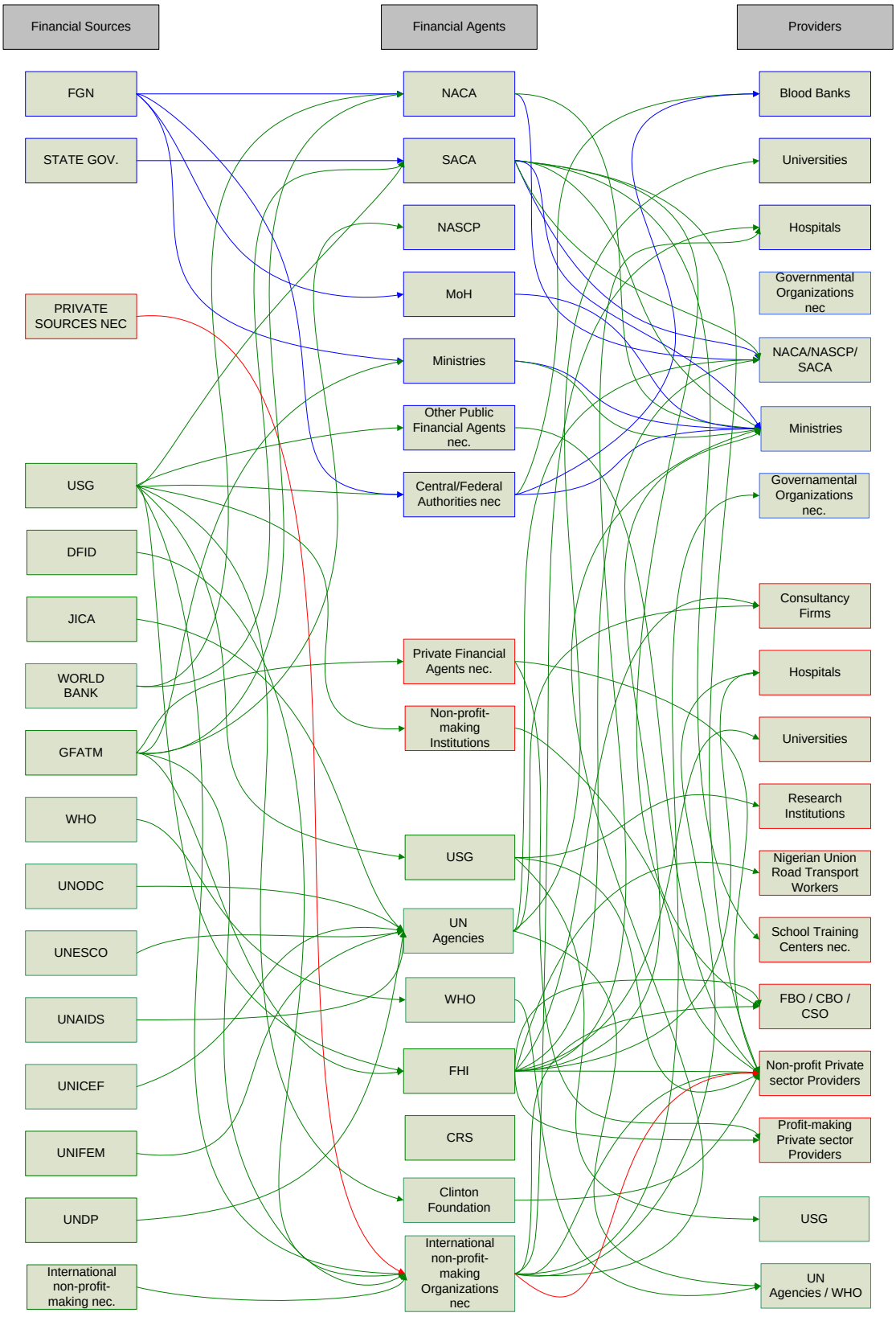
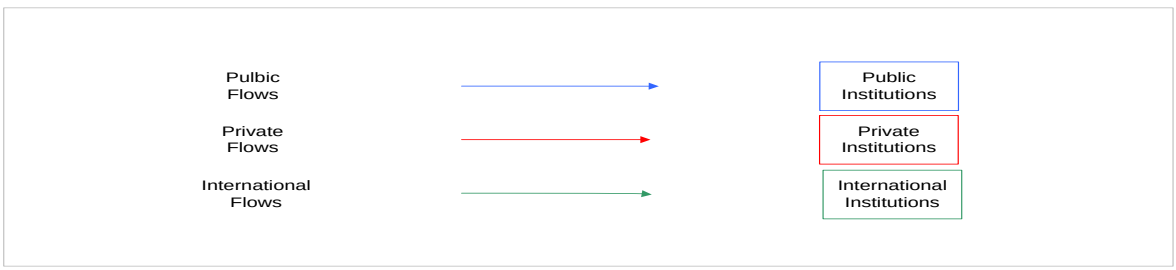


Figure 2 National Response – NASA Mapping of actors and funding flow



2.0 Study Design and Methodology

2.1 Context for the Assessment

Nigeria conducted the first ever NASA in 2009 to track the flow of financial resources from funding source to the beneficiary population covering the period 2007 and 2008.This exercise served as baseline for the most recent one which covered the periods 2009 and 2010. It was also in response to the 2009 sustainability study of HIV/AIDS services in Nigeria (HAPSAT) which revealed that it was not possible to get a comprehensive picture of how and where resources are being expended, how much was spent in specific service delivery points or geographical areas, or on specific activities as the nation responded to the epidemic.[7] The 2011 and 2012 will be used to measure the national commitment and action towards the 2001 UNGASS Declaration and the national strategic framework and action plan.

Nigeria, Africa's most populous country with An estimated population of 166.2(Fed, government gazette vol.961,Feb.2009) million has a national HIV prevalence of 4.1%. The prevalence ranged from 1.0% in Kebbi State to 12.7% in Benue State. A total of 16 States and FCT had prevalence above 5%. Five of the six States in the South South Zone, three of the five in the South East Zone, five of the seven in North Central Zone, two of the six in North East Zone, and one of the six in South West Zone had prevalence of 5% and above. The three States with the highest rates were Benue, Akwa Ibom and Bayelsa.[8]

2.2 Objectives

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

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

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

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

2.3 Scope of the Assessment

The assessment focused on tracking national level HIV expenditure available at central level and 8 ENR supported States for the year 2011 and 2012. Data collection covered domestic and external spending in HIV and AIDS, including funds channelled through the government. The assessment did not include household out-of-pocket expenditure on HIV and AIDS but estimations were made base on previous studies.

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

[8] National HIV Sero-Prevalence Sentinel Survey Among the Antenatal Clinic Attendees,2010

2.4 NASA Methodology

The National HIV and AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. The tool tracks actual expenditure (public, private and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprises the National Response to HIV and AIDS[9].

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

In addition to establishing a finance tracking system of HIV and AIDS activities, NASA facilitates a standardized approach to reporting of indicators that monitor the progress towards the achievement of the targets of the *Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS)[10].

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

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

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

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

NASA 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,

[9] 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.

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

provision and consumption. Expenditures are reconciled from these three dimensions using data triangulation.

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

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

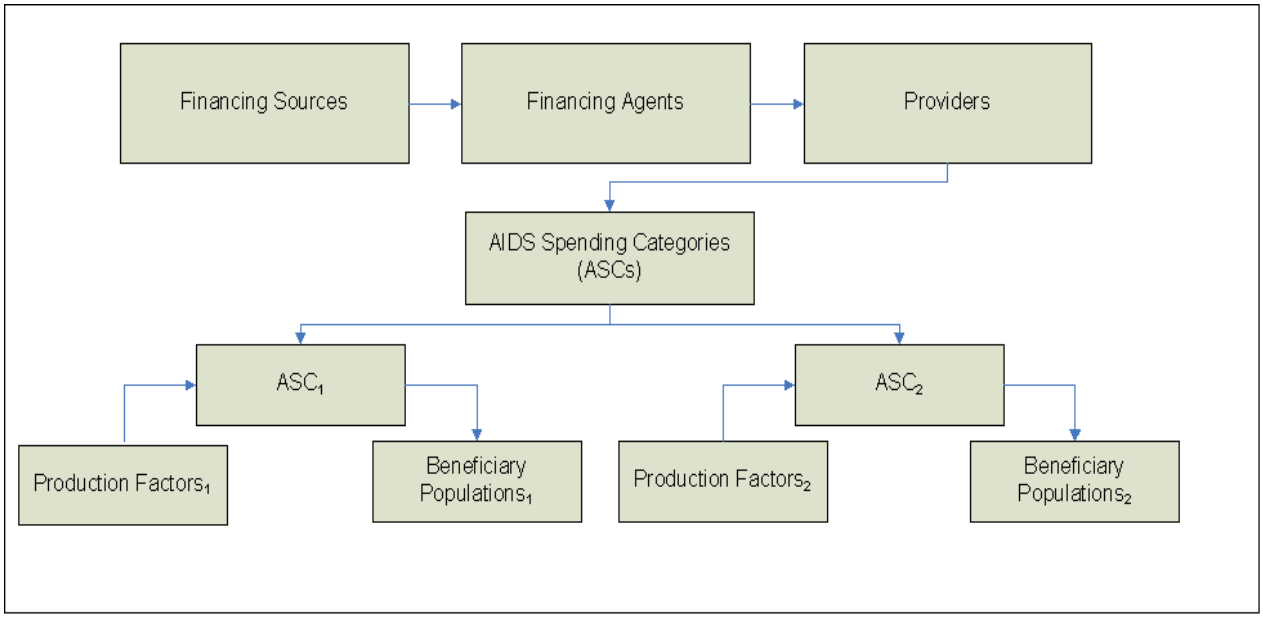


Figure 3 Transactions

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

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

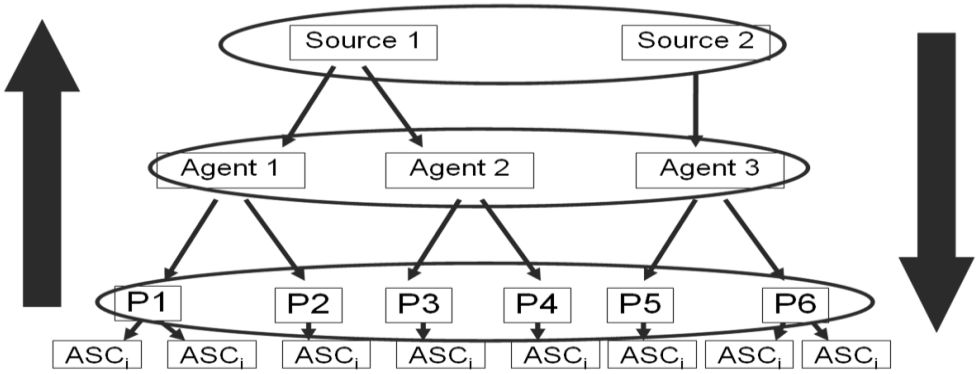


Figure 4 "Bottom up" and "Top down" approach

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 the table below.

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

2.5 NASA Preparatory Activities

The 3rd of its series NASA in Nigeria was conducted by the national core team made up of a lead national Technical advisor, a senior consultant and two national data managers under the direct supervision of NACA Director of strategic knowledge management, ENR Programme Director and UNAIDS Nigeria M & E Advisor. A five day workshop facilitated by the lead national Technical advisor was held for the core team.

A steering committee made up of officers from different governmental institutions (NACA, Ministry of Health, Ministry of Finance, the Ministry of National Planning and/or other Governmental offices),UNAIDS, PEPFAR and ENR was set up to provide supervision on the overall process and to facilitate data collection. The timeline of the NASA implementation is presented in Appendix 2.Several advocacy and sensitization meetings were held with partners to facilitate the process. Data collection forms were refined and distributed to key HIV/AIDS national response actors. The NASA teams obtained all necessary permissions from the national authorities to access relevant data and conduct the assessment. The letter of support for the mission is presented in Appendix (.18.).

2.6 Data Collection and Processing

2.6.1 Sources of Data

In collaboration with national stakeholders, NASA team identified and mapped HIV financial sources, financial agents, service providers, and AIDS spending categories. Although a lot of sources of data (detailed expenditure records) were obtained from the primary sources for 2011 and 2012, secondary sources were widely used where primary sources were not available (e.g. expenditure of NGOs who received direct funding from donors which were not captured, donor report or more detailed data on expenditure). In some cases costing techniques were used to estimate some of the expenditures of HIV and AIDS related activities using the best available data and most suitable assumptions. For the list of institutions visited to collect HIV and AIDS expenditure data (Appendix 1) and the status of data collected refer to Appendix (..20.).

2.6.2 Qualitative Data Collection

The initial data collection process involved cascaded training at the National and state level. The members of the Core team (1 Senior Consultants and 2 Data Managers) and 8 State Consultants (drawn from Akwa Ibom, Benue, Cross River, Anambra, Kaduna, Lagos, Nassarawa, and Ogun States) were trained at the National level for a week. The second level of trainings was at the National and State levels for the focal persons (Finance and Programme Officers) from each of the donor institutions and implementing partners except the USG and its' IPs who gave EA data through the PEPFAR Coordinator. The objective of the second level training was to acquaint them with the NASA process, enable them to reconstruct all the transactions related to HIV and AIDS activities showing the actual spending, consumption and delivery to the beneficiary population and enable them to completely fill the NASA data forms. The training session was also an opportunity to sensitize and solicit their support for the release of financial data. A mapping of all institutions involved in the HIV/AIDS response was carried out followed by a desk review of key National policy documents, programme documentation and available budgetary and expenditure reports for the period 2011-2012. This review was followed by six weeks of data collection from institutions.

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

suit the country context and sent to all identified institutions. NASA consultants were also on hand to support organizations to complete the questionnaires and PEPFAR gave their data centrally and also lend support in the data analysis.

2.6.3 Data Processing

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

(ii) Which providers were receiving funds and from what sources;

(iii) Amount of funding allocated to services and functions related to HIV/AIDS.

The RTS results databases were then exported to Excel to produce summary tables and graphics for analysis.

2.6.4 Data Validation

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

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

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

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

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

2.7 Limitations of the Assessment

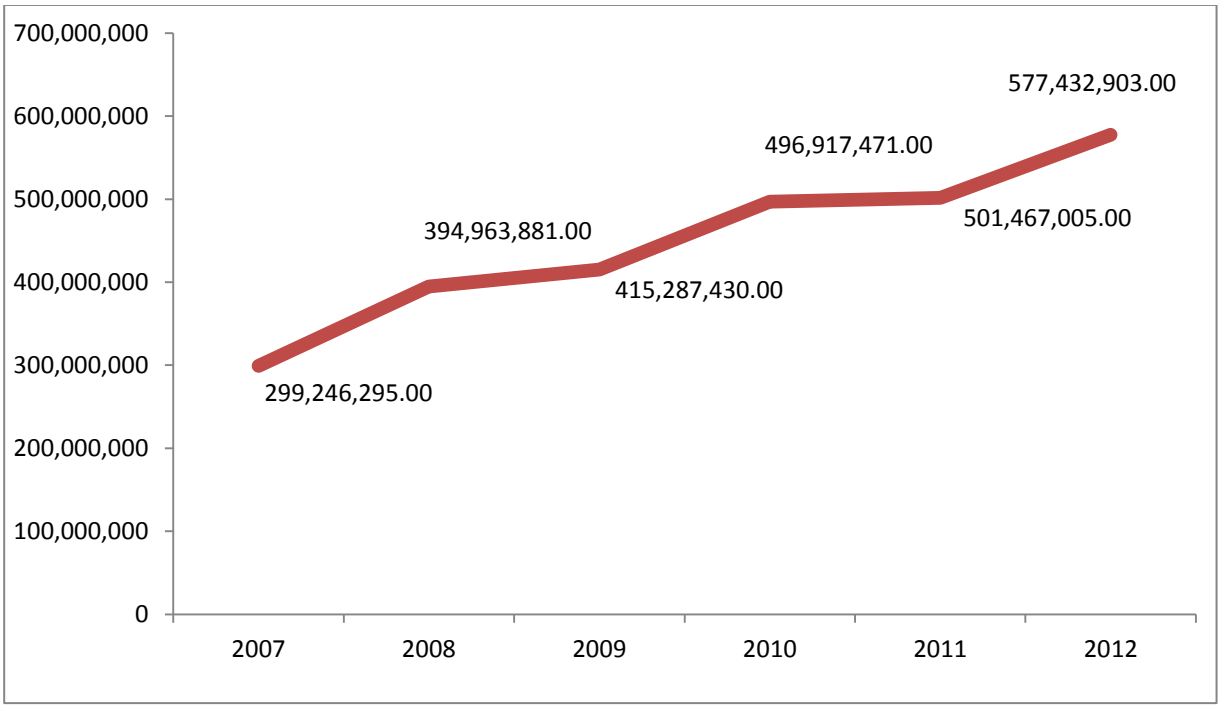
Tracking the HIV and AIDS expenditure proved to be a challenging task and there are a number of limitations to the study. The major ones include the following:

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

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

3.1 Findings of 2011 and 2012 NASA

Figure 5 Total Expenditure Trend 2007-2012(USD) in Nigeria



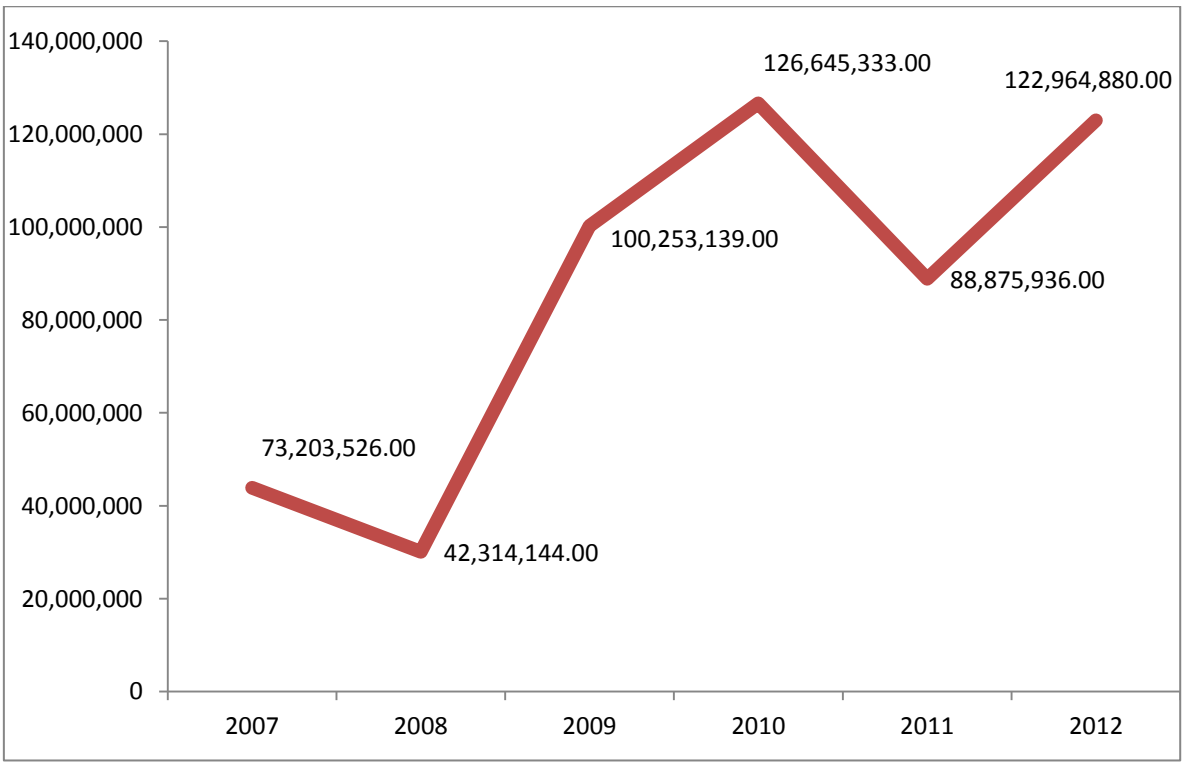


Figure 6 Public Sector Expenditure Trend 2007-2012(USD) in Nigeria

3.1 Total expenditure on HIV and AIDS with sources of Funding

The total expenditure on HIV and AIDS in Nigeria for 2011 and 2012 was 501,467,005 USD and 577,432,903 USD respectively, showing a steady increase from 299,246,295 USD (2007) to 394,963,881USD (2008), 415,287,430 USD (2009) and 496,917,471USD in 2010 respectively.

The main source of funds was from international organisations for the two years, $411,383,229 (82.04%) for 2011 and 445,192,106 USD (77.52%) for 2012 which was the same trend observed in previous years: 255,392,257 USD(85.4%) in 2007; 364,581,432USD(92.3%) in 2008, 317,218,608 (76.39%) in 2009 and 370,927,337USD (74.65%) in 2010 respectively.

Further analysis of the NASA data showed that Public sector contribution increased from 30,082,450 USD (7.6%) in 2008 to 125, 39,587USD (25.18%) in 2010, before dipping to 88,875,936 in 2011 (17.7%) and increasing again to 122,964,880.00 (21.29 %) in 2012. On the other hand private sector contributions were 300,000USD (0.1%) in 2008; 850,547 (0.17%) in 2010; 1,207,840 USD (0.21%) and 9,275,917 (1.61%) for 2011 and 2012.

Figures 8 and 9 show spending by Financing Sources for 2011 and 2012. The direct bilateral funds priority spending area was care and treatment, while for public funds the priority spending area was human resources. Programmes management was priority for multilateral and international non-profit agencies and foundations and this has been the trend in previous NASA studies.

Table 2 Financing Sources in 2011 and 2012 – Table (1st and 2nd digits analysis):

Financing Source	USD 2011		USD 2012	
	Amount(USD)	%	Amount(USD)	%
FS.01 Public Sources	88,875,936	17.72	**122,964,880**	**21.30**
FS.02 Private Funds	**1,207,840**	0.24	**9,275,917**	**1.61**
FS.03 International Funds	**411,383,229**	82.04	**445,192,106**	**77.10**
FS.03.01 Direct bilateral contributions	383,496,400	76.47	418,775,926	**72.52**
FS.03.02 Multilateral Agencies	27,262,947	5.44	25,521,561	**4.42**
FS.03.03 International non-profit-making organizations and foundations	475,753	0.09	392,724	**0.07**
FS.03.04 International profit-making organizations	148130	0.03	501,894	**0.09**
Total	**501,467,005**	**100**	**577,432,903**	**100**

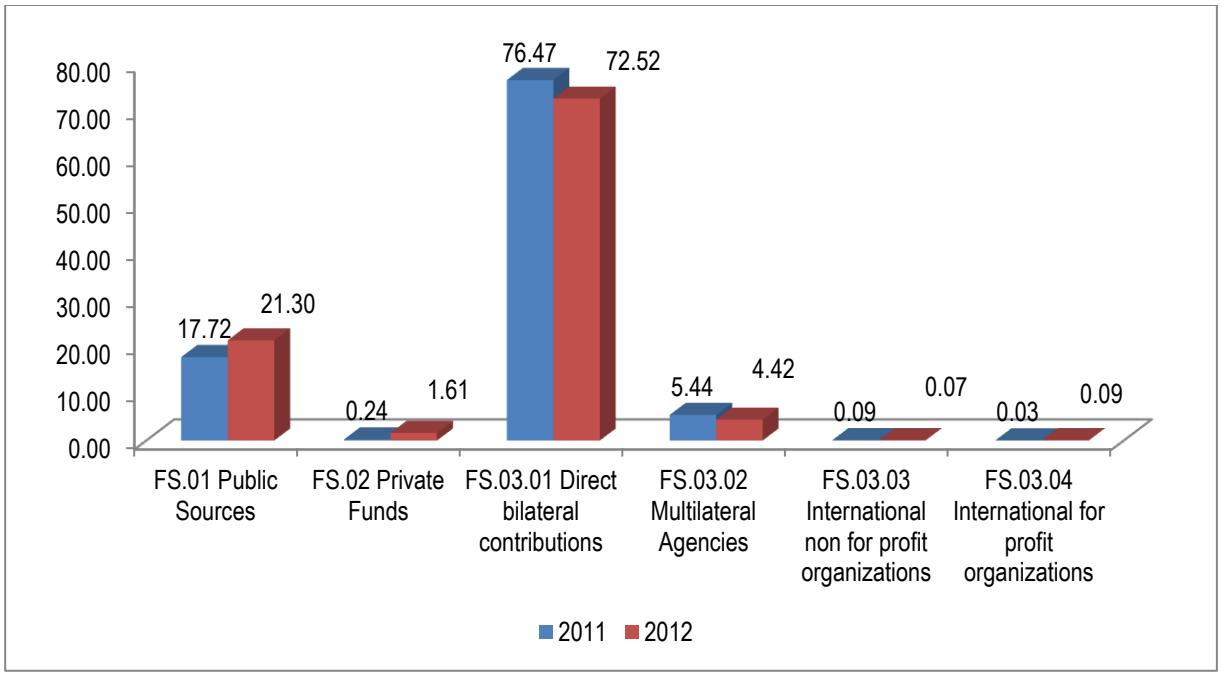


Figure 7 Financing Source in 2011 and 2012

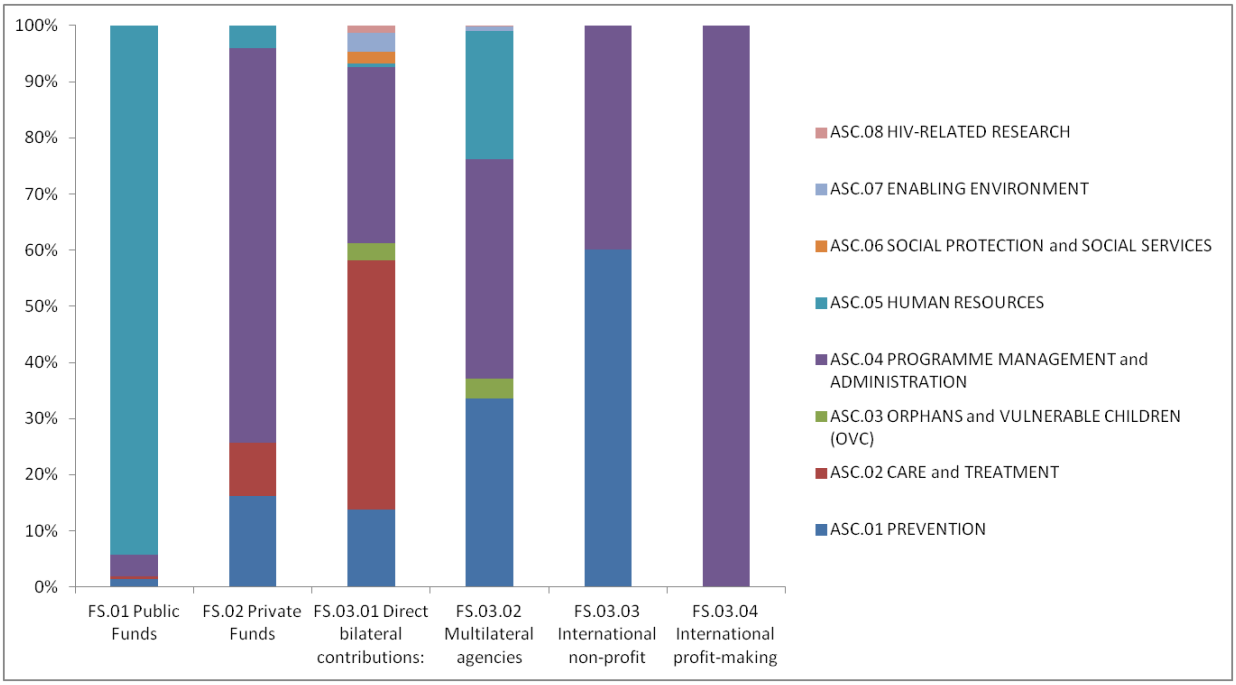


Figure 8 Spending by Financing Sources 2011

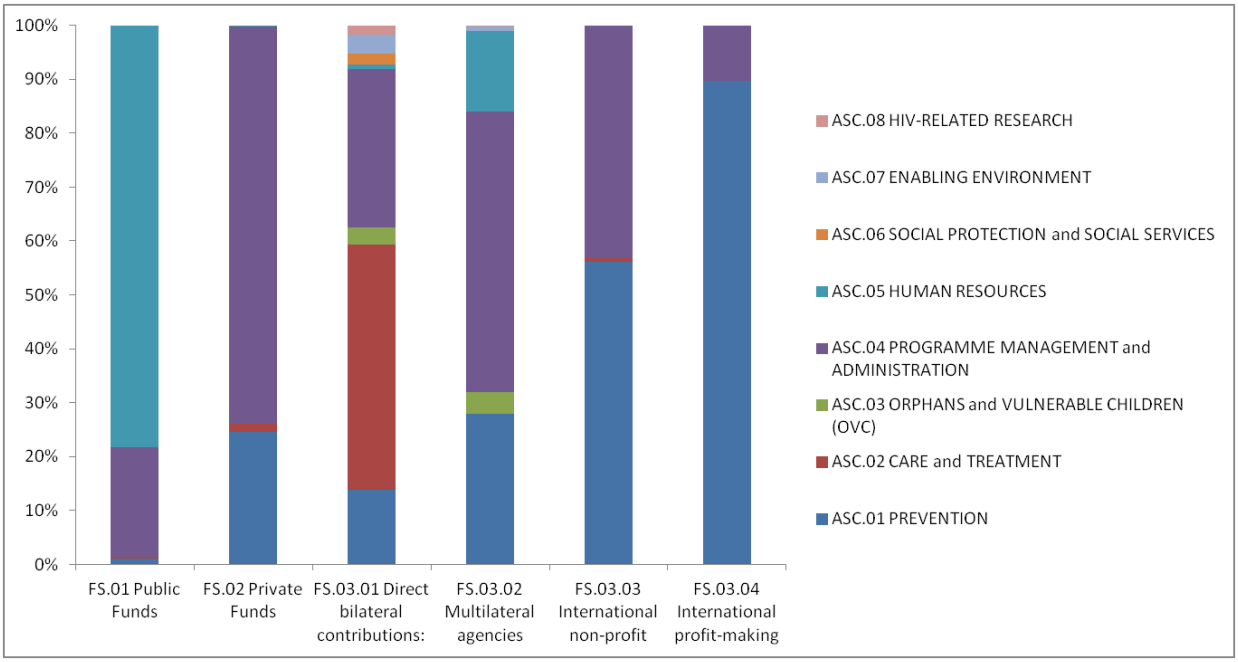


Figure 9 Spending by Financing Sources 2012

3.2 Expenditure by Programmatic Decision Makers

Table 3 shows the first and second digit analysis of the Financing Agents for 2011 and 2012. In 2011 and 2012, the centre of decisions on goods/services to be purchased, the provider of those goods/services and beneficiary populations was largely determined by the international purchasing organizations with 79.48% and 76.50% compared to 69.4% in 2010, 75.4% in 2009, 84% in 2008 and 71.4% in 2007.The Public sector followed with 17.93% and 21.44% for 2011 and 2012 from 25.2% in 2010, 23.6% in 2009, 15% in 2008 and 28.4% in 2007,while the private sector had 2.59% and 2.06% in 2011 and 2012 compared to 5.4% in 2010 and 1% in 2008 and 2009.

Table 3 Financing Agents in 2011 and 2012 (1st and 2nd digits analysis)

Financing Agent	USG 2011	%	USD 2012	%
FA.01 Public sector	**89,894,897**	17.93	**123,800,364**	**21.44**
FA.02 Private Sector	**12,993,176**	2.59	**11,904,339**	**2.06**
FA.03 International Purchasing Organizations	**398,578,932**	79.48	**441,728,200**	**76.50**
FA.03.01 Country offices of bilateral Agencies	383,412,027	76.46	418,667,801	72.51
FA.03.02 Multilateral Agencies	7,609,969	1.52	9,819,604	1.70
FA.03.03 International non-for profit Making organizations and foundations	66,723	0.01	14,184	0.00
FA.03.04 International for-profit organizations	148,130	0.03	6,396,894	1.11
FA.03.99 Other international financing agents n.e.c.	7,342,084	1.46	6,829,717	1.18
Total U$S	**501,467,005**	**100**	**577,432,903**	**100**

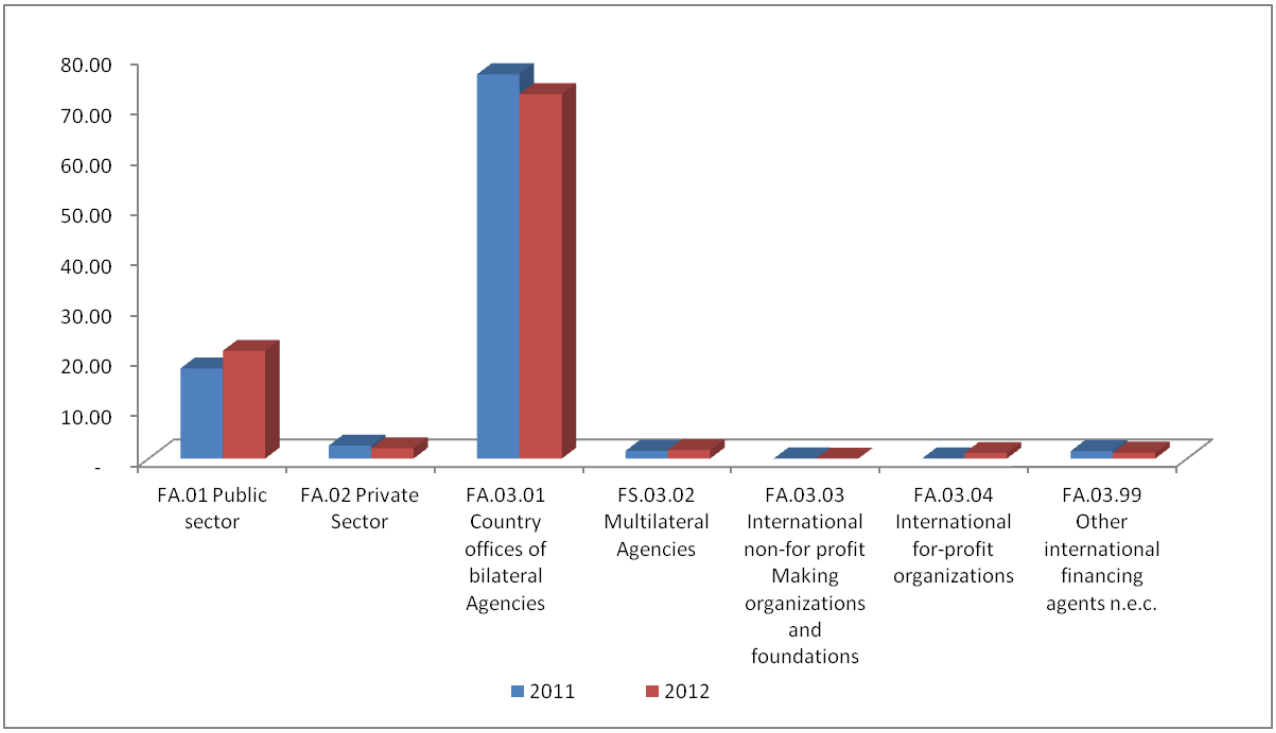


Figure 10 Financing Agents in 2011 and 2012

Table 4 Financing Sources to financing agents- 2011

FINANCIAL SOURCES		Central Government Revenue	Private Funds	Direct Bilateral Contributions	Multilateral Agencies	International not-for-profit Organizations and Foundations	International Organizations for-profit	TOTAL
FINANCING AGENTS	Public Sector	88,875,936			1,018,961			**89,894,897**
	Private Sector		1,207,840		11,785,336			**12,993,176**
	Bilateral Agencies			383,412,027				**383,412,027**
	Multilateral Agencies			84,373	14,458,650			**14,543,023**
	International non-profit					475,752		**475,752**
	international for profit						148,130	**148,130**
	Total	**88,875,936**	**1,207,840**	**383,496,400**	**27,262,947**	**475,752**	**148,130**	**501,467,005**

Table 5 Financing Sources to financing agents-2012

FINANCIAL SOURCES		Central Government Revenue	Private Funds	Direct Bilateral Contributions	Multilateral Agencies	International not-for-profit Organizations and Foundations	International Organizations for-profit	TOTAL
FINANCING AGENTS	Public Sector	122,964,880			808,337	27,147		**123,800,364**
	Private Sector		3,380,917		8,523,422			**11,904,339**
	Bilateral Agencies			418,667,801				**418,667,801**
	Multilateral Agencies			108,125	16,189,802	36,630		**16,334,557**
	International non-profit					328,948		**328,948**
	international for profit		5,895,000				501,894	**6,396,894**
	Total				**25,521,561**			**577,432,903**

3.3 HIV Expenditure through Provider of Service

The results presented in table 6 shows that more than half of the HIV goods and services were provided by the public sector in both years which is 55% and 57% percent respectively compared to 35.76% in 2010, 33.9% in 2009, 39.9% and 42.5% in 2008 and 2007. While the private sector and non-profit making institutions accounted for 44% and 42% in the provision of HIV goods and services compared to 60.85% in 2010, 64.7% in 2009, 53% in 2008 and 47.9% in 2007 demonstrating a decline in private sector involvement as providers of services. The contributions of the Bilateral and Multilateral entities was 2% for goods and services compared to the figure of 9.6% in 2007.

Table 6 HIV Service providers in 2011 and 2012(1st digit analysis)

HIV/AIDS Service Providers (1st and 2nd digits analysis)	2011		2012	
	Amount (USD)	Percentage (%)	Amount (USD)	Percentage (%)
PS.01-Public Sector Providers	273,835,863	55.00	326,503,352	57.00
PS.02-Private Sector non-profit Providers	219,760,302	44.00	240,918,309	42.00
PS.03-Bilateral and Multilateral entities	7,870,840	2.00	10,011,242	2.00
Total	501,467,005	100.00	577,432,903	100.00

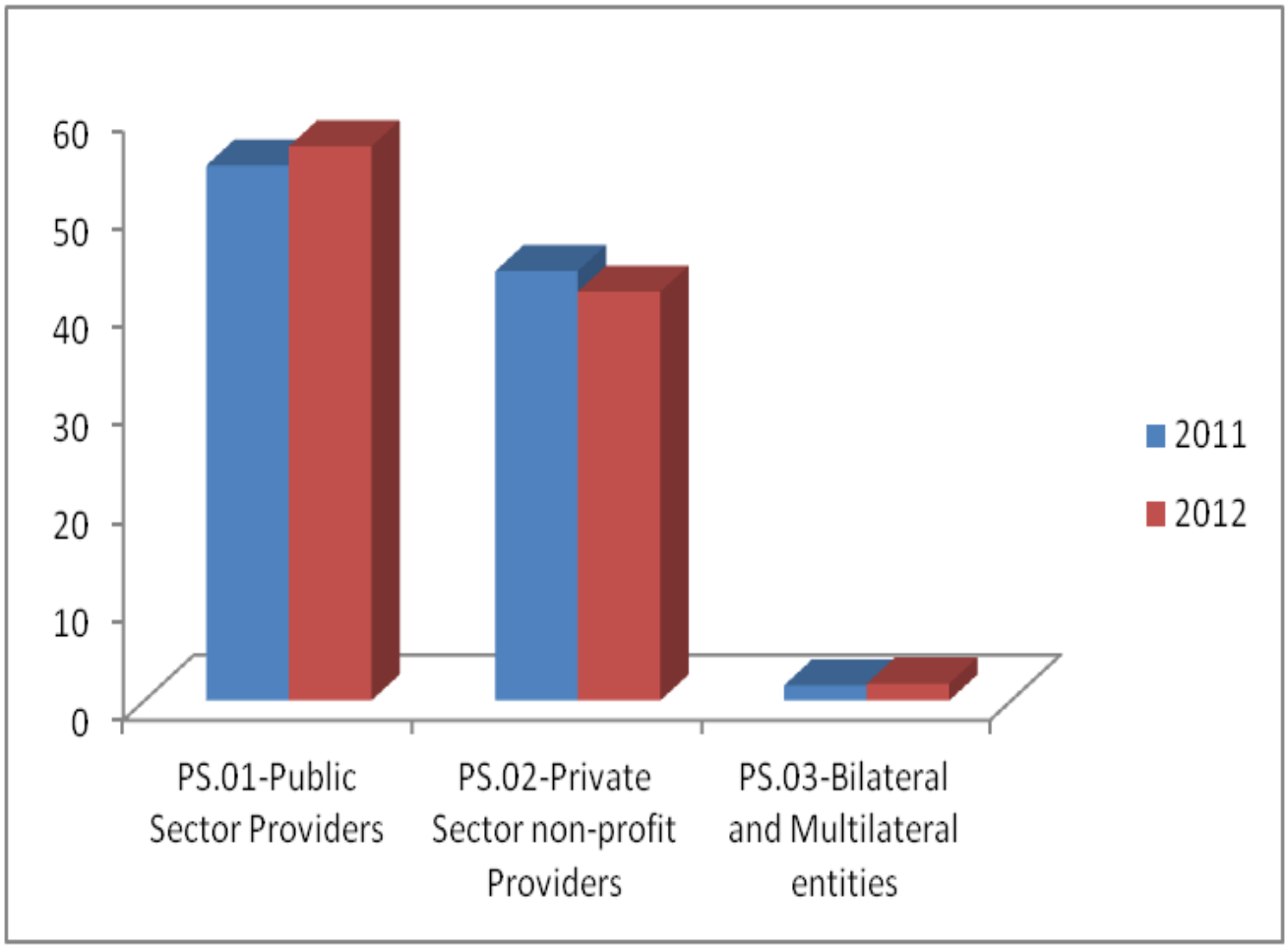


Figure 11 HIV/AIDS Service Providers in 2011 and 2012

3.4 Expenditure on HIV goods and services

The main area of spending in 2011 and 2012 as depicted in table 7 was on care and treatment $171million (34.12%) in 2011 and $191million (33.16%) in 2012 following similar trends in previous studies i.e. $186 million (37.4%) in 2010, $204 million (49.2%) in 2009, $185 million (47.1%) in 2008 and $135 million (44%) in 2007. Figures 12 and figure 13 are graphical representations of the broad AIDS spending categories for 2011 and 2012 respectively.

AIDS Spending Categories	2011		2012	
	AMOUNT(USD)	%	AMOUNT(USD)	%
ASC.01 Prevention	63,525,516	12.67	68,879,597	11.93
ASC.02 Care & Treatment	171,094,653	34.12	191,463,353	33.16
ASC.03 OVC	12,934,848	2.58	14,394,105	2.49
ASC.04 Program management	135,085,394	26.94	168,644,890	29.21
ASC.05 Human Resources	92,574,388	18.46	103,029,640	17.84
ASC.06 Social Protection	7,865,514	1.57	8,786,223	1.52
ASC.07 Enabling Environment	13,607,710	2.71	15,168,221	2.63
ASC.08 Research	4,778,982	0.95	7,066,874	1.22
Total	**501,467,005**	**100**	**577,432,903**	**100**

Table 7 AIDS spending categories in 2011 and 2012(1st digit analysis)

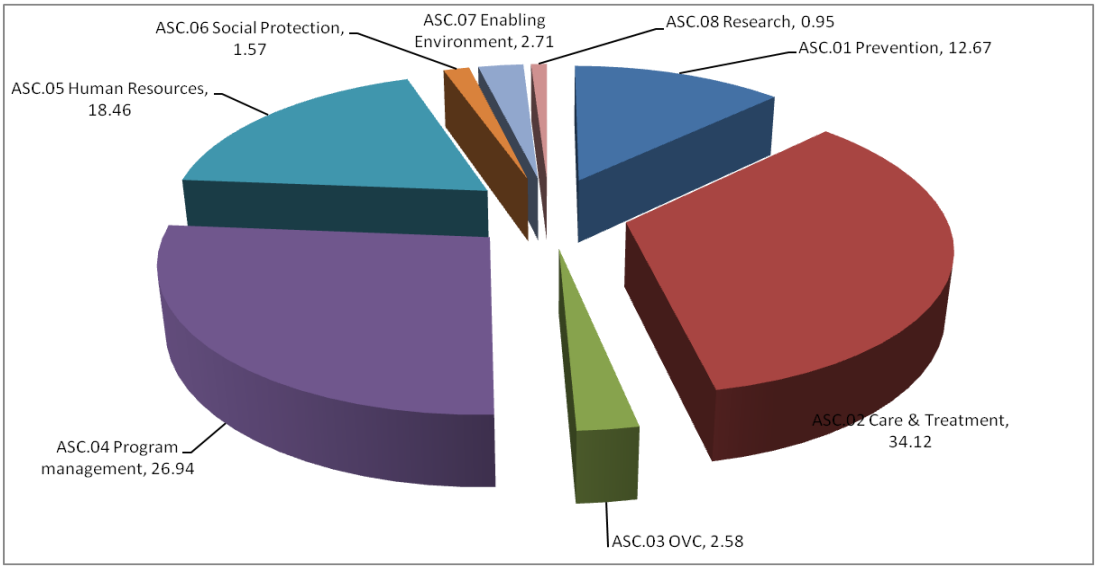


Figure 12 Broad AIDS Spending Categories in 2011

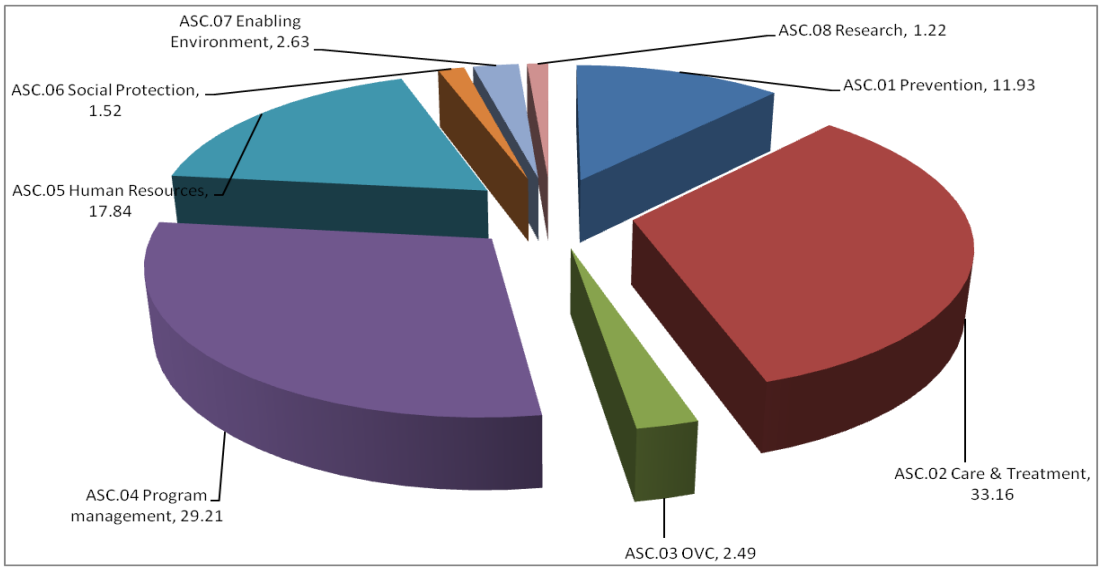


Figure 13 Broad AIDS Spending categories in 2012

3.5 Expenditure on beneficiary populations

Non targeted interventions accounted for majority of the funding (48.81% in 2011, 48.64% in 2012 respectively), followed closely by People Living with HIV/AIDS with (35.01%) in 2011 and (36.33%) in 2012. Specific accessible populations were the least beneficiaries in this study, as compared to 2007 to 2010 where the Most at – Risk –Populations (MARPS) were the least beneficiaries, 0.08% in 2007, 0.1% in 2008, 0.09% in 2009 and 0.11% in 2010 against the increased observed 2.06% and 3.44% for 2011 and 2012

Table 10 highlights the beneficiary populations in the years under review.

BENEFIACIARY POPULATION	2011		2012	
	AMOUNT(USD)	%	AMOUNT(USD)	%
BP.01-People Living With HIV	175,581,071	35.01	209,757,517	36.33
BP.02-Most-at-risk populations	10,342,359	2.06	19,855,006	3.44
BP.03-Other Key Populations	31,473,398	6.28	35,350,187	6.12
BP.04-Specific Accessible Population	2,446,177	0.49	2,056,840	0.36
BP.05-General Population	36,850,416	7.35	29,521,495	5.11
BP.06-Non-Targeted Interventions	244,773,583	48.81	280,891,858	48.64
Total	**501,467,005**	**100**	**577,432,903**	**100**

Table 8 Beneficiary Populations of the HIV and AIDS response in 2011 and 2012(1st digit analysis)

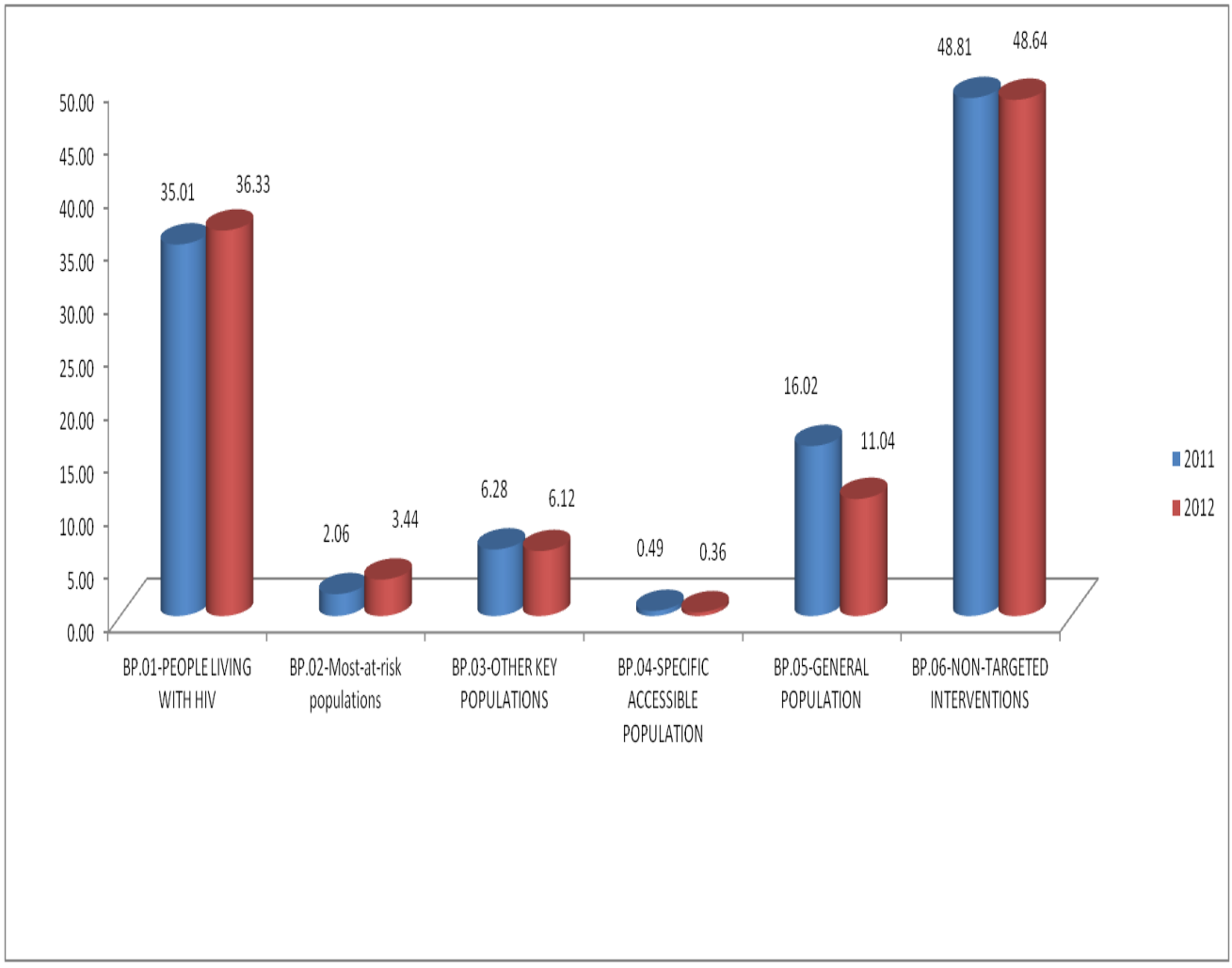


Figure 14 Beneficiary population in 2011 and 2012

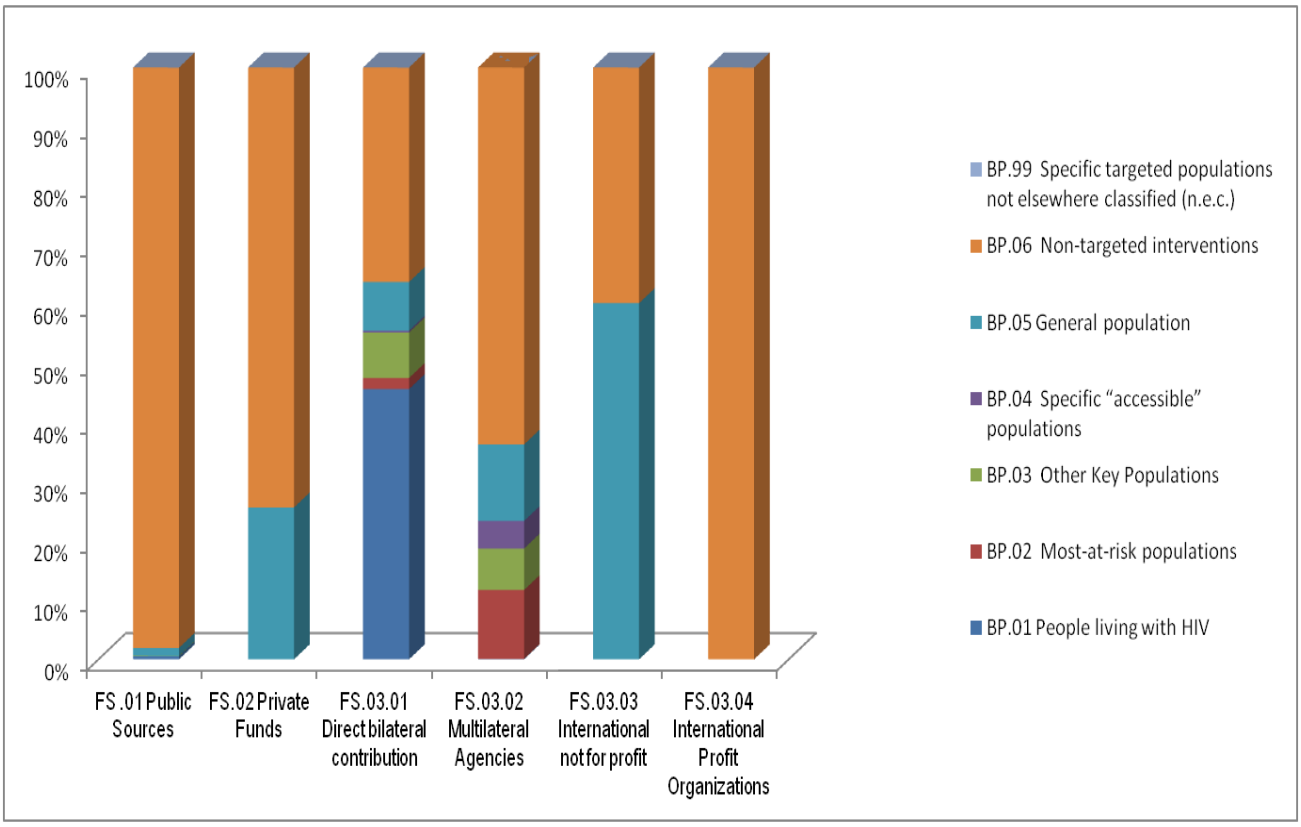


Figure 15 Beneficiary populations by Financing Source-2011

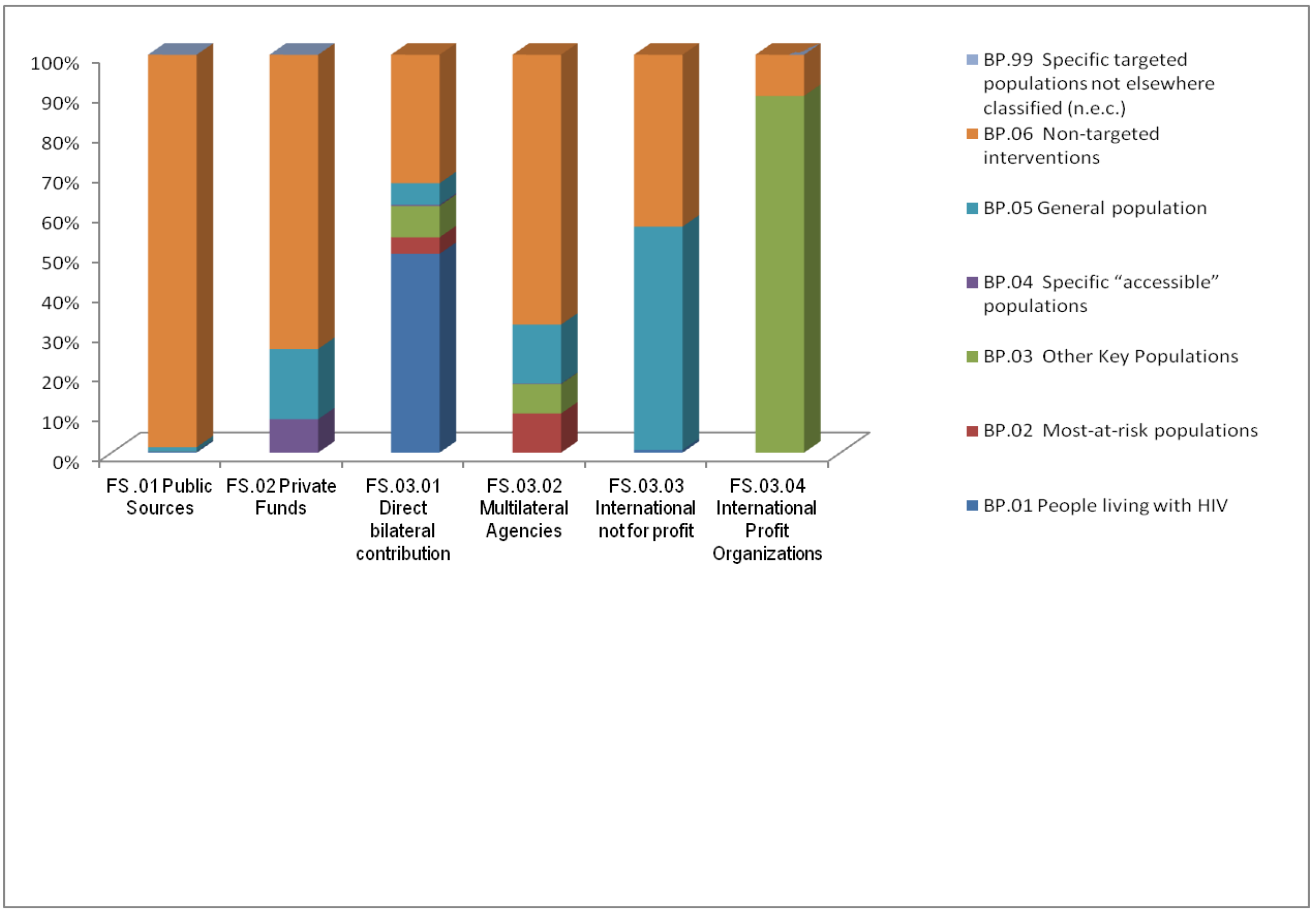


Figure 16 Beneficiary populations by Financing Source-2012

4.0 Discussion of Result

4.1 Financing Sources

The HIV/AIDS expenditure by Government in 2012 was 21.9 % ($122,964,880) and witnessed a slight decrease of (0.03%) when compared to the expenditure in 2010 which was 25% ($126,645,333). Conversely, the major part of the funding for the implementation of HIV/AIDS goods and services in Nigeria relied heavily on international funds 82.04% and 77.10% in 2011 and 2012 respectively, with the United States of America accounting for most of the bilateral contributions through PEPFAR.

4.2 Financing Agents

In the context of programmatic decisions (type of goods and services to purchase, service providers and beneficiary population) the international/purchasing organizations accounted for most of the decisions taken with (79.48 % and 76.50% in 2011 and 2012 respectively), which has been the observed trend in the previous studies. These international Financing Agents are made up of country offices of bilateral agencies, International not-for-profit making organizations and foundations and multilateral agencies. It is only logical for the bilateral and multi-lateral entities to account for majority of the decisions taken, as they cover the highest contributions to the national response for the period in review.

4.3 HIV/AIDS Service Providers

The public sector which comprises of Governmental ministries, parastatals and entities inside ministries. This sector was responsible for more than half of the goods and services provided in the HIV response for the period in review, followed closely by the private sector. This is an improvement from the previous studies, where the private sector has been the main provider of service. The bilateral and multilateral entities provided minimal services in both years studied.

4.4 AIDS Spending Categories

Like in previous NASA care and treatment category accounted for the highest expenditure with 34.12% and 33.16% in 2011 and 2012 respectively. The National Strategic plan 2010-2015 a proposed 50.0% expenditure on prevention but only recorded 12.67% and 11.93% in 2011 and 2012.The other intervention areas that accounted for high expenditure were Program Management and Human Resources. Orphans and Vulnerable Children showed a slight increase from the previous studies although this wasn't very significant; other intervention areas received comparatively minimal expenditure with Social Protection, Enabling Environment and research areas each not exceeding more than 3% of the overall expenditure in both years.

4.5 Beneficiary Population

Most of the expenditure of the period under review was captured as Non Targeted Population; due to planning and coordination activities, followed by the People Living with HIV/AIDS, due to the fact that the bulk of the expenditure was on care and treatment, in previous studies most of the expenditures have always been captured under care and treatment. The general population as seen a tremendous increase in funding for 2011 which was 16.02% but for 2012 there was drop by 1% even though both years are still below set target of 50.0% set in the NSP 2010-2015. This poses a challenge to all stakeholders in Nigeria HIV response programmes in attaining the "getting to zero" target of 2015. The population that were least beneficial in both years were the Specific Accessible Populations.

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

There are an estimated 34 million persons globally infected with HIV, (17.2 million men and 16.8 million women).Another 2.5million estimated newly infected occur annually, 7000 new infections occurring each day and at least 95% of all new infections occur in less developed countries. Of the 34 million PLHIV globally 22.5 million (68%) are in sub-Sahara Africa and 3.5 million in Nigeria, making Nigeria the country with the second highest number of PLWHA in the world (UNAIDS 2012). Access to improve care and treatment of PLWHAs has made more people with HIV/AIDS are live longer, therefore the number of PLWHA in Nigeria remain high (given that the population is huge).

The review of NASA over a four years period (2007 – 2012), shows that the expenditure on HIV has increased from $299 million in 2007 to $577 million in 2012. Consequently, overall the expenditure in most categories has also increased (except bilateral service provision). During this period, there are some notable variations in the pattern of spending. Public funds accounts for 21.3% of total funds and international funding is about 77.1% ($445 million in 2012).Though the government has taken step to address this huge financial gap in the national response. It is still heavily reliant on international funding. The evidence suggests that some African countries are similarly reliant on international funding (Ghana 75%), Kenya (75%)[11] and Lesotho (64%) [3] for their national HIV response.

4.6.1. Expenditure by service provider and programmatic area

In terms of expenditure by service providers, the expenditure by public providers increased from $177 million (36%) in 2010 to $326 million (57%) in 2012.The period under review shows that, service provision by private non-profit providers and Bilateral/multilaterals decreased. The increased expenditure in service provision by public providers probably indicates a higher capacity development and ownership of the national programme.

A review of HIV/AIDS expenditure by programmatic area in the past 6 years shows prevention range from 12.6% $38 million (in 2007), 12.45% (in 2010) and 11.92% in 2012 with $62million (12.5%) and $67million actually spent in and 2010 and 2012 respectively. An increase of 76% on the expenditure for prevention has occurred over the 6 year.

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

Given the significant increase in expenditure for prevention, the targets for prevention were not achieved. These findings indicate that a lot of prevention work should be carried among these high priority groups. The expenditure on the MARPS has increase from 0.1% ($558,000 in 2010) to 3% ($19,855,006.00 in 2012) though this increase is still low considering the need to reach this group with more services. The MARPs groups (FSW, MSM) are disproportionately affected by HIV, since they constitute only about 3.5% of the population. In fact, it is of great concern that HIV prevalence has increased among MSM from 13.5% in 2007 to 17.2% (2010). Consequently, it is important to target resources efficiently

[11] Kenya National AIDS Spending Assessment : Report for the financial years 2006/07 and 2007/08-
[12] Federal Ministry of Health 2010. HIV Integrated Biological and Behavioural Surveillance Survey (IBBSS) 2010

at these groups and increase the level of knowledge about HIV and its prevention. Prevention programmes should be evaluated for their cost-effectiveness and non-effective interventions should be de-commissioned.

An estimated 281,181 number of new HIV infections were reported in 2012.The Mode of Transmission (MOT) study reported that 62% of new infections occur among persons perceived as practicing 'low risk sex' in the general population including married sexual partners and the leading route of transmission is heterosexual intercourse accounting for over 80% of HIV infections. Therefore evidence-based preventive interventions should be funded to ensure that higher numbers of Nigerians remain HIV negative.

Given, that 95% of Nigerians are HIV negative and that prevention is a major cornerstone and strategy for the national response, resources should be efficiently and effectively used to address the HIV epidemic. Therefore, HIV prevention intervention programmes should seek to address the key drivers of the HIV epidemic in Nigeria including: low personal risk perception, multiple concurrent sexual partnerships, intense transactional and inter-generational sex, ineffective and inefficient sexual health services, inadequate access to and poor quality of healthcare services, gender inequalities, HIV stigma and discrimination (HIV NSP2010- 2015).

In 2011 and 2012 people living with HIV took 35% (N175, 581,071.00,) and 36% (N209,757,517.00) of total expenditure for HIV. Programme management which is classified as non –targeted had 49% for both 2011 and 2012 total HIV expenditures.

Treatment and care in 2011 and 2012 had $171 million (34%) and $191 million (33%) respectively, which are below the cost estimates of $303 million (2011) and $363 million (2012) proposed by the sustainability analysis report. Monetary allocations for treatment and care should be adequate and effectively managed to ensure that 1.5 million PLWHA eligible for ART received their therapy. As at 2012, only 33% of eligible PLWHA were on ART, even though the treatment target for 2012 was 56 %(NSP 2010 – 2015).

4.6.2. Research

The NACA national HIV/AIDS strategic priorities identify research as one of the strategic priorities for 2010 -2011[13]; in 2012 $7,066,874 (1.22%) went to research as compared to $2.1 million (0.42%) in 2010, though an increase it is below the 5% budgetary allocation stipulated in the National HIV /AIDS Research Policy 2010[14]. Although expenditure allocations for research has increased from $68,376 (in 2007) to $2.1 million (in 2010) and to 7million in (2012), biomedical and operations research in Nigeria is required to inform HIV policy, planning and effective programme implementation. Efforts to promote the research agenda are being made: with the recent publications of National HIV/AIDS Research Policy and the National research agenda on HIV/AIDS in Nigeria 2010-2015 and the setting up of an operations research technical committee group will go a long way to promote HIV/AIDS research activities.

[13]NACA January 2010. National HIV/AIDS strategic priorities 2010 -2011
[14]NACA. National HIV/AIDS Research Policy 2010, p29

4.6.3. Monitoring and Evaluation (M & E)

The NOPII 2011- 2016 is the revised NNRIMS operational plan according to the principle of the three ones. The M&E process has improved tremendously from the paper base to the electronic base using the DHIS 2.0, which has been upgraded to 2.13.

The National Policy on HIV/AIDS 2009 recommended that a minimum of 8% of HIV/AIDS programme budget of all institutions engaged in the implementation of HIV activities should be committed to M & E[15]. In 2010 $8,594,124 and $6,795,424 in 2012 was expended for M&E, which shows a decrease in 2012 and the expenditure in both years fall short of the stipulated 8% of the total budgets. The data collection system has improved based on improved database platforms. The capacity of the states has been built on the DHIS 2.0 HIV instance and step down training to the LGAs and facility levels, where over 73% of states now submit data through the DHIS 2.0.The standardization and harmonization of the non-health sector indicators, data collection and reporting tools has been concluded. The data validation process has been scale down to the state level to ensure availability of reliable data at all levels.

4.6.4. Coordination of the national HIV response

Some of the infrastructures and global mechanism for an effective national HIV response are in place in Nigeria. Nigeria has complied with the 'three ones' principles. The latest NSP 2010-15, re-positioned HIV prevention as a core strategy for halting the HIV epidemic and major progress achieved in reducing the national HIV prevalence to 4.1% among pregnant women attending ante natal clinics (ANC), from a peak of 5.8% in 2001 and from 3.6% in 2007 to 3.4% in 2012(NARHS 2012) in the general population. The recently launched Presidents' Comprehensive Response Plan (PCRP) will make the states take ownership of the response and not see it as a national programme. There is however need to conduct more cost – effectiveness and evaluation studies to evaluate all HIV programmes in the country against their set objectives. The expenditures for social protection in 2012 is 1.52% (8,786) which is low considering the link of social issues with HIV/AIDS.

4.6.5. The out of pocket expenditure (OOP)

Most HIV/AIDS services are rendered free, but the projection estimates on out of pocket expenditure for 2011 and 2012 base on the out of pocket expenditure study conducted for 2009 and 2010 revealed that individuals spent a total of $228 million and $259million in 2011 and 2012 respectively. About 14.5% of their household incomes were spent in accessing HIV services, which is above the 10% catastrophic threshold. It may be comparatively cheaper and beneficial for PLWHA to channel some of these funds into an insurance scheme for effective service delivery.

4.6.6. Budgets against actual expenditure in the National Response

[15]NACA. National Policy on HIV/AIDS. October 2009.

[6]Federal Ministry of Health (FMoH) [Nigeria].2013. National HIV/AIDS and Reproductive Health Survey 2012 (NARHS plus).

The national strategic plan costed for HIV AIDS in 2010[6] was $673,002,995.00 the national AIDS spending assessment for 2012 recorded an expenditure of $577,432,903.00, which is 86% of total budgeted figures. This may look good and encouraging for the national response. However the fact remains that the funds for implementation of vast majority of HIV AIDS goods and services is largely dependent on international funds (82% and 77% for 2011 and 2012 respectively)

Budget against expenditure for 2012.

S/N	Item	Amounts Budgeted in 2012	Expenditures in 2012	% of 2012 budget expended.
1	Total Budget	$673,002,995.00	$577,432,903.00	86%
2	Prevention	$143,699,547.00	$68,879,597.00	48%
3	Care and treatment	$432,361,367.00	$191,463,353.00	44%
4	M&E and research	$61,182,090.00	$13,841,293.00	23%

In the period under review, prevention recorded a slight decrease in expenditure (12.45% 2010 and 11.9% 2012) though with an increase in absolute figures $62 million (2010) and 67 million in (2012). The figures for 2012 are 48% of the total planned for prevention in 2012 compare to 12% in 2010. This indicate the need for increase prevention activities, which the government is already undertaking through the MARPs and the general prevention programmes nationwide

The expenditure for HIV care and treatment in 2012 was $191million and reaching (44%) of the planned figure of $432million. To be able to place the 1.5million PLWA eligible for ART on treatment, there is need to increase funding for care and treatment.

The national strategic plan 2010-2015, grouped Monitoring and Evaluation and research together. The expenditure for research and monitoring and evaluation amounted to $13,841,293.00 (23%) against the $61,182,090.00planned.This is inadequate for effective monitoring and evaluation and research activities of the national HIV response. Considerably more attention needs to be given to the important areas.

5.0 Conclusion and Recommendation

#	Key Message	Details
1.	**HIV spending:**	HIV spending in the country increased from $501,467,005 in 2011 to $577,432,903 in 2012.
2.	**Decreased spending by Government:**	HIV spending by Government in 2012 decreased by 3% compared to 2010. ($126 million in 2010 to $122 million in 2012)*
3.	**Funding of the HIV response:**	The HIV response in Nigeria is highly dependent on international funds with bilateral agencies as the main source of international funds.
4.	**Financial decision making for the HIV response:**	The programmatic decisions on what HIV goods and services that were purchased, provider of the goods and services and the beneficiary population were determined by the international organizations.
5.	**Profile of Spending:**	Most of the HIV spending in 2011 and 2012 was on Care and treatment.
6.	**People living with HIV/AIDS was the main beneficiary population:**	People living with HIV/AIDS benefited from most of the HIV expenditure in the years under review.
7.	**Relatively low spending on the general population.**	The expenditure on the general population increased to 16.02% of the total expenditure in 2012 compared to 5.6% in 2009. This is still considered low.

5.1 Recommendations

#	Key Message	Details
1.	**Institutionalize NASA**	Institutionalize the NASA process in Nigeria for ease of data collection and reporting on HIV and AIDS spending. The key issues that need to be addressed are: a) greater advocacy to all stake holders especially the private sector b) streamlining of financial disbursement and reporting mechanisms c) NACA coordinating mandate has to be enforced - through a suitable mechanism that will effectively and efficiently 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.	**Use NASA for National planning**	Use NASA data to determine the comprehensiveness and robustness of the national HIV/AIDS strategic plan and framework. Use NASA data for priority setting in HIV/AIDS planning processes.
3.	**Increase level of spending on General population:**	HIV/AIDS Prevention programmes targeting general population should be strengthened and expanded. The mode of HIV transmission study conducted in Nigeria revealed that about 60% of new infections will occur among the general population(Low risk and casual heterosexual)
4.	**Improve Government Spending**	Government spending on the HIV national response should be increased in line with the strategic framework and action plan to reduce dependence on international funds, for scale up of all interventions, exit strategy for reducing donor funds and most importantly for sustainability
5.	**Dissemination of report**	The dissemination of an abridged form of the report in the 6 geographical regions of the country will ensure that the document is used for planning and allocation of resources.

Appendices

Contacted Institutions and data collectors

Appendix 1 Contacted Institutions and data collectors

S/N	Institution	Contact person
1	Access Bank	Omobolanle Babatunde
2	Adeoyo Maternity Hospital	NiL
3	Association for Reproductive and Family Health	Adebayo Sunmola
4	Benue State Ministry Of Health and Human Resources	Dr.G.M.G. Dura
5	Family Health International	Nkata Chuku
6	Federal Ministry of Education	Offiah Biddy
7	Federal Ministry of Health	Dr Francis Ukwuije
8	Federal Ministry of Women Affairs and Social Dev	Odo T.I
9	Federal Road Safety Corp	Cecelia C. Ejindu
10	Federation of Muslim Women Association of Nigeria	Hajiya Iyabo Sanni
11	First Step Action For Children Initiative	Rosemary Hua
12	For profit private Hospital	NIL
13	Government Hospital	NIL
14	Greenwatch initiative	Emmanuel Tembe
15	Hygeia Foundation	Dr Etsetowaghan
16	I Care Women and Youth Initiative	Abdullahi Bala
17	Institute of Human Virology,Nigeria	Debo Olateju
18	International Labour Office	Pius Udo
19	International Centre for AIDS care & treatment programme	Bola Oyeledun
20	Family Health International	Nkata Chuku
21	Joint United Nations Programme On HIV/AIDS	Are Shodeinde
22	Lagos State Ministry of Education	Mrs. M.K Hazoume
23	Management Sciences For Health	Donna Coulibay
24	Measure Evaluation	NIL
25	Millennium Development Goal Office	Dr. Ibrahim Kana
26	Nassarawa State AIDS Control Agency	NIL
27	National Agency for the Control of AIDS	Dr Kayode Ogungbemi
28	National Population Council	Usman Abdul Razak
29	National Youth Service Corps	Victor Uyanne
30	Network of People living with HIV/AIDS in Nigeria	Edward Ogenyi
31	Old Netim Health and Development Organisation	NIL
32	Partners For Development	Ediri Iruaga
33	Pathfinder International	OlamideOyelade
34	Society For Family Health	Scott Adamu
35	United Nations Children's Fund	Dr. Victoria
36	United Nations Development Programme	David Owolabi
37	United Nations Population Fund	Uzoma Okoye
38	US President's Emergency Plan for AIDS Relief (PEPFAR)	Dr. Murphy Akpu
39	Women, Youth and Children Upliftment	Lilian Ekanem
40	World Health Organization	Malan Bungudu
41	Youth Empowerment Foundation	NIL

42	FMW A& SD	Hayatu F. Z
43	NBS	Oriokpa V. I.
44	CISHAN	Walter U
45	Population council	Usman Abdul Razak
46	Federal Ministry of Education	Adamu Jibrilla
47	Ministry of Defence	Pat Matemilola
48	NASCP	Gwomson Dauda
49	UNAIDS	Archana Sood
50	UN Women	Mrs Ekaete
51	UNFPA	Godwin Asuquo

Time line for NASA implementation

Appendix 2 Time line for NASA implementation

Timelines for the implementation of NASA 2013																							
	July				August				Sept				October				November				December		
	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3	wk4	wk1	wk2	wk3
Hiring of consultants																							
Setting of secretariat																							
Development of implementation plan																							
Stakeholders meeting																							
NASA Core team training																							
Training of focal persons from organisations																							
Data collection																							
Data processing and analysis																							
Out of pocket/Government expenditure for Human Resource and triangulation of NASA findings																							
Data validation by Institutions																							
Report writing																							
Presentation of preliminary findings																							
Final report																							

Reported Official Development assistance for HIV to Nigeria, 2001-2012 (US$ millions)

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

Appendix 3 Official Development assistance for HIV to Nigeria, 2001-2012

Donor	2001	2002	2003	2004	2005	2006	2009	2010	2011	2012
Canada	-	6.365	-	2.031	4.434	2.577	1.758	0.882	0.017	0.019
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		0.007	
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	2.301	1.790
United States	-	4.781	33.738	54.962	51.538	95.693	170.503	286.028	74.150	70.715
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	0.773	0.689
UNAIDS	1.103	0.275	0.884	-	1.125	-	1.151	0.988	0.054	0.028
UNFPA	-	-	0.030	-	-	-	0.279	0.315	0.284	0.314
GFATM	-	-	2.523	0.303	15.273	19.678	6.675	40.182	3.750	2.630
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**	**81.33**	**76.18**

Source: OECD database

Assumption on Exchange rate

The Naira to US dollars exchange fluctuated tremendously in 2011 and 2012. An average exchange rate of N156 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 2011 and 2012
- Disaggregation of the first and second line ARVs distributed by adult and pediatrics

Appendix 4 Assumptions for ART laboratory monitoring and OI diagnostics estimations

	2011	2012
Number of patients on ART	432,285	491,021
Male patients on ART	N/A	
Female patients on ART	N/A	

Source: Federal Ministry of Health

Type of test	Number of tests per patient per year	Cost per test	Cost of tests in 2011	Cost of tests in 2012
HIV Serology	1	$2.61	$1,128,263.85	$1,281,564.81
CD4	2	$65.36	$28,254,147.60	$32,093,132.56
Hb	3	$1.31	$566,293.35	$643,237.51
Liver function test	2	$9.80	$4,236,393.00	$4,812,005.80
Renal function test	2	$13.07	$5,649,964.95	$6,417,644.47
HB2Aq	1	$4.58	$1,979,865.30	$2,248,876.18
UDRL and TPHA (STI tests)	1	$3.27	$1,413,571.95	$1,605,638.67
Chest testing	1	$11.76	$5,083,671.60	$5,774,406.96
sputum test	1	$3.92	$1,694,557.20	$1,924,802.32

Source: Federal Ministry of Health

STI treatment estimations

STIs

In Nigeria, there are about 3 million reported annual cases of STI's mainly caused by Chlamydia, N. Gonorrhoea and trichomonas vaginalis. There are also increasing reports of genital ulcer disease (GUD) due to chancroid, herpes, and primary syphilis.[16].

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

OI prophylaxis and treatment estimations

Appendix 5 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 (2011)		Year 2 (2012)	
Candidiasis							Patient Population			
							Number of tabs/pop	Total Cost	Number of tabs/pop	Total Cost
	Oral	Nystatin- 500,000 IU	4x/day for 5 days	20	1	0.0461	6059460	279341.11	7183620	331164.88
	Oesophagitis	Fluconazole- 200 mg	1/day for 105 days	105	1	0.0416	31812165	1323386.1	37714005	1568902.6
	Vulvo-vaginal	Clotrimazole- 500 mg	1/day	1	6	0.183	1817838	332664.35	2155086	394380.74
Herpes								0	0	0
	Oral and genital	Acyclovir 200 mg	5/day for 10 days	50	1	0.045	15148650	681689.25	17959050	808157.25
	Herpes zoster	Acyclovir 200 mg	20/day for 10 days	200	1	0.045	60594600	2726757	71836200	3232629
Diarrhea								0	0	0
	Bacterial	Metronidazole 400 mg	2x/day for 10 days	20	2	0.0039	12118920	47263.788	14367240	56032.236
		Cotrimoxazole 960 mg	2x/day for 10 days	20	2	0.0228	12118920	276311.38	14367240	327573.07
		Ciprofloxacin 500 mg	1x/day for 10 days	10	2	0.0253	6059460	153304.34	7183620	181745.59
Pneumonia								0	0	0

	Bacterial	Amoxycillin 500 mg	4x/day for 10 days	40	1	0.0352	12118920	426585.98	14367240	505726.85
	PCP prophylaxis	Cotrimoxazole 960 mg	1x/day for 360 days	360	1	0.0228	109070280	2486802.4	129305160	2948157.6
	PCP	Cotrimoxazole 960 mg	8x/day for 21 days	168	1	0.0228	50899464	1160507.8	60342408	1375806.9
Crypcococal Mengitis								0	0	0
		Amphotericin B 50 mg (INJ)	1 (0.7 mg/kg) x/day for 14 days	14	1	7.1837	4241622	30470540	5028534	36123480
		Flucytosine 100 mg	1x/day for 14 days	14	1	N/A	4241622	0	5028534	0
		Fluconazole- 200 mg	2x/day for 56 days	56	1	0.0416	16966488	705805.9	20114136	836748.06
Toxoplasmosis								0	0	0
	<60 kg	Pyrimethamine-25 mg	2x/day for 42 days	42	1	0.0055	12724866	69986.763	15085602	82970.811
	>60 kg	Pyrimethamine-25 mg	3x/day for 42 days	42	1	0.0055	12724866	69986.763	15085602	82970.811
		Clotrimoxazole 960 mg	2x/day for 42 days	84	1	0.0228	25449732	580253.89	30171204	687903.45
Fungal Skin Infections		Miconazole, 2% in 30 mg	2 tube/patient	2	2	0.333	1211892	403560.04	1436724	478429.09
Scabies		Benzyl Benzoate, 25 %, 100ml	1bottle/patient	1	1	0.0025	302973	757.4325	359181	897.9525
Bacterial Skin Infections		Amoxycillin 500 mg	4x/day for 5 days	20	1	0.0352	6059460	213292.99	7183620	252863.42
TOTAL								**42,408,797.16**		**50,276,540.07**

Source: NACA

Calculation of opportunistic infection drugs

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

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

Government Expenditure on Human Resources Estimates

Appendix 6: Government Expenditure on Human Resources Estimates

Methodology

The data used in this NASA report for Government Expenditure on Human Resources were estimates based on the survey report on Government Expenditure on Human Resources[1] for the year 2009 and 2010. Using the 2010 figures as the base year, projections were done to calculate estimates for the years 2011 and 2012. The annual growth rate of each category of health personnel[2] was used to project for the year 2011 and 2012.

Assumptions

1. There was no salary increase for all categories of health workers between 2010 and 2012.

Limitation

1. There was limited availability of financial data on human resource for HIV/AIDS programmes
2. There are limited literatures on the subject of expenditure on Human Resources for Health
3. A survey was not conducted to determine the estimate for government expenditure on human resources for HIV/AIDS due to lack of funding

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[1] National Agency for the Control of AIDS (NACA) 2011: Government Expenditure on Human Resources

[2] Federal Ministry of Health (FMOH) 2012: Human Resources for Health Report 2012

The out of pocket expenditure (OOP) for 2011 and 2012

Appendix 7 out of pocket expenditure (OOP) for 2011 and 2012

HIV service	2011	2012
Laboratory	N164,268,300.00 ($1,026,677.00)	N186,587,980.00 ($1,166,175.00)
ART	N1,117,193,662.00 ($6,982,460.00)	N1,268,994,672.00 ($7,931,217.00)

Non-ART	N3,314,7614.00 ($207,173.00)	N37,651,490.00 ($235,322.00)

1.Laboratory services: Include test s like HIV serology,CD4,Hb,Liver function test, Renal function test ,HBsAg, UDRL and TPHA (STI test),chest testing and sputum test.
2. ART: Payments made for ARVS.
3. Non-ART: Payments made for drugs other than ARVs.
4. HIV Services: Any care that is paid for and received on account of accessing ART by a PLWHA

Summary of findings

Annual household income	N586,584 ($3,910)
Average annual out–of-pocket expenditure for HIV services	N84,480 ($563)
Total annual out-of pocket expenditure for HIV services in 2011	N36,519,436,800.00 ($228,246,480.00)
Total annual out-of pocket expenditure for HIV services in 2012	N41,481,454,080.00 ($259259088.00)
The proportion of household income spent on HIV services	14.5%
Average annual OOP spend on condoms	N7,728 ($52)
Total annual OOP spend on condoms in 2011	N1,971,010,944.00 ($12,318,818.00)
Total annual OOP spend on condoms in 2012	N2,238,817,056.00 ($13,992,607.00)

PEPFAR-NASA categories Crosswalk for Nigeria

Appendix 8 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

Financing Source	USD 2011		USD 2012	
	Amount(USD)	%	Amount(USD)	%
FS.01 Public Sources	88,875,936	**17.72**	122964880	**21.30**
FS.01.01.01 Central government revenue	88,875,936	**17.72**	122964880	**21.30**
FS.02 Private Funds	**1,207,840**	**0.24**	1207840	**0.21**
FS.02.01 Profit-making institutions and corporations	392,218	**0.08**	8415812	**1.46**
FS.02.03 Non-profit-making institutions (other than social insurance)	572,147	**0.11**	640785	**0.11**
FS.02.99 Private financing sources n.e.c.	243,475	**0.05**	219320	**0.04**
FS.03 International Funds	**411,383,229**	**82.04**	**445,192,105**	**77.10**
FS.03.01 Direct bilateral contributions	383,496,400	**76.47**	**418,775,926**	**72.52**
FS.03.01.04 Government of Canada	84,373	**0.02**	108125	**0.02**
FS.03.01.12 Government of Japan	35,352	**0.01**	N/A	**N/A**
FS.03..01.21 Government of United Kingdom	11,536,819	**2.30**	10333940	**1.79**
FS.03.01.22 Government of the United States of America	371,839,856	**74.15**	408333861	**70.72**
FS.03.02 Multilateral Agencies	27,262,947	**5.44**	**N/A**	
FS.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	18,802,876	**3.75**	15184368	**2.63**
FS.03.02.08 UNAIDS Secretariat	268,649	**0.05**	164164	**0.03**
FS.03.02.09 United Nations Children's Fund (UNICEF)	3,874,252	**0.77**	3977578	**0.69**
FS.03.02.11 United Nations Development Programme (UNDP)	857,150	**0.17**	1258157	**0.22**
FS.03.02.17 United Nations Population Fund (UNFPA)	1,424,648	**0.28**	1814453	**0.31**
FS.03.02.18 World Bank (WB)	2,034,276	**0.41**	3122841	**0.54**
FS.03.02.20 World Health Organization (WHO)	1,096	**0.00**	N/A	**N/A**
FS.03.03 International non-profit-making organizations and foundations	475,753	**0.09**	392,724	
FS.03.03.01 International HIV/AIDS Alliance	**N/A**		N/A	
FS.03.03.25 The Clinton Foundation	7,843	**0.00**	14184	**0.00**
FS.03.03.31 United Nations Foundation	N/A		36630	**0.01**
FS.03.03.34 International Planned Parenthood Federation	58,880	**0.01**	27147	**0.00**
FS.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	409,030	**0.08**	314,764	
FS.03.04 International for Profit Making	148130	**0.03**	501894	**0.09**
Total	**501,467,006**	**100**	**577,432,903**	**100**

Appendix 10 Spending pattern by financing source-2011

AIDS Spending Categories	FS.01 Public Funds	%	FS.02 Private Funds	%	FS.03.01 Direct bilateral contributions:	%	FS.03.02 Multilateral agencies	%	FS.03.03 International non-profit	%	FS.03.04 International profit-making	%	Total
ASC.01 PREVENTION	1,243,346	1.40	195,735	16.21	52,656,365	13.73	9,143,750	33.54	286,320	60.18			63,525,516
ASC.02 CARE and TREATMENT	459,053	0.52	114,246	9.46	170,502,126	44.46	19,228	0.07		0.00			171,094,653
ASC.03 ORPHANS and VULNERABLE CHILDREN (OVC)	20,469	0.02		0.00	11,950,600	3.12	963,779	3.54		0.00			12,934,848
ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION	3,420,824	3.85	850,119	70.38	119,811,998	31.24	10,664,891	39.12	189,432	39.82	148,130	100	135,085,394
ASC.05 HUMAN RESOURCES	83,732,244	94.21	47,740	3.95	2,584,917	0.67	6,209,487	22.78		0.00			92,574,388
ASC.06 SOCIAL PROTECTION and SOCIAL SERVICES		0.00		0.00	7,865,514	2.05		0.00		0.00			7,865,514
ASC.07 ENABLING ENVIRONMENT		0.00		0.00	13,399,473	3.49	208,237	0.76		0.00			13,607,710
ASC.08 HIV-RELATED RESEARCH		0.00		0.00	4,725,407	1.23	53,575	0.20		0.00			4,778,982
Total	88,875,936	100	1,207,840	100	383,496,400	100	27,262,947	100	475,752	100	148,130	100	501,467,005

Appendix 11 Spending categories by financing source-2012

AIDS Spending Categories	FS.01 Public Funds	%	FS.02 Private Funds	%	FS.03.01 Direct bilateral contributions:	%	FS.03.02 Multilateral agencies	%	FS.03.03 International non-profit	%	FS.03.04 International profit-making	%	Total
ASC.01 PREVENTION	1,217,082	0.99	2,281,582	24.60	57,595,600	13.75	7,114,999	27.88	220,335	56.10	450,000	90	**68,879,598**
ASC.02 CARE and TREATMENT	449,357	0.37	134,832	1.45	190,876,389	45.58		0.00	2,775	0.71		0	**192,487,926**
ASC.03 ORPHANS and VULNERABLE CHILDREN (OVC)	20,037	0.02		0.00	13,349,495	3.19	1,024,573	4.01		0.00		0	**14,394,105**
ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION	24,963,148	20.30	6,843,843	73.78	123,298,245	29.44	13,318,144	52.18	169,615	43.19	51,894	10	**168,644,889**
ASC.05 HUMAN RESOURCES	96,315,256	78.33	15,660	0.17	2,886,132	0.69	3,812,592	14.94		0.00		0	**103,029,640**
ASC.06 SOCIAL PROTECTION and SOCIAL SERVICES		0.00		0.00	8,786,223	2.10		0.00		0.00		0	**8,786,223**
ASC.07 ENABLING ENVIRONMENT		0.00		0.00	14,967,967	3.57	200,254	0.78		0.00		0	**15,168,221**
RELATED RESEARCH		0.00		0.00	7,015,875	1.68	50,999	0.20		0.00		0	**7,066,874**
Total	**122,964,880**	**100**	**9,275,917**	**100**	**418,775,926**	**100**	**25,521,561**	**100**	**392,725**	**100**	**501,894**	**100**	**577,432,903**

Appendix 12 Financing Agents in 2011 and 2012 (2nd and 3rd digit analysis)

Financing Agent	USG 2009	%	USD 2010	%
FA.01 Public Sector	**89,894,897**	**15.95**	**123,800,364**	**19.77**
FA.01.01.01.01 Ministry of Health (or equivalent sector entity)		**0.00**	21,614,581	**3.45**
FA.01.01.01.05 Ministry of Finance (or equivalent sector entity)	83,379,061	**14.79**	95,969,533	**15.32**
FA.01.01.01.06 Ministry of Labour (or equivalent sector entity)	26,593	**0.00**	N/A	**N/A**
FA.01.01.01.10 National AIDS Commission	5,596,365	**0.99**	5,553,906	**0.89**
FA.01.01.02.06 State/Province/Department AIDS Commission	892,878	**0.16**	662,344	**0.11**
FA.02. Private sector	**12,993,176**	**2.31**	**11,904,339**	**1.90**
FA.02.05 Non-profit-making institutions (other than social insurance)	12,357,483	**2.19**	9,164,207	**1.46**
FA.02.06 Private non-parastatal organizations and corporations (other than health insurance	392,218	**0.07**	442,890	**0.07**
FA.02.99 Other private financing agent not elsewhere classified (n.e.c.)	243,475	**0.04**	2,297,242	**0.37**
FA.03 International Purchasing organizations	**460,722,833**	**81.74**	**490,588,889**	**78.33**
FA.03.01.12 Government of Japan	35,352	**0.01**		
FA.03.01.21 Government of the United Kingdom	11,536,819	**2.05**	10,333,940	**1.65**
FA.03.01.22 Government of the United States of America	371,839,856	**65.97**	408,333,861	**65.20**
FA.03.02.07 UNAIDS Secretariat	247,446	**0.04**	90,668	**0.01**
FA.03.02.08 United Nations Children's Fund (UNICEF)	3,895,455	**0.69**	4,014,208	**0.64**
FA.03.02.09 United Nations Development Fund for Women (UNIFEM)	72,318	**0.01**	143,496	**0.02**
FA.03.02.10 United Nations Development Programme (UNDP)	857,150	**0.15**	1,258,157	**0.20**

FA.03.02.16 United Nations Population Fund (UNFPA)	1,424,648	**0.25**	1,814,453	**0.29**
FA.03.02.17 World Bank (WB)	1,099,801	**0.20**	2,460,497	**0.39**
FA.03.02.19 World Health Organization (WHO)	13,151	**0.00**	38,125	**0.01**
FA.03.03.34 International Planned Parenthood Federation	58,880	**0.01**	**N/A**	**N/A**
FA.03.03.99 Other International not-for-profit organizations n.e.c.	7,843	**0.00**	14,184	**0.00**
FA.03.04 International for-profit organizations	148,130	**0.03**	6,396,894	**1.02**
FA.03.99 Other international financing agents n.e.c.	69,485,984	**12.33**	55,690,406	**8.89**
Total	563,610,906	**100**	626,293,592	**100**

HIV/AIDS Service Providers in 2011 and 2012 (2nd and 3rd digit analysis)

Appendix 13 HIV/AIDS Service Providers in 2011 and 2012 (2nd and 3rd digit analysis)

HIV/AIDS Service Providers (3rd digit analysis)	2011		2012	
	Amount (USD)	(%)	Amount (USD)	(%)
PS.01-Public Sector Providers	**273,835,863**	**54.61**	**326,503,352**	**56.54**
PS.01.01.01 Hospitals (Governmental)	167,646,463	**33.43**	185,899,320	**32.19**
PS.01.01.06 Blood banks (Governmental)	704,488	**0.14**	780,027	**0.14**
PS.01.01.10.03 Higher education (Governmental)	312,842	**0.06**	349,462	**0.06**
PS.01.01.14.01 National AIDS commission (NACs)	9,082,602	**1.81**	11,132,935	**1.93**
PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	4,588,014	**0.91**	26,224,141	**4.54**
PS.01.01.14.03 Departments inside the Ministry of Education or equivalent	2,535,646	**0.51**	26,316	**0.00**
PS.01.01.14.04 Departments inside the Ministry of Social Development or equivalent			16,434	**0.00**
PS.01.01.14.05 Departments inside the Ministry of Defence or equivalent	650,719	**0.13**	718,519	**0.12**
PS.01.01.14.06 Departments inside the Ministry of Finance or equivalent	83,379,061	**16.63**	95,969,533	**16.62**
PS.01.01.14.07 Departments inside the Ministry of Labour or equivalent	26,593	**0.01**		
PS.01.01.14.08 Departments inside the Ministry of Justice or equivalent			13,158	**0.00**
PS.01.01.14.99 Government entities n.e.c.	3,693,643	**0.74**	4,492,739	**0.78**
PS.01.01.99 Governmental organizations n.e.c.	1,215,792	**0.24**	880,768	**0.15**
PS.02-Private Sector non-profit Providers	**219,760,302**	**43.82**	**240,918,309**	**41.72**
PS.02.01.01.08 Pharmacies and providers of medical goods (Non-profit non faith-based)			1,253,076	
PS.02.01.01.14 Self-help and informal community-based organizations (Non-profit non faith-based)	414,957	**0.08**	880,835	**0.15**
PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	167,475,453	**33.40**	183,235,908	**31.73**
PS.02.01.01.99 Other non-profit non-faith-based providers n.e.c	8,155,622	**1.63**	7,752,054	**1.34**
PS.02.01.02.01 Hospitals (Non-profit faith-based)	28,809,859	**5.75**	28,370,109	**4.91**
PS.02.01.02.08 Pharmacies and providers of medical goods (Non-profit faith-based)	1,121,766	**0.22**		
PS.02.01.02.99 Other non-profit faith-based private sector providers n.e.c.				**0.00**
PS.02.01.99 Other non-profit private sector providers n.e.c.	11,536,819	**2.30**	10,333,940	**1.79**
PS.02.02.01 Hospitals (For profit)	1,462,003	**0.29**	2,033,283	**0.35**
PS.02.02.15 "Workplace" (For profit)	392,218	**0.08**	442,890	**0.08**
PS.02.02.99 For profit private sector providers n.e.c.	391,605	**0.08**	6,396,894	**1.11**
PS.02.99 Private sector providers n.e.c.			219,320	**0.04**
PS.03-Bilateral and Multilateral entities	**7,870,840**	**1.57**	**10,011,242**	**1.73**
PS.03.01 Bilateral agencies	1,495,969	**0.30**	1,965,979	**0.34**
PS.03.02 Multilateral agencies	6,374,871	**1.27**	8,045,263	**1.39**
Total	**501,467,005**	**100**	**577,432,903**	**100**

Appendix 14 AIDS Spending Categories in 2011 and 2012 (2nd and 3rd digit analysis)

Financing Agent	USG 2011	%	USD 2012	%
ASC 01-Prevention	**63,525,516**	**12.67**	**68,879,597**	11.93
ASC.01.01.01 Health-related communication for social and behaviour change	5,410,183	1.08	14,609,258	2.53
ASC.01.01.98 Communication for social and behaviour change not broken down by type	5,889,045	1.17	295,544	0.05
ASC.01.02 Community mobilization	195,735	0.04	217,972	0.04
ASC.01.03 Voluntary counselling and testing (VCT)	8,069,694	1.61	8,472,953	1.47
ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations		0.00	55,555	0.01
ASC.01.05 Prevention – youth in school	1,374,289	0.27	6,067	0.00
ASC.01.06 Prevention – youth out-of-school	179,521	0.04	146,635	0.03
ASC.01.08.01 VCT as part of programmes for sex workers and their clients	1,943,046	0.39	6,932,686	1.20
ASC.01.08.04 Behaviour change communication (BCC) as part of programmes for sex workers and their clients	1,229,835	0.25	956,339	0.17
ASC.01.08.98 Programmatic interventions for sex workers and their clients not broken down by type	4,631,806	0.92		0.00
ASC.01.09.01 VCT as part of programmes for MSM			2,292,517	0.40
ASC.01.09.98 Programmatic interventions for MSM not disaggregated by type	1,975,013	0.39		0.00
ASC.01.10.01 VCT as part of programmes for IDUs			653,112	0.11
ASC.01.10.98 Programmatic interventions for IDUs not disaggregated by type	562,659	0.11		0.00
ASC.01.11.98 Programmatic interventions in the workplace not broken down by type	N/A		779,221	0.13
ASC.01.12 Condom social marketing	3,637,226	0.73	455,262	0.08
ASC.01.14 Public and commercial sector female condom provision	286,321	0.06	220,335	0.04
ASC.01.17.01Pregnant women counselling and testing in PMTCT programmes	4,556,076	0.91	5,017,411	0.87
ASC.01.17.02 Antiretroviral prophylaxis for HIV-infected pregnant women and newborns	7,739,323	1.54	8,644,867	1.50
ASC.01.17.98 PMTCT not broken down by intervention	104,839	0.02	580,067	0.10
ASC.01.18 Male circumcision	4,100	0.00	4,580	0.00
ASC.01.19 Blood safety	5,867,408	1.17	6,554,227	1.14
ASC.01.20 Safe medical injections	1,997,529	0.40	2,024,818	0.35
ASC.01.21 Universal precautions	1,177,467	0.23	1,246,042	0.22
ASC.01.22.01 PEP in health care setting	1,437,307	0.29	1,605,554	0.28
ASC.01.22.03 PEP after unprotected sex	1,595,640	0.32	2,067,609	0.36
ASC.01.22.98 Post-exposure prophylaxis not broken down by intervention	1,456,999	0.29	1,627,549	0.28
ASC.01.98 Prevention activities not broken down by intervention	2,204,456	0.44	3,413,418	0.59
ASC.02-Care and Treatment	**171,094,653**	**34.12**	**191,463,353**	33.16
ASC.02.01.01 Provider-initiated testing and counselling (PITC)	4,767,166	0.95	5,325,194	0.92
ASC.02.01.02.01 outpatient prophylaxis	57,123	0.01	67,416	0.01
ASC.02.01.02.02 OI outpatient treatment	76,351	0.02	67,416	0.01
ASC.02.01.03.01.01 First-line ART – adults	66,979,800	13.36	74,818,859	12.96
ASC.02.01.03.01.02 Second-line ART – adults	2,651,284	0.53	2,961,580	0.51
ASC.02.01.03.01.03 Adult multidrug ART after second-line treatment failure	139,541	0.03	155,873	0.03
ASC.02.01.03.02.01 First-line ART – paediatric	45,331,833	9.04	50,638,216	8.77
ASC.02.01.03.02.02 Second-line ART – paediatric	1,888,826	0.38	2,109,926	0.37
ASC.02.01.03.02.98 Paediatric antiretroviral therapy not broken down by line of treatment	N/A		2,775	0.00
ASC.02.01.04 Nutritional support associated with antiretroviral therapy	103,458	0.02	532,872	0.09

ASC.02.01.05 Specific HIV-related laboratory monitoring	35,042,413	6.99	39,144,352	6.78
ASC.02.01.08 Outpatient palliative care	6,727,913	1.34	7,515,459	1.30
ASC.02.01.09.01 Home-based medical care	1,410,367	0.28	1,575,460	0.27
ASC.02.01.09.02 Home-based non medical/non-health care	1,723,782	0.34	1,925,562	0.33
ASC.02.02.02 Inpatient palliative care	3,735,743	0.74	4,173,036	0.72
ASC.02.98 Care and treatment services not broken down by intervention	459,053	0.09	449,357	0.08
ASC.03-Orphans and Vulnerable Children	**12,934,848**	**2.58**	**14,394,105**	2.49
ASC.03.01 OVC Education	5,129,433	1.02	5,735,195	0.99
ASC.03.02 OVC Basic health care	2,890,183	0.58	3,230,932	0.56
ASC.03.03 OVC Family/home support	3,930,984	0.78	4,391,131	0.76
ASC.03.04 OVC Community support	963,779	0.19	1,016,810	0.18
ASC.03.98 OVC Services not broken down by intervention	20,469	0.00	20,037	0.00
ASC 04-Programme Management and administration	**135,085,394**	**26.94**	**168,644,889**	29.21
ASC.04.01 Planning, coordination, and programme management	60,999,367	12.16	90,839,838	15.73
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	46,215,155	9.22	46,071,452	7.98
ASC.04.03 Monitoring and evaluation	6,280,183	1.25	6,808,733	1.18
ASC.04.04 Operations research	2,514,234	0.50	2,816,170	0.49
ASC.04.05 Serological-surveillance (serosurveillance)	303,617	0.06	339,157	0.06
ASC.04.06 HIV drug-resistance surveillance	33,736	0.01	37,684	0.01
ASC.04.07 Drug supply systems	11,349,576	2.26	13,972,699	2.42
ASC.04.08 Information technology	4,268,727	0.85	4,748,604	0.82
ASC.04.10.01 Upgrading laboratory infrastructure and new laboratory equipment	2,222,457	0.44	2,312,513	0.40
ASC.04.10.98 Upgrading and construction of infrastructure not broken down by intervention	898,341	0.18	698,039	0.12
ASC.04.99 Programme management and administration n.e.c		0.00		0.00
ASC 05- Human Resources	**92,574,388**	**18.46**	**103,029,640**	17.84
ASC.05.01.03.01Monetary incentives for other staff for prevention	348,101	0.07	348,101	0.06
ASC.05.02 Formative education to build-up an HIV workforce	446,917	0.09	499,231	0.09
ASC.05.03 Training	8,234,699	1.64	6,027,780	1.04
ASC.05.98 Human resources not broken down by type	83,544,671	16.66	96,154,528	16.65
ASC 06-Social Protection and Social services	**7,865,514**	**1.57**	8,786,223	1.52
ASC.06.02 Social protection through in-kind benefits	4,435,584	0.88	4,954,798	0.86
ASC.06.04 HIV-specific income generation projects	3,429,930	0.68	3,831,425	0.66
ASC 07-Enabling Environment	**13,607,710**	**2.71**	15,168,221	2.63
ASC.07.01Advocacy	208,237	0.04	200,254	0.03
ASC.07.03 AIDS-specific institutional development	11,897,157	2.37	13,289,796	2.30
ASC.07.98 Enabling environment not broken down by type	1,502,316	0.30	1,678,171	0.29
ASC 08-HIV- Related Research	**4,778,982**	**0.95**	**7,066,874**	1.22
ASC.08.01 Biomedical research	1,319,973	0.26	810,966	0.14
ASC.08.02 Clinical research	1,759,963	0.35	1,351,611	0.23
ASC.08.04.01 Behavioural research	N/A		982,989	0.17
ASC.08.04.02 Research in economics	53,575	0.01	30,000	0.01
ASC.08.05 Vaccine-related research	1,319,973	0.26	3,735,360	0.65
ASC.08.98 HIV-related research activities not broken down by type	325,498	0.06	155,948	0.03
TOTAL	**501,467,005**	**100**	**577,432,903**	**100**

Beneficiary Populations in 2011 and 2012 (2nd and 3rd digit analysis)

Appendix 15 Beneficiary Populations in 2011 and 2012 (2nd and 3rd digit analysis)

BENEFIACIARY POPULATION	2011		2012	
	AMOUNT(USD)	%	AMOUNT(USD)	%
BP.01-PEOPLE LIVING WITH HIV	**175,581,071**	**35.01**	**209,757,517**	**36.33**
BP.01.01.01-Adult and young men (aged 15 and over) living with HIV	69,770,625	**13.91**	77,936,312	**13.50**
BP.01.02.98-Children (under 15 years) living with HIV not broken down by gender	47,220,659	**9.42**	52,748,142	**9.13**
BP.01.98-People living with HIV not broken down by age or gender	58,589,787	**11.68**	79,073,063	**13.69**
BP.02-Most-at-risk populations	**10,342,359**	**2.06**	**19,855,006**	**3.44**
BP.02.01-Injecting drug users (IDU) and their sexual partners	562,659	**0.11**	653,112	**0.11**
BP.02.02.01-Female sex workers and their clients	7,804,687	**1.56**	7,889,025	**1.37**
BP.02.03 Men who have sex with men (MSM)	1,975,013	**0.39**	2,292,517	**0.40**
BP.02.98-Most at-risk populations not broken down by type	N/A		9,020,352	**1.56**
BP.03-OTHER KEY POPULATIONS	**31,473,398**	**6.28**	**35,350,187**	**6.12**
BP.03.01-Orphans and vulnerable children (OVC)	12,934,848	**2.58**	14,394,105	**2.49**
BP.03.02-Children born or to be born of women living with HIV	12,400,238	**2.47**	14,255,220	**2.47**
BP.03.11-Children and youth out of the school	270,904	**0.05**	146,635	**0.03**
BP.03.14-Recipients of blood or blood products	5,867,408	**1.17**	6,554,227	**1.14**
BP.04-SPECIFIC ACCESSIBLE POPULATION	**2,446,177**	**0.49**	**2,056,840**	**0.36**
BP.04.03-Junior high/high school students	1,268,710	**0.25**	6,067	**0.00**
BP.04.05-Health care workers	1,177,467	**0.23**	1,246,042	**0.22**
BP.04.10-Factory employees (i.e. for workplace interventions)	N/A		779,221	**0.13**
BP.04.98 Specific “accessible ” populations not disaggregated by type	N/A		25,510	**0.00**
BP.05-GENERAL POPULATION	**36,850,416**	**7.35**	**29,521,495**	**5.11**
BP.05.01.02-Female adult population	286,320	**0.06**	220,334	**0.04**
BP.05.01.98 General adult population (older than 24 years) not disaggregated by gender	16,272	**0.00**	N/A	
BP.05.02.01 Boys	4,100	**0.00**	4,580	**0.00**
BP.05.98-General population not broken down by age or gender	36,543,724	**7.29**	29,296,581	**5.07**
BP.06-NON-TARGETED INTERVENTIONS	**244,773,583**	**48.81**	**280,891,858**	**48.64**
BP.06-NON-TARGETED INTERVENTIONS	244,773,584	**48.81**	280,891,858	**48.64**
Total	**501,467,005**	**100**	**577,432,903**	**100**

Appendix 16 Financing sources expenditure by beneficiary populations-2011

FS/BP	FS .01 Public Sources	FS.02 Private Funds	FS.03.01 Direct bilateral contribution	FS.03.02 Multilateral Agencies	FS.03.03 International not for profit	FS.03.04 International Profit Organizations	TOTAL
BP.01 People living with HIV	459,053		175,102,790	19,228			**175,581,071**
BP.02 Most-at-risk populations			7,169,478	**3,172,881**			**10,342,359**
BP.03 Other Key Populations	63,119		29,498,608	1,911,671			**31,473,398**
BP.04 Specific "accessible" populations			1,177,467	1,268,710			**2,446,177**
BP.05 General population	1,200,696	309,981	31,528,578	3,524,841	286,320		**36,850,416**
BP.06 Non-targeted interventions	87,153,068	897,859	139,019,479	17,365,616	189,432	148,130	**244,773,584**
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)							-
TOTAL	**88,875,936**	**1,207,840**	**383,496,400**	**27,262,947**	**475,752**	**148,130**	**501,467,005**

Appendix 17 Financing sources expenditure by beneficiary populations-2012

FS/BP	FS .01 Public Sources	FS.02 Private Funds	FS.03.01 Direct bilateral contribution	FS.03.02 Multilateral Agencies	FS.03.03 International not for profit	FS.03.04 International Profit Organizations	TOTAL
BP.01 People living with HIV	449,357		209,305,385		2,775		**209,757,517**
BP.02 Most-at-risk populations			17,342,398	2,512,608			**19,855,006**
BP.03 Other Key Populations	61,786		32,953,023	1,885,378		450,000	**35,350,187**
BP.04 Specific "accessible" populations		779,221	1,246,042	31,577			**2,056,840**
BP.05 General population	1,175,333	1,637,193	22,704,008	3,784,627	220,335		**29,521,496**
BP.06 Non-targeted interventions	121,278,404	6,859,503	135,225,070	17,307,371	169,615	51,894	**280,891,857**
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)							-
TOTAL	**122,964,880**	**9,275,917**	**418,775,926**	**25,521,561**	**392,725**	**501,894**	**577,432,903**

Letter used for data collection

Appendix 18 Letter to Donors and Government Ministries

The_____ 16th June 2013

_____

_____

Sir/Ma,

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

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

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

NASA is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV/AIDS and it describes the allocation of funds, from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the disease using the bottom-up and top-down approach. Financial resources are tracked by financing source whether it is public, private or international and among the different providers and beneficiaries (target groups).
To this end, your organization has been selected to be a part of this training. We hereby request that two representatives (preferably finance officers and programme officers) from your organization be sent to participate in the two day training on the NASA methodology and tracking tools. Your organizations' representatives at this meeting will also be the focal persons for the NASA consultants to liaise with when the actual data collection activity will commence in your organization.

The Objectives of this training are:
1. To sensitize key stakeholders on the NASA project
2. To provide technical training on the NASA methodology, tracking tools and analysis
The detail for this meeting is as follows:
Venue: Bolton White Hotel, Garki, Abuja.

Date: 5th & 6th August, 2013

Time: 9 am daily

Thank you.

Prof. John Idoko
Director General

Appendix 19 NASA Data Collection Form

FORM [1] – Year: _____ (2011 or 2012)

HIV RESPONSE INSTITUTIONS

This information is confidential

Year under study: ***Date:*** **/ / 2012**

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)

			Exchange rate Range(Average)
Select with an x if values are in local currency:	Nigerian naira		
Select with an x if values are in USD (***Recommended***):	USD		
Other (Euro, etc), please specify:	_____		

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 2011*	*Amount received in 2012*	*Amount spent in 2011*	*Amount spent in 2012*	*Amount transferred to other Institutions in 2011*	*Amount transferred to other Institutions in 2012*	*Who took decision on the funds for goods and services to purchase, provider of goods and services and beneficiary population*
OF [1]							
OF [2]							
OF [3]							
OF [4]							
OF [5]							
OF [6]							
OF [7]							
OF [8]							
OF [9] Personal Donation							
OF [10] Own funds							
TOTAL							

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

3. Use of Funds:

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

OF [1] Funds				
Activity (Description)	NASA Code for the Activity (please refer to NASA Catalogues code and name)	Beneficiary population (Description)	2011	2012

OF [1] Funds - Production Factors 2011										
Salaries	**Antiretrovirals**	**Condoms**	**Other material and supplies**	**Services**	**Buildings (constructions, renovations)**	**Laboratory upgrading**	**Equipment**	**Other capital expenditures**	**No information on PF**	**Total**

OF [1] Funds - Production Factors 2012										
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 2011*	*Amount transferred in 2012*	***Amount reported as spent in 2011***	***Amount reported as spent in 2012***
DF [1]				
DF [2]				
DF [3]				
DF [4]				
DF [5]				
DF [6]				
DF [7]				
DF [8]				
DF [9]				
DF [10]				
TOTAL				

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

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

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

OF [1] Funds				
Activity (Description)	NASA Code for the Activity (please refer to NASA Catalogues code and name)	Beneficiary population (Description)	2011	2012

OF [1] Funds - Production Factors 2011										
Salaries	**Antiretrovirals**	**Condoms**	**Other material and supplies**	**Services**	**Buildings (constructions, renovations)**	**Laboratory upgrading**	**Equipment**	**Other capital expenditures**	**No information on PF**	**Total**

OF [1] Funds - Production Factors 2012										
Salaries	**Antiretrovirals**	**Condoms**	**Other material and supplies**	**Services**	**Buildings (constructions, renovations)**	**Laboratory upgrading**	**Equipment**	**Other capital expenditures**	**No information on PF**	**Total**

5. Condom distribution:

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

Name of the Institution from which the condoms were received	Description of the condom distribution	Beneficiary population receiving the condoms. (e.g.: general population). Please use NASA catalogue to identify the Beneficiary	Quantity received in 2011 (units)	Quantity received in 2012 (units)	Quantity distributed in 2011 (units)	Quantity distributed in 2012 (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 2011 (units)	Quantity received in 2012 (units)	Quantity distributed in 2011 (units)	Quantity distributed in 2012 (units)

Appendix 20 Status on data collected

Institution	2011		2012	
	Transaction	Type of Data	Transaction	Type of Data
Adeoyo Maternity Hospital	↓	RE	↓	RE
Akwa Ibom State Action Committee on AIDS	↓↑	RE,B	↓↑	RE,B
Akwa Ibom State Ministry of Education	↓↑	RE,B	↓↑	RE,B
Anambra State Action Committee on AIDS	↓	RE	↓	RE
Association for Reproductive and Family Health	↓↑	RE,B	↓↑	RE,B
Benue State Ministry Of Health and Human Resources	↓↑	RE,B	↓↑	RE,B
Cross Rivers State Ministry of Health	↓↑	RE,B	↓↑	RE,B
Enhancing Nigeria Response to HIV and AIDS Programme	↓↑	RE,B	↓↑	RE,B
US President's Emergency Plan for AIDS Relief (PEPFAR)	↓↑	RE,B	↓↑	RE,B
Family Health Care Nassarawa	↓↑	RE	↓↑	RE
Family Health International	↓↑	RE,B	↓↑	RE,B
Federal Ministry of Education	↓	RE,B	↓	RE,B
Federal Ministry of Health	↓	RE,B	↓	RE,B
Federal Ministry of Women Affairs and Social Dev	↓	RE,B	↓	RE,B
Federal Road Safety Corp	↓	RE,B	↓	RE,B
Federation of Muslim Women Association of Nigeria	↓	RE,B	↓	RE,B
Hygeia Foundation	↓↑	RE,B	↓	RE,B
Institute of Human Virology, Nigeria	↓↑	RE,B	↓↑	RE,B
International Labour Office	↓↑	RE,B	↓↑	RE,B
International Centre for Aids care & treatment programme	↓↑	RE,B	↓↑	RE,B

Lagos State Ministry of Education	⬇	RE,B	⬇	RE,B
Millennium Development Goal Office	⇵	RE	⇵	RE
Nassarawa State AIDS Control Agency	⇵	RE,B	⇵	RE,B
National Agency for the Control of AIDS	⇵	RE,B	⇵	RE,B
National Population Council	⇵	RE,B	⇵	RE,B
National Youth Aid Program	⇵	RE,B	⇵	RE,B
National Youth Service Corps	⬇	RE,B	⬇	RE,B
Network of People living with HIV/AIDS in Nigeria	⬇	RE,B	⬇	RE,B
Ogun State Action Committee on AIDs	⇵	RE,B	⇵	RE,B
United Nations Development Programme Akwa Ibom	⇵	RE	⇵	RE
United Nations Children's Fund	⇵	RE	⇵	RE
United Nations Development Programme	⇵	RE,B	⇵	RE,B
United Nations Population Fund	⇵	RE,B	⇵	RE,B
World Health Organization	⇵	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

Appendix 61 2011 Financing Sources to AIDS Spending Categories - USD

AIDS Spending Categories Level 1	AIDS Spending Categories	FS.01 Public funds Total	FS.02 Private Funds Total	FS.03.01 Direct bilateral contributions	FS.03.02 Multilateral Agencies	FS.03.03 International not-for-profit organizations and foundations	Grand Total
ASC.01 Prevention	ASC.01.01.01 Health-related communication for social and behavioural change			4,453,166	922,926		5,376,092
	ASC.01.01.98 Communication for Social and behavioural change not disaggregated by type	291,558		5,597,487			5,889,045
	ASC.01.02 Community mobilization		195,735				195,735
	ASC.01.03 Voluntary counselling and testing (VCT)			5,894,243	1,976,746		7,870,989
	ASC.01.05 Prevention – youth in school				1,374,289		1,374,289
	ASC.01.06 Prevention – youth out-of-school				137,924		137,924
	ASC.01.08.01 VCT as part of programmes for sex workers and their clients				1,943,046		1,943,046
	ASC.01.08.04 Behaviour change communication as part of programmes for sex workers and their clients				1,229,835		1,229,835
	ASC.01.08.98 Programmatic interventions for sex workers and their clients not disaggregated by type			4,631,806			4,631,806
	ASC.01.09.98 Programmatic interventions for MSM not disaggregated by type			1,975,013			1,975,013
	ASC.01.10.98 Programmatic interventions for IDUs not disaggregated by type			562,659			562,659
	ASC.01.12 Condom social marketing			3,314,262	322,964		3,637,226
	ASC.01.14 Public and commercial sector female condom provision					286,320	286,320
	ASC.01.17.01 Pregnant women counselling and testing in PMTCT				215,309		

	programmes	11,090		3,869,661			4,096,060
	ASC.01.17.02 Antiretroviral prophylaxis for HIV-infected pregnant women and newborns			7,739,323			7,739,323
	ASC.01.17.98 PMTCT not disaggregated by intervention	31,560		71,616	1,663		104,839
	ASC.01.18 Male circumcision			4,100			4,100
	ASC.01.19 Blood safety			5,867,408			5,867,408
	ASC.01.20 Safe medical injections			1,997,529			1,997,529
	ASC.01.21 Universal precautions			1,177,467			1,177,467
	ASC.01.22.01 PEP in health care setting			1,437,307			1,437,307
	ASC.01.22.03 PEP after unprotected sex			1,595,640			1,595,640
	ASC.01.22.98 Post-exposure prophylaxis not disaggregated by intervention			1,456,999			1,456,999
	ASC.01.98 Prevention activities not disaggregated by intervention	909,138		1,010,679	2,076		1,921,893
ASC.01 Prevention Total		1,243,346	195,735	52,656,365	8,126,778	286,320	62,508,544
	ASC.02.01.01 Provider- initiated testing and counselling (PITC)			4,767,166			4,767,166
	ASC.02.01.02.01 OI outpatient prophylaxis		57,123				57,123
	ASC.02.01.02.02 OI outpatient treatment		57,123				57,123
	ASC.02.01.03.01.01 First-line ART – adults			66,979,800			66,979,800
	ASC.02.01.03.01.02 Second-line ART – adults			2,651,284			2,651,284
	ASC.02.01.03.01.03 Adult multidrug ART after second-line treatment failure			139,541			139,541
	ASC.02.01.03.02.01 First-line ART – paediatric			45,331,833			45,331,833
	ASC.02.01.03.02.02 Second-line ART – paediatric						

				1,888,826			1,888,826
	ASC.02.01.04 Nutritional support associated to ARV therapy			103,458			103,458
	ASC.02.01.05 Specific HIV-related laboratory monitoring			35,042,413			35,042,413
	ASC.02.01.08 Outpatient palliative care			6,727,913			6,727,913
	ASC.02.01.09.01 Home-based medical care			1,410,367			1,410,367
	ASC.02.01.09.02 Home-based non medical/non-health care			1,723,782			1,723,782
	ASC.02.02.02 Inpatient palliative care			3,735,743			3,735,743
	ASC.02.98 Care and treatment services not disaggregated by intervention	459,053					459,053
ASC.02 Care and treatment Total		459,053	114,246	170,502,126	-	-	171,075,425
ASC.03 Orphans and vulnerable children (OVC)	ASC.03.01 OVC Education			5,129,433			5,129,433
	ASC.03.02 OVC Basic health care			2,890,183			2,890,183
	ASC.03.03 OVC Family/home support			3,930,984			3,930,984
	ASC.03.04 OVC Community support				963,779		963,779
	ASC.03.98 OVC Services not disaggregated by intervention	20,469					20,469
ASC.03 Orphans and vulnerable children (OVC) Total		20,469	-	11,950,600	963,779	-	12,934,848
ASC.04 Programme management and administration	ASC.04.01 Planning, coordination and programme management	3,420,824	689,323	47,662,291	8,022,225	327,827	60,122,490
	ASC.04.02 Administration and transaction costs associated with managing and disbursing funds			46,215,155			46,215,155
	ASC.04.03 Monitoring and evaluation			5,669,080	611,103		6,280,183
	ASC.04.04 Operations research			2,514,234			2,514,234
	ASC.04.05 Serological-surveillance (serosurveillance)			303,617			303,617

	ASC.04.06 HIV drug-resistance surveillance			33,736			33,736
	ASC.04.07 Drug supply systems		103,673	11,217,662	28,241		11,349,576
	ASC.04.08 Information technology			4,249,603	19,124		4,268,727
	ASC.04.10.01 Upgrading laboratory infrastructure and new equipment		57,123	1,946,620	218,714		2,222,457
	ASC.04.10.98 Upgrading and construction of infrastructure not disaggregated by intervention				888,606	9,735	898,341
ASC.04 Programme management and administration Total		3,420,824	850,119	119,811,998	9,788,013	337,562	134,208,516
	ASC.05.01.03.01 Monetary incentives for other staff for prevention				348,101		348,101
	ASC.05.02 Formative education to build-up an HIV workforce			446,917			446,917
	ASC.05.03 Training	353,183	47,740	1,972,390	5,740,188		8,113,501
	ASC.05.98 Human resources not disaggregated by type	83,379,061		165,610			83,544,671
ASC.05 Human resources Total		83,732,244	47,740	2,584,917	6,088,289	-	92,453,190
ASC.06 Social protection and social services (excluding OVC)	ASC.06.02 Social protection through in-kind benefits			4,435,584			4,435,584
	ASC.06.04 HIV-specific income generation projects			3,429,930			3,429,930
ASC.06 Social protection and social services (excluding OVC) Total		-	-	7,865,514	-	-	7,865,514
ASC.07 Enabling environment	ASC.07.01 Advocacy				208,237		208,237
	ASC.07.03 AIDS-specific institutional development			11,897,157			11,897,157
	ASC.07.98 Enabling environment not disaggregated by type			1,502,316			1,502,316
ASC.07 Enabling environment Total		-	-	13,399,473	208,237	-	13,607,710
AIDS-related research (excluding operat	ASC.08.01 Biomedical research			1,319,973			1,319,973

	ASC.08.02 Clinical research			1,759,963			1,759,963
	ASC.08.04.02 Research in economics				53,575		53,575
	ASC.08.05 Vaccine-related research			1,319,973			1,319,973
	ASC.08.98 HIV and AIDS-related research activities not disaggregated by type			325,498			325,498
ASC.08 HIV and AIDS-related research (excluding operations research) Total		-	-	4,725,407	53,575	-	4,778,982
Grand Total		**88,875,936**	**1,207,840**	**383,496,400**	**25,228,671**	**623,882**	**499,432,729**

Appendix 72 2012-Financing sources to AIDS Spending categories - USD

AIDS Spending Categories Level 1	AIDS Spending Categories	FS.01 Public funds Total	FS.02 Private Funds Total	FS.03.01 Direct bilateral contributions	FS.03.02 Multilateral Agencies	FS.03.03 International not-for-profit organizations and foundations	Grand Total
ASC.01 Prevention	ASC.01.01.01 Health-related communication for social and behavioural change			13,321,180	1,242,578		14,563,758
	ASC.01.01.98 Communication for Social and behavioural change not disaggregated by type	285,399					285,399
	ASC.01.02 Community mobilization		203,660				203,660
	ASC.01.03 Voluntary counselling and testing (VCT)			6,584,182	1,669,310		8,253,492
	ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations				55,555		55,555
	ASC.01.06 Prevention – youth out-of-school				146,635		146,635
	ASC.01.08.01 VCT as part of programmes for sex workers and their clients			5,376,417	1,556,269		6,932,686
	ASC.01.08.04 Behaviour change communication as part of programmes for sex workers and their clients				956,339		956,339
	ASC.01.09.01 VCT as part of programmes for MSM			2,292,517			
	ASC.01.10.01 VCT as part of programmes for IDUs			653,112			
	ASC.01.11.98 Programmatic interventions in the workplace not disaggregated by type		779,221				
	ASC.01.12 Condom social marketing			15,356	439,906		455,262
	ASC.01.14 Public and commercial sector female condom provision					220,335	220,335
	ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes	10,856		4,322,434	293,270		4,626,560
	ASC.01.17.02 Antiretroviral prophylaxis for HIV-infected pregnant women and newborns						8,644,867

				8,644,867			
	ASC.01.17.98 PMTCT not disaggregated by intervention	30,893		82,000		450,000	562,893
	ASC.01.18 Male circumcision			4,580			4,580
	ASC.01.19 Blood safety			6,554,227			6,554,227
	ASC.01.20 Safe medical injections			2,024,818			2,024,818
	ASC.01.21 Universal precautions			1,246,042			1,246,042
	ASC.01.22.01 PEP in health care setting			1,605,554			1,605,554
	ASC.01.22.03 PEP after unprotected sex			2,067,609			2,067,609
	ASC.01.22.98 Post-exposure prophylaxis not disaggregated by intervention			1,627,549			1,627,549
	ASC.01.98 Prevention activities not disaggregated by intervention	889,934	1,298,701	1,173,156			3,361,791
ASC.01 Prevention Total		1,217,082	2,281,582	57,595,600	6,359,862	670,335	68,124,461
	ASC.02.01.01 Provider- initiated testing and counselling (PITC)			5,325,194			5,325,194
	ASC.02.01.02.01 OI outpatient prophylaxis		67,416				67,416
	ASC.02.01.02.02 OI outpatient treatment		67,416				67,416
	ASC.02.01.03.01.01 First-line ART – adults			74,818,859			74,818,859
	ASC.02.01.03.01.02 Second-line ART – adults			2,961,580			2,961,580
	ASC.02.01.03.01.03 Adult multidrug ART after second-line treatment failure			155,873			155,873
	ASC.02.01.03.02.01 First-line ART – paediatric			50,638,216			50,638,216
	ASC.02.01.03.02.02 Second-line ART – paediatric			2,109,926			2,109,926

	ASC.02.01.03.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment					2,775	2,775
	ASC.02.01.04 Nutritional support associated to ARV therapy			532,872			532,872
	ASC.02.01.05 Specific HIV-related laboratory monitoring			39,144,352			39,144,352
	ASC.02.01.08 Outpatient palliative care			7,515,459			7,515,459
	ASC.02.01.09.01 Home-based medical care			1,575,460			1,575,460
	ASC.02.01.09.02 Home-based non medical/non-health care			1,925,562			1,925,562
	ASC.02.02.02 Inpatient palliative care			4,173,036			4,173,036
	ASC.02.98 Care and treatment services not disaggregated by intervention	449,357					449,357
ASC.02 Care and treatment Total		449,357	134,832	190,876,389	-	2,775	191,463,353
ASC.03 Orphans and vulnerable children (OVC)	ASC.03.01 OVC Education			5,729,866			5,729,866
	ASC.03.02 OVC Basic health care			3,228,498			3,228,498
	ASC.03.03 OVC Family/home support			4,391,131			4,391,131
	ASC.03.04 OVC Community support				1,016,810		1,016,810
	ASC.03.98 OVC Services not disaggregated by intervention	20,037					20,037
ASC.03 Orphans and vulnerable children (OVC) Total		20,037	-	13,349,495	1,016,810	-	14,386,342
ASC.04 Programme management and administration	ASC.04.01 Planning, coordination and programme management	24,963,148	6,587,565	47,215,590	9,767,835	214,769	88,748,907
	ASC.04.02 Administration and transaction costs associated with managing and disbursing funds			45,872,919	198,533		46,071,452
	ASC.04.03 Monitoring and evaluation			6,318,986	469,698	6,740	6,795,424
	ASC.04.04 Operations research			2,808,541	7,629		2,816,170

	ASC.04.05 Serological-surveillance (serosurveillance)			339,157			339,157
	ASC.04.06 HIV drug-resistance surveillance			37,684			37,684
	ASC.04.07 Drug supply systems		188,862	13,783,837			13,972,699
	ASC.04.08 Information technology			4,747,046			4,747,046
	ASC.04.10.01 Upgrading laboratory infrastructure and new equipment		67,416	2,174,485	70,612		2,312,513
	ASC.04.10.98 Upgrading and construction of infrastructure not disaggregated by intervention				698,039		698,039
ASC.04 Programme management and administration Total		24,963,148	6,843,843	123,298,245	11,212,346	221,509	166,539,091
	ASC.05.01.03.01 Monetary incentives for other staff for prevention				348,101		348,101
	ASC.05.02 Formative education to build-up an HIV workforce			499,231			499,231
	ASC.05.03 Training	345,723	15,660	2,201,906	3,246,581		5,809,870
	ASC.05.98 Human resources not disaggregated by type	95,969,533		184,995			96,154,528
ASC.05 Human resources Total		96,315,256	15,660	2,886,132	3,594,682	-	102,811,730
ASC.06 Social protection and social services (excluding OVC)	ASC.06.02 Social protection through in-kind benefits			4,954,798			4,954,798
	ASC.06.04 HIV-specific income generation projects			3,831,425			3,831,425
ASC.06 Social protection and social services (excluding OVC) Total		-	-	8,786,223	-	-	8,786,223
ASC.07 Enabling environment	ASC.07.01 Advocacy				185,020		185,020
	ASC.07.03 AIDS-specific institutional development			13,289,796			13,289,796
	ASC.07.98 Enabling environment not disaggregated by type			1,678,171			1,678,171
ASC.07 Enabling environment Total		-	-	14,967,967	185,020	-	15,152,987

ASC.08 HIV and AIDS-related research (excluding operations research)	ASC.08.01 Biomedical research			810,966			810,966
	ASC.08.02 Clinical research			1,351,611			1,351,611
	ASC.08.04.01 Behavioural research			982,989			982,989
	ASC.08.04.02 Research in economics				30,000		30,000
	ASC.08.05 Vaccine-related research			3,735,360			3,735,360
	ASC.08.98 HIV and AIDS-related research activities not disaggregated by type			134,949			134,949
ASC.08 HIV and AIDS-related research (excluding operations research) Total		-	-	7,015,875	30,000	-	7,045,875
Grand Total		**122,964,880**	**9,275,917**	**418,775,926**	**22,398,720**	**894,619**	**574,310,062**

NATIONAL AIDS SPENDING ASSESSMENT (NASA)

FOR THE PERIOD: 2011-2012

LEVEL AND FLOW OF RESOURCES AND EXPENDITURES

OF THE NATIONAL HIV AND AIDS RESPONSE

NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA)

Joint United Nations Programme on HIV/AIDS

Enhancing Nigeria's Response to HIV & AIDS Programme