ZAMBIA NATIONAL AIDS SPENDING ASSESSMENT (NASA): 2019-2021

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(NASA): 2019 – 2021

National HIV / AIDS / STI / TB Council
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LIST OF ABBREVIATIONS

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
ART	Antiretroviral therapy or Antiretroviral treatment
ARV	Antiretroviral
ARVs	Antiretroviral drugs
ASC	AIDS Spending Category
BP	Beneficiary Population
CHAZ	Churches Health Association Zambia
CMSA	Compulsory Medical Saving Accounts
COP	Country Operational Plan
CPUP	Community-based: pick up points
DHIS	District Health Information System
DOT	Directly observed treatment
ER	Expenditure reporting (PEPFAR data)
ECOSOC	Economic and Social Council
eMTCT	Elimination of mother-to-child transmission
EU	European Union
FAO	Food and Agriculture Organisation
FAP	Financing Agent Purchaser
FNDP	Fifth National Development Plan
FS	Financing source
GAM	Global AIDS Monitor (formerly GARPR)
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GRZ	Government of the Republic of Zambia
HA	Health Accounts
HAPT	Health Accounts Production Tool
HBC	Home-based Care
HIV	Human Immuno-deficiency Virus
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IFMIS	Integrated Financial Management Information System
IGA	Income Generation Activities

ILO	International Labour Organization
INGO	International Non-governmental Organisation
IOM	International Organization for Migration
IP	Implementing Partners (of PEPFAR)
IT	Information Technology
KP	Key Population
LFA	Local Fund Agents (for GF)
LIC	Low Income Country
LMIC	Lower-Middle Income Country
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MDR- TB	Multidrug-resistant Tuberculosis
MOE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Council
NASA	National AIDS Spending Assessment
NASF	National AIDS Strategic Framework
NDP	National Development Plan
NEC	Not elsewhere classified
NGO	Non-governmental organisation
NHA	National Health Accounts
NHSP	National Health Strategic Plan
OI	Opportunistic Infection
OOPE	Out-of-pocket Expenditure
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	(United States) President's Emergency Plan for AIDS Relief
PF	Production Factor
PHC	Primary Health Care
PITC	Provider initiated testing and counselling
PLHIV	People Living With HIV
PMTCT	Prevention of mother-to-child transmission

PPP	Public Private Partnerships
PR	Principal Recipient (of Global Fund)
PrEP	Pre-Exposure Prophylaxis
PS	Provider of Services
PSI	Population Services International
PWID	People who inject drugs
RTT	Resource Tracking Tool (NASA)
SADC	Southern African Development Community
SBCC	Social and behavioural change communication
SDGs	Sustainable Development Goals
SHA	System of Health Accounts
SR	Sub-recipient (of Global Fund)
STI	Sexually Transmitted Infection
SW	Sex Worker
T&T	Test and Treat
TB	Tuberculosis
TG	Transgender
TWG	Technical working group
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly on HIV/AIDS
UN-HABITAT	United Nations Human Settlements Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNODC	United Nations Office on Drugs and Crime
USD	United States Dollar
USG	United States Government
VMMC	Voluntary Medical Male Circumcision
WB	World Bank
WFP	World Food Programme

WHO	World Health Organization
ZAMPHIA	Zambia Population-based HIV Impact Assessment
ZMW	Zambian Kwacha

FOREWORD

Zambia's HIV and tuberculosis response resources have increased dramatically over the past decade, demonstrating the spirit of global solidarity and mutual accountability. Significant progress has been made in reducing new infections, preserving human life and combating discrimination and stigma as a result of these investments. Today, I can confidently assert that ending the AIDS and tuberculosis epidemics in Zambia is more of a reality than a pipe dream.

Considering the future resource requirements to combat the two diseases, increasing levels of funding are required to contain and maintain epidemic control. The HIV and TB pandemics require long-term, forward-looking, sustained investments, leadership and political commitment. Therefore, the National AIDS Spending Assessment (NASA) has allowed us to prove the worth of our combined efforts in aiding Zambia in achieving its strategic focus area of eliminating AIDS and tuberculosis by 2030. Through this NASA, previously unknown gaps and priorities have been identified, allowing us to better allocate our resources and close the gap between underserved communities.

We are aware that there is no easy way to bring an end to AIDS and tuberculosis. Your continued commitment, our most respected partners, should be enhanced. This is extremely important as we approach the deadline we set for ourselves to eliminate AIDS and tuberculosis. Our collective efforts should guarantee that services continue being accessible to everyone in the country as we press towards our goal of eliminating AIDS and tuberculosis. It is against this background that I am making a plea for our cooperating partners, civil society organisations, people living with HIV, the commercial sector, communities and individual benefactors to recommit themselves and stand in solidarity with the Zambian government to maintain the investments that have already been made and fill in the funding gaps.

I wish to emphasise once more that, although time set for us to achieve our strategic focus of eliminating AIDS and tuberculosis is fast approaching, we have "Miles to Go." It is, therefore, necessary to double or triple our efforts, especially in providing resources for preventing new infections; keeping people living with HIV alive; and dealing with the structural and social elements that drive epidemics.

The Government of the Republic of Zambia remains committed to playing a much more significant role in the AIDS and tuberculosis epidemic response and pledges to maximize efficiency in the use of available resources, in order to reach and maintain control of the epidemic.

Sylvia T. Masebo, MP

MINISTER OF HEALTH

ACKNOWLEDGMENT

The National HIV/AIDS/TB STIs Council of Zambia wishes to express its profound gratitude to the Joint United Nations Programme on AIDS (UNAIDS) for the financial and technical support rendered to undertaking this National AIDS Spending Assessment (NASA), which covers the period 2019 - 2021.

I wish to extend the Council's gratitude to the NASA Technical Working Group, under the leadership of the Ministry of Finance. The Group's dedication to ensuring that the NASA is not only successfully conducted but also conducted following the due process is highly commended.

I am also cognisant of the indisputable fact that the NASA exercise would not have been completed without the willingness and ability of the stakeholders and respondents who shared their financial expenditure data. I, therefore, wish to sincerely thank all stakeholders for availing the data that informed the NASA findings.

I wish to extend my profound appreciation to Vianney Nikukiye, the external consultant, and David Masengu, the national consultant, for their expertise and technical support from the design through to the conclusion of the NASA.

I further wish to thank all the data collectors and supervisors whose untiring efforts resulted in the collection of high-quality financial data from the various stakeholders across the entire country.

Finally, I wish to recognise the leadership and technical guidance of the project leads - Katongo Silwizya and Peter Ndemena of the National HIV/TB/STIs Council; and Heston Phillips and Kenneth Mwansa of the UNAIDS Country Office, whose steadfastness, commitment and leadership resulted in the successful conduct of the NASA.

Professor Lloyd Mulenga

Acting Director General

National HIV/AIDS/TB/STI Council

EXECUTIVE SUMMARY

The results show that total expenditure on HIV and AIDS interventions in Zambia increased moderately from Four hundred and fifty million, two hundred and ninety-seven thousand, four hundred and fifty-three United States Dollars (**USD$450, 297, 453)** in 2019; Four hundred and ninety-four million, three and forty-nine thousand, nine hundred and eighty-one United States Dollars (**USD$ 494, 349, 981)** in 2020; and Five hundred and four million, four hundred and twelve and sixty-five United States Dollars (**USD$ 504, 412, 065)** in 2021, representing an increase of **10 per cent** in 2020 and **two per cent** (2%) in 2021. Total expenditure over the three-year period amounted to One billion, four hundred and forty-nine million, fifty-nine thousand, four hundred and ninety-nine United States Dollars (**USD$ 1, 449, 059, 499)**. From 2019 to 2021, the increase rate in expenditure on the HIV and AIDS response was **12 per cent.**

The national response to HIV and AIDS in Zambia **depends essentially on two external donors: the United States of America Government (USG) and the Global Fund (GF).** During the period 2019 to 2021, the United States of America (USA) contributed **76.32 per cent** of national HIV and AIDS expenditure followed by the Global Fund with **17.32 per cent.** The contributions of these two donors alone amounted to **91.75 per cent** in 2019, **91.37 per cent** in 2020 and **89.35 per cent** in 2021.

This shows that the bulk of the expenditure on HIV and AIDS in Zambia, during the period under review, came from international sources, accounting for about **92.2 per cent** . The Government of the Republic of Zambia (GRZ) contributed about **7.77 per cent.** Domestic corporations accounted for about **0.02 per cent** of the total expenditure. It is, therefore, evident that the response to HIV and AIDS in Zambia depends largely on external funding. This high dependence on external financing poses a risk to sustainable financing of Zambia's National Strategic Framework for HIV and AIDS.

To ensure sustainability of funding for the HIV and AIDS response, this situation must change. The Government must commit to gradually but substantially increase its contribution to the HIV and AIDS response.

From 2019 to 2021, the funds were sourced from various pools: direct bilateral financial transfers entities accounted for the highest proportion of HIV and AIDS financing **(74%)** followed by direct multilateral financial transfers **(18%)** and internal transfers and grants **(8%).** Other classifications represent **0.02 per cent** of shares.

People obtained health services through the main types of financing arrangements as follows: Central government schemes were the most used **(86%)** followed by Resident foreign agencies schemes **(10%)**. The third largest scheme used was not-for-profit organisation **(4%).** For-profit enterprises not elsewhere classified accounted for **0.02 per cent** of shares.

The entities that pooled financial resources to finance service provision programmes, and also make programmatic decisions, showed that the resources for funding the response to HIV and AIDS mainly were managed by the public sector **(86%)**, followed by international purchasing organisations **(10%)** and the private sector **(4%).**

The entities that engaged in the production, provision and delivery of HIV and AIDS services showed that the public sector provided **69 per cent** of shares followed by bilateral, multilateral entities, international NGOs and foundations with **16 per cent** of shares and private sector

providers (non-profit providers and profit-making private sector providers) with **15 per cent** of shares.

The health providers provided services using various Service Delivery Modalities (SDM): Facility-based service modalities took the largest share, at **67 per cent,** followed by non-applicable (AIDS Spending Category which does not have a specific SDM), at **22 per cent.** The third largest expenditure was on home and community-based service modalities, with **eight per cent** of share. Modalities not disaggregated took the fourth place, with **three per cent** of share**.**

The inputs (labour, capital, workshop facilities, promotion materials, travel etc.) that were used by providers to provide services show that current expenditures accounted for the largest share of spending for the entire period **(94%)** followed by production factors not disaggregated **(3.30%)** and capital expenditures **(2.62%)**.HIV-related interventions and activities done in order to reach the expected achievements in addressing the pandemic showed that care and treatment took the highest share, at **56 per cent,** followed by programme enablers and systems strengthening, at **23 per cent.** The third largest expenditure was on prevention, with **12 per cent** share. HIV testing and counselling (HTC) accounted for **five per cent** of share. Development synergies accounted for **three per cent** share, social protection and economic support accounted for **two per cent** share. The remaining subcategories (social enablers, research) combined accounted for **0.08 per cent** of total HIV and AIDS spending.

From 2019 to 2021, people living with HIV accounted for **56 per cent** of total expenditure followed by non-targeted interventions, at **26 per cent** of share. The third largest expenditure was on vulnerable, accessible and other target populations with **per cent** of share. The fourth was Key populations with **two per cent** of share and the fifth was Specific targeted populations not elsewhere classified which accounted for **0.15 per cent** of share. As can be shown, the epidemic vectors (key populations) do not even benefit from **three per cent** of the total expenditure. Resource allocation should increasingly be evidence-based.

The main limitations of the exercise related to challenges in obtaining data from some stakeholders including Government (due to the current planning and budgeting system which does not allow for disaggregated expenditure data) and the private sector which had a very low response rate.

Policy implications and recommendations

i. It may be necessary to provide the framework for resource tracking at intervention level by developing a National Operational Plan for the National AIDS Strategic Framework (NASF), which will provide the basis for tracking resources at intervention level. This will also enhance resource allocation once there is visibility regarding where resources are spent;
ii. Though there is increased Government spending on Health and the HIV national response, clearly demonstrating commitment towards increased resource allocation and the achievement of the Abuja target, more still needs to be done in order to reduce dependence on donor funding. An exit strategy for reducing donor funding and achieving sustainability needs to be developed;
iii. Institutionalise the National AIDS Spending Assessment (NASA) process in Zambia for ease of data collection and reporting on HIV and AIDS spending; and

Develop innovative ways of compelling the private sector to report HIV and AIDS spending, such as tying the issuance of annual licences to HIV and AIDS reporting as a matter of compliance.

1. INTRODUCTION AND BACKGROUND

1.1 Zambia socio-economic profile

Economic growth

Zambia's economy is showing encouraging signs of stabilising after a period of macroeconomic imbalances that weakened economic performance. Between 2015 and 2021, economic growth slowed down and averaged 2.5 per cent per year, lower than the annual population growth rate of 2.8 per cent. In the Vision 2030, the Government's objective is to attain and sustain an annual real economic growth rate of between six and 10 per cent.

Zambia's economy is heavily dependent on copper mining and rain-fed agriculture. Although economic diversification has been on the agenda for three decades, the country remains heavily reliant on the same sectors (mining and quarrying, wholesale and retail trade, agriculture, forestry, and fisheries). Retrospective analysis shows that Zambia's past growth (averaging 7.4 per cent between 2004 and 2014) helped achieve middle-income status but had a limited impact on poverty.

During the period 2006 to 2010, annual real Gross Domestic Product (GDP) growth rate was favourable, averaging 8.7 per cent, with the highest annual growth rate registered at 10.3 per cent in 2010. Growth was mainly driven by the construction, transport, and mining sectors, spurred by increased investment in the mining sector (see Figure 1). Between 2011 and 2016, however, the economic growth rate slowed down, and averaged 4.9 per cent. The growth was driven by Information and Communication Technologies (ICT), wholesale and retail trade, as well as the construction sector. The ICT sector experienced significant structural growth due to the progressive migration from 2G to 4G technologies, and the resultant increased adoption rates; increased data usage; and wider signal penetration rates, especially in rural areas. Growth in wholesale and retail trade was mainly driven by increase in consumption; import and export of manufactured food products; as well as investment in retail outlets. The performance of the construction sector was mainly driven by increased public sector investment in infrastructure.

During the period 2017 to 2021, growth declined further with the real growth rate averaging 1.4 per cent, largely due to unfavourable weather conditions which impacted the agriculture and energy sectors in the earlier years of the period. Another notable development was in 2020 when economic growth contracted by 2.8 per cent, registering the first recession since 1998. This was mainly due to the effect of disruptions in supply chains and containment measures associated with the COVID-19 pandemic on sectors such as tourism, construction, wholesale and retail trade as well as manufacturing. The situation was compounded by the country's worsening fiscal position resulting from increased borrowing on the domestic market, which crowded out the private sector. In 2021, real GDP growth recovered to 3.6 per cent, with the agriculture, manufacturing, energy, wholesale and retail trade as well as the ICT sectors driving growth. Mining output declined despite a pick-up in global economic activity and commodity prices. The average real GDP growth of 5.2 per cent attained over the period 2006 to 2021, falls below the Vision 2030 target of between six to 10 per cent. Growth will, therefore, have to be significantly higher over the next two Plan periods to attain the aspirations of the Vision 2030.

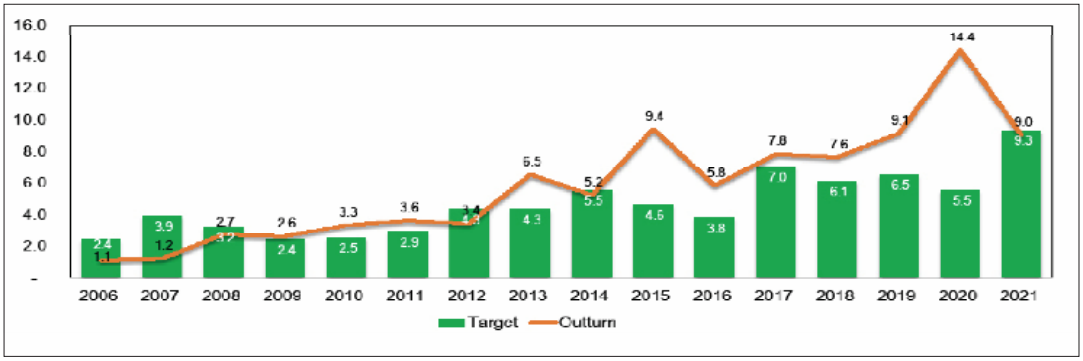
Figure 1: Real GDP Growth (%) vs Targeted Growth (2006-2021)

Source: *Eighth National Development Plan (2022-2026), August 2022*

Fiscal performance

Over the period 2006 to 2021, fiscal performance was characterised by a deterioration in the overall deficit (see Figure 2). During the period from 2006 to 2010, the overall fiscal deficits were below target between 2006 and 2008, while in 2009 and 2010 the deficits were above target. The fiscal deficit during the Fifth National Development Plan (FNDP) period averaged 2.2 per cent. In the earlier years of the Plan, this was attained due to relatively favourable revenue performance and expenditure policy, which focused on poverty reduction. In the latter years, fiscal operations were affected by the global financial crisis. Total domestic revenue collections during the FNDP period averaged 17.5 per cent, broadly in line with the target of 17.7 per cent of GDP. Expenditure averaged 23.1 per cent of GDP, against an average target of 23.8 per cent of GDP.

Figure 2: Fiscal Deficit as a percentage of GDP (2006-2021)



Source: *Eighth National Development Plan (2022-2026), August 2022*

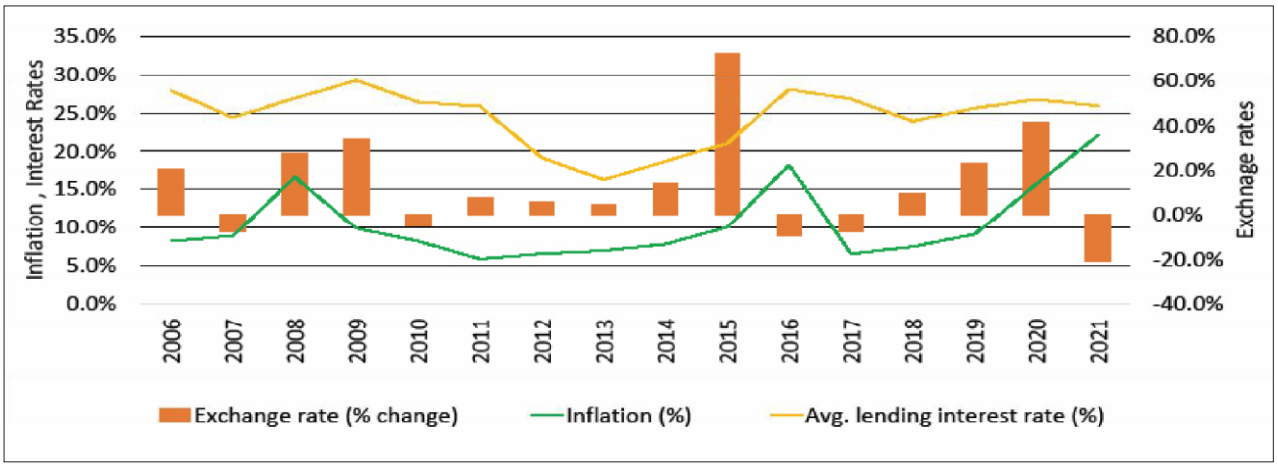
Debt position

In tandem with the increase in the fiscal deficit, the debt position of the country increased substantially over the review period. As a proportion of GDP, the public debt stock (domestic and external) significantly increased from 22 per cent in 2006 to 119 per cent in 2021. The stock of domestic debt (government securities and bonds) increased to K193 billion by the end of 2021 from K6.24 billion in 2006. The rapid increase in the debt stock over the period reflected increasing recourse to domestic borrowing as external financing sources reduced. In addition, there was a sharp rise in domestic arrears, excluding fuel and electricity, which more than doubled to K45.5 billion at the end of September 2021 from K20.92 billion at the close of 2017. The pending bills were owed to road contractors, suppliers of goods and services, value-added tax (VAT) refunds and personnel-related emoluments for public service workers.

Monetary and financial sector performance

During the period 2006 to 2021, inflation averaged 11.0 per cent (see Figure 3). However, this outturn was higher than the single-digit inflation envisaged in the Vision 2030. During the Seventh National Development Plan (7NDP) period, inflationary pressures increased, and inflation averaged 12.0 per cent, up from 9.2 per cent during the Sixth National Development Plan (SNDP) period. The rise in inflation was on account of increased food prices arising from the adverse impact of erratic rainfall on agricultural output and the pass-through effect from the depreciation of the Kwacha. High food prices that characterised the review period were a reflection of structural bottlenecks in the agriculture sector, particularly the high dependence on rainfall, which tends to adversely impact crop production during periods of drought.

Figure 3: Inflation, Exchange Rate and Lending Rates (2006-2021)



Source: *Eighth National Development Plan (2022-2026), August 2022*

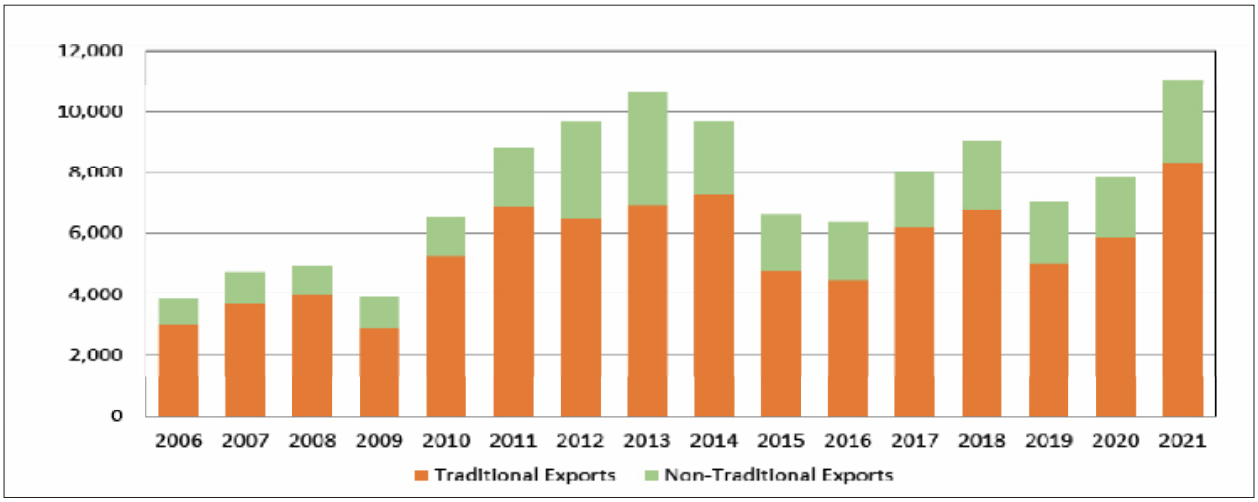
External sector performance

During the period 2006 to 2020, the performance of the external sector was generally favourable as an average current account surplus of 1.4 per cent of GDP per annum was recorded. During the 7NDP period, the current account surplus rose to an average of 3.6 per cent of GDP. The rise in net exports on the back of the increase in copper earnings largely underpinned the current account surplus.

Merchandise exports continued to be dominated by traditional exports, particularly copper, over the period 2006 to 2020 (see Figure 4). Traditional exports accounted for an average of 75 per cent of total exports with the balance coming from non-traditional exports such as

sugar, cement and agricultural products. This reflects the country's narrow export base and the need to diversify the sources of export earnings.

Figure 4: Non-Traditional Exports and Traditional Exports (US$' million)

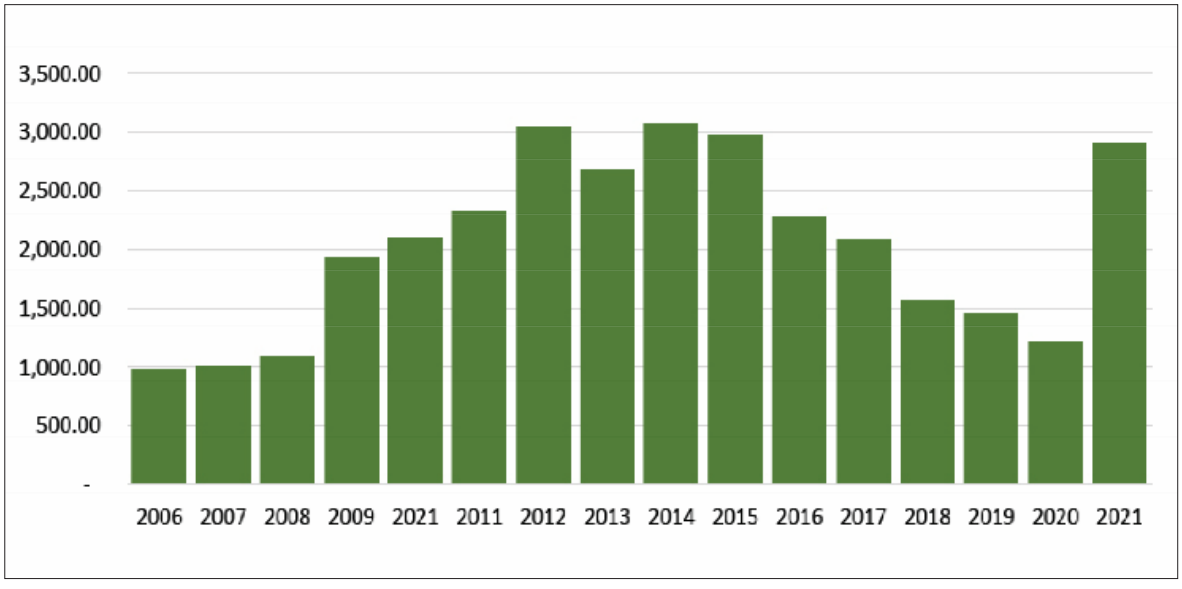


Source: *Eighth National Development Plan (2022-2026), August 2022*

Gross international reserves

Gross international reserves (GIRs) steadily increased between 2006 and 2014 (see Figure 5). This was in part due to Zambia's attainment of the Highly Indebted Poor Country (HIPC) Initiative Completion Point in 2006, which resulted in significant debt relief that eased pressure on international reserves. Additionally, the issuance of three Eurobonds amounting to US$3.0 billion increased GIRs to an all-time high of US$3.1 billion in 2014.

Figure 5: Gross International Reserves (US$' million)



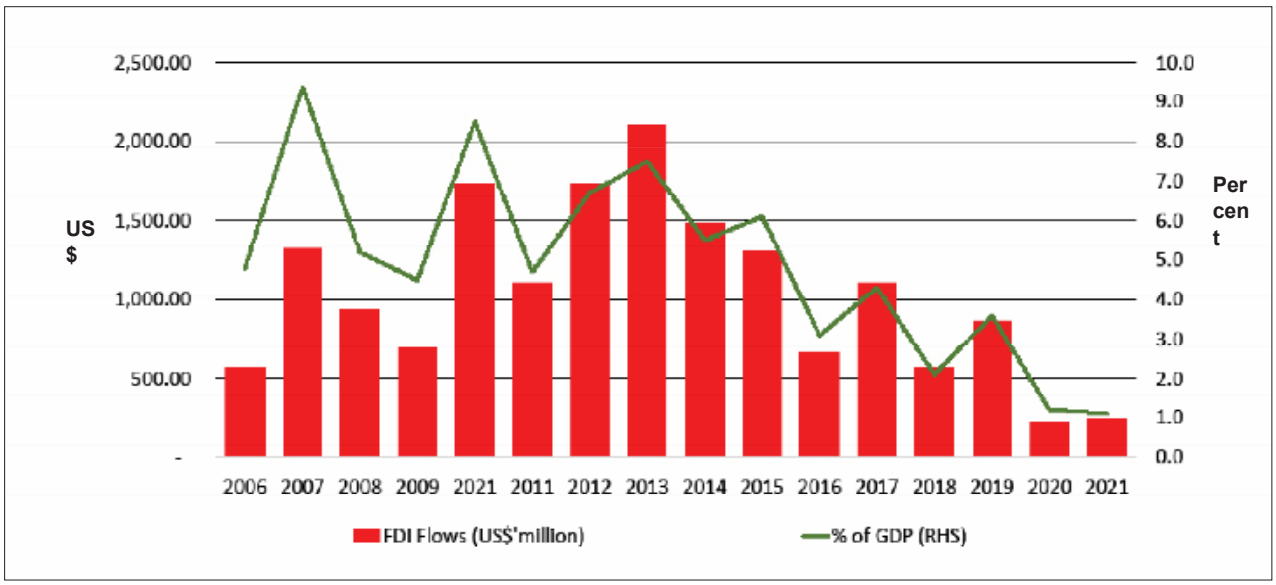
Source: *Eighth National Development Plan (2022-2026), August 2022*

International reserves declined steadily to US$1.2 billion (equivalent to 2.4 months of import cover) in 2020 from US$2.1 billion (equivalent to 2.9 months of import cover) in 2017. The

decline was mainly due to increased external debt service. In 2021, however, international reserves rose to US$2.8 billion (equivalent of 4.4 months of import cover). This followed the receipt of Special Drawing Rights (SDRs) 937.6 million (equivalent of US$1.3 billion) from the International Monetary Fund (IMF). At 4.4 months of import cover, international reserves, however, remain far below the Vision 2030 target of at least 12 months of import cover. In this regard, there is need to step up efforts to enhance the accumulation of international reserves.

Foreign direct investment (FDI) inflows averaged US$1.1 billion per annum between 2006 and 2021 (see Figure 6). Mining continued to be the largest destination for FDI inflows. FDI declined steadily after 2013 largely attributed to changes in tax policy for the mining sector, volatile international commodity prices, particularly for copper, and the unfavourable macroeconomic environment. The concentration of FDI inflows in the mining sector calls for concerted efforts to attract investments in other key sectors such as manufacturing, agriculture and tourism, if the economy is to be transformed so as to create jobs and enhance livelihoods.

Figure 6: Foreign Direct Investment Inflows (2006-2021)



Source: *Eighth National Development Plan (2022-2026), August 2022*

Employment and job creation

The country's overall unemployment rate reduced during the period from 16.0 per cent in 2005 to 7.8 per cent in 2012. However, the trend was reversed thereafter with the unemployment rate rising to 12.5 per cent in 2021. In 2021, the youth unemployment rate was estimated at 17.4 per cent compared to 14 per cent in 2005. The unemployment rate was also higher in urban areas than in rural areas (see Table 1). Further, disparities in gender were observed, with unemployment among females being higher.

Table 1: Unemployment Rates (%) 2005-2020

Year	Overall Unemployment Rate	Youth Unemployment rate				
		Both Sexes	Male	Female	Rural	Urban
2005	16.0	14.0	4.0	22.0	7.0	23.0
2008	7.9	14.0	14.9	13.1	5.5	36.0
2012	7.8	10	8.5	11.3	4.4	17.2
2017	12.6	17.4	16.2	19.1	15.7	18.5
2018	11.4	16	14.6	18.2	13.6	17.5
2019	12.8	17.9	17.4	18.6	17.6	18.1
2020	13.8	19.9	17.6.	22.9	18.	20.8
2021	12.5	17.4	14.9	21.2	17.8	17.1

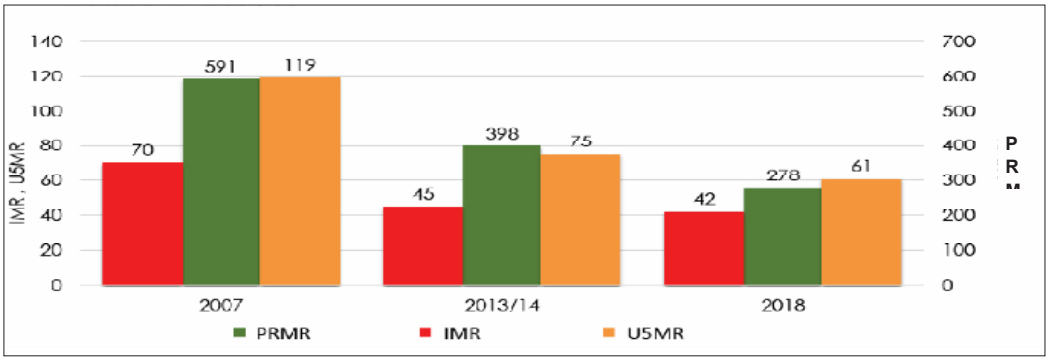
Source: *Eighth National Development Plan (2022-2026), August 2022*

Population dynamics

Population growth between 2006 and 2020 averaged 2.8 per cent per annum. In 2010, the population was 13.1 million and was estimated at 17.9 million in 2020. Further, the population was higher in rural than in urban areas. The rural population was 7.9 million in 2010 and was estimated at 10.1 million in 2020. Over the same period, the urban population was 5.2 million in 2010 and was estimated at 7.8 million in 2020.

This high rate of population growth is attributed to the interplay between high fertility and reducing mortality. While the country experienced a slight reduction in the total fertility rate (TFR) from an average of 6.2 births per woman in 2007 to 4.7 births in 2018, mortality rates reduced during the same period (see Figure 7). Pregnancy-related mortality (PRMR) reduced from 591 deaths per 100,000 live births in 2007 to 278 deaths per 100,000 live births in 2018, a reduction from 398 per 1,000 live births in 2014. The maternal mortality ratio (MMR) was 252 deaths per 100,000 live births in 2018. The infant mortality rate (IMR) reduced to 42 deaths in 2018 from 70 deaths per 1,000 live births in 2007, while the under-five mortality rate (U5MR) reduced to 61 deaths in 2018 from 119 deaths per 1,000 live births in 2007.

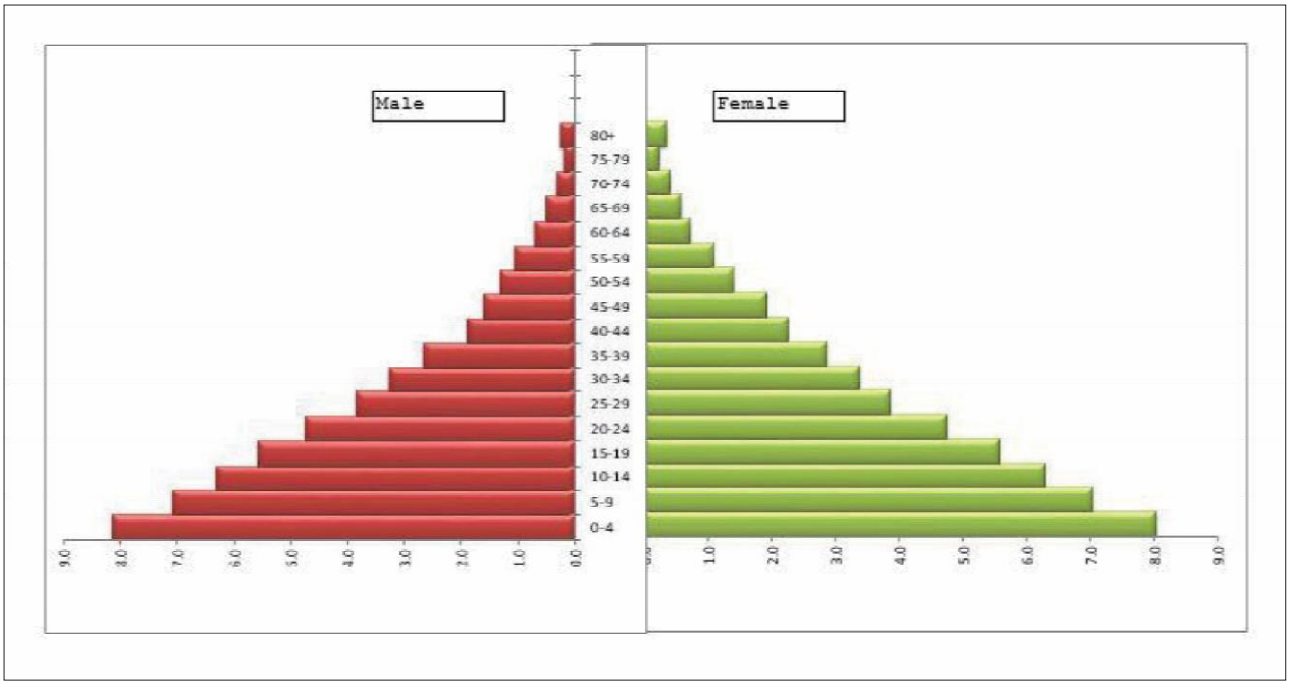
Figure 7: Selected Demographic Indicators 2007 - 2018



Source: *Eighth National Development Plan (2022-2026), August 2022*

The relatively high population growth rate for Zambia has culminated into a young population with about 46 per cent of the population aged below 15 years, and approximately 80 per cent of the population aged below 35 years. This implies that the child dependency ratio remains high at an average of 88 persons aged 0-15 years per 100 persons aged 15-64 years. (See Figure 8).

Figure 8: Population by Age and Sex, Zambia, 2021



Source: *Eighth National Development Plan (2022-2026), August 2022*

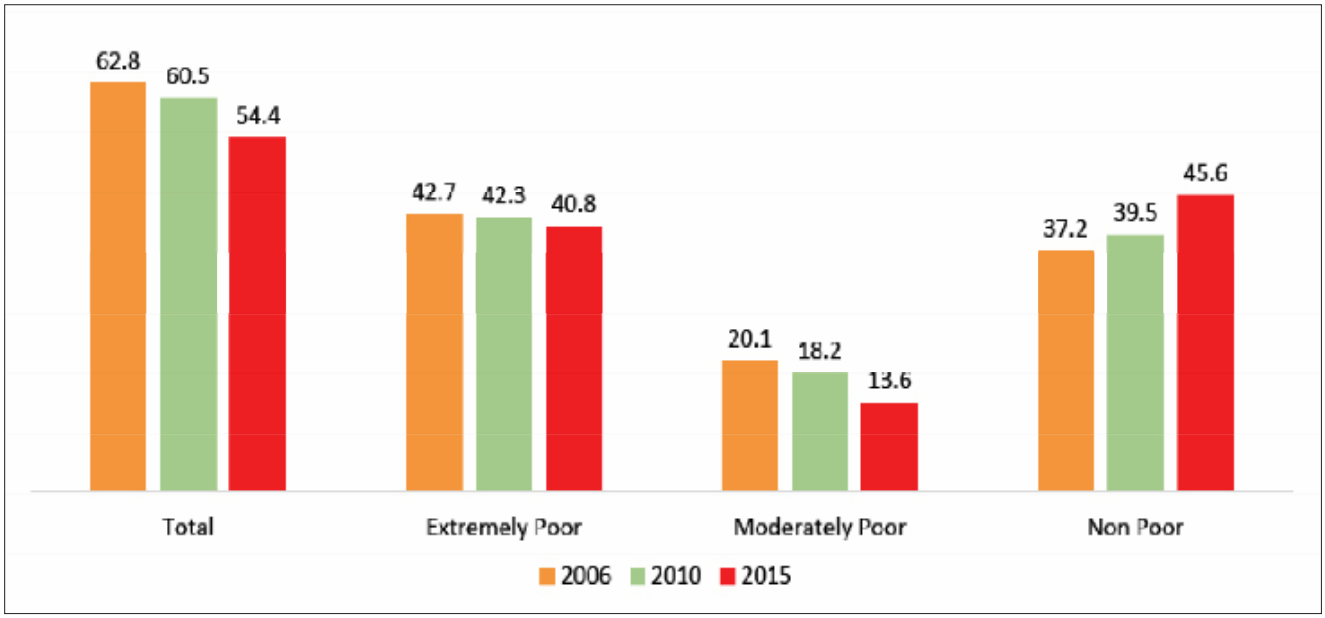
The population age structure is expected to remain relatively unchanged up to 2035, unless the implementations of interventions, aimed at attaining the demographic dividend, are put in place (see Figure 9). To attain the demographic dividend, there is a need to prioritise strategic investments in human capital (health and education), implement sound economic and governance policies, as well as sustain all necessary commitments for opening the demographic window of opportunity. This entails the prioritisation of investments aimed at creating opportunities and a supportive environment for innovation and entrepreneurship for the growing labour force, particularly the young people, persons with disabilities (PWDs), and women.

Poverty and inequality

Zambia still ranks among the countries with high incidences of poverty and inequality in Africa, as well as globally. This is despite several interventions made in education and skills development, health, water and sanitation, as well as job creation and empowerment of citizens. However, some reduction in poverty levels was recorded during the previous National Development Plan (NDP) periods. Poverty levels in the period 2006-2015 reduced by 8.4 percentage points to 54.4 per cent in 2015 from 62.8 per cent in 2006. This notwithstanding, extreme poverty or the proportion of individuals whose consumption was less than the cost of the food basket only marginally improved to 41 per cent of the total population in 2015 from 43 per cent in 2006.

Analysis by rural-urban residence indicates that poverty in rural areas remained higher at 76.6 per cent compared to 23.4 per cent in urban areas as of 2015. Extreme poverty was also higher in the rural areas at 60.8 per cent. These persistently high poverty levels in rural areas were mostly attributed to inadequate nutrition, households' inability to afford agricultural inputs, low wages or salaries and lack of capital to start or expand own business. Figure 9 below shows poverty trends for the period between 2006 and 2015.

Figure 9: Poverty Trends (%), 2006-2015



Source: *Eighth National Development Plan (2022-2026), August 2022*

Macroeconomic objectives

The Government of Zambia seeks to restore macroeconomic stability by raising real GDP growth as well as attaining fiscal and debt sustainability to improve the livelihoods of the Zambian people, especially the vulnerable. Attaining this will require strong policy action and the implementation of structural reforms.

a) Pursuant to the above, the macroeconomic objectives are to:
b) Achieve an annual real GDP growth rate of at least 4.5 per cent by 2026;
c) Reduce the fiscal deficit to 3.6 per cent of GDP by 2026;
d) Maintain an annual domestic revenue to GDP ratio of at least 21 per cent;
e) Contain domestic borrowing to less than 4.8 per cent of GDP by 2026;
f) Dismantle domestic arrears and curtail accumulation of new arrears;
g) Reduce and maintain inflation within the target range of 6-8 per cent;
h) Maintain international reserves of at least 3 months of import cover; and
i) Reduce the external debt to 60 per cent of GDP and ensure sustainability.

Refer to Table 2 for key macroeconomic targets, including the real GDP growth rate, inflation and domestic borrowing.

Table 2: Key Macroeconomic Indicators, 2022-2026

Key Performance Indicator	Baseline (2021)*	2022	2023	2024	2025	2026	Source of Statistics
Real GDP growth rate (%)	3.6	3.5	3.7	4.4	4.2	4.5	ZamStats/MoFNP
GDP at constant prices (ZMW millions)	143,447.6	147,197.00	152,506.50	158,467.20	165,188.00	172,686.60	ZamStats/MoFNP
GDP at market prices (ZMW millions	424,269.0	460,616.5	522,881.0	583,733.2	649,115.8	717,592.7	ZamStats/MoFNP
CPI* inflation (%, end period)	16.4	<10	6-8	6-8	6-8	6-8	ZamStats/BoZ
Domestic borrowing (% of GDP)	7.7	5.9	5.6	5.8	5.9	4.8	MoFNP
Domestic revenue (% of GDP)	23.6	21.2	21.8	22.3	22.9	23.0	MoFNP
Overall fiscal deficit (% of GDP)	9.0	6.7	6.3	5.2	4.6	3.6	MoFNP
Gross international reserves (months of import cover)	4.4	≥3.0	≥3.0	≥3.0	≥3.0	≥3.0	BoZ
*Note that all baseline data is preliminary with the exception of CPI inflation and gross international reserves							
*CPI: Consumer Price Index							

Source: *Eighth National Development Plan (2022-2026), August 2022*

Macroeconomic policies

Achieving higher and inclusive growth

The policy over the 8NDP period (2022-2026) is to improve living standards as well as to reduce poverty and inequality by creating conditions for strong and inclusive growth. This is anchored on ***Economic Transformation and Job Creation*** through implementation of interventions to enhance production and productivity in the agriculture, tourism, mining and manufacturing sectors. Further, the Government will pursue an export oriented economic transformation agenda.

Fiscal policy and reforms

To achieve fiscal sustainability, a combination of measures, including enhancements in domestic resource mobilisation, expenditure rationalisation and debt restructuring, will be pursued.

Key interventions in tax policy will include enhancing compliance while streamlining the structure of tax incentives to support economic transformation. The capacity of local authorities will also be strengthened to enhance revenue collection.

Total expenditure (including amortisation) is projected to reduce to 30.0 per cent of GDP in 2026 from 33.9 per cent in 2021 This will largely be attained through significant reforms on subsidies, particularly in the energy and agriculture sectors, as well as rationalising spending on capital projects with emphasis on public private partnership (PPP) due to fiscal constraints. In this regard, the focus will be on reducing the pace of debt accumulation to attain long-term debt sustainability.

Debt management strategy

During the 8NDP period, the Government will revise the Loans and Guarantees (Authorisation) Act of 1969 to enhance transparency in debt management and provide for parliamentary oversight in the contraction of loans. Further, a Medium-Term Debt Management Strategy covering the period 2023 to 2025 will be developed for the country to return to sustainable debt levels. Under domestic debt, the focus will be on the issuance of longer-dated instruments, taking into account market conditions and costs to reduce the refinancing risk. With regard to external debt, the Government will seek to restructure debt under the auspices of the G20 Common Framework on Debt Treatment.

Dismantling of domestic arrears

The Government has prioritised the dismantling of domestic arrears and will, therefore, develop an arrears dismantling strategy to be implemented over the 8NDP period. The strategy will address the existing stock of arrears relating to personal emoluments, bills for consumption of public utilities, value-added tax (VAT) refunds, Farmer Input Support Programme (FISP), crop purchases under the Food Reserve Agency, pension benefits, awards and compensation, capital expenditure on civil works including road construction, as well as that of other suppliers of goods and services. Further, arrears on fuel and electricity (debt to independent power producers and power imports) which are foreign currency-denominated will be addressed through this strategy.

The key measures of the strategy include increasing budgetary allocations to liquidate the arrears, undertaking debt and/or cheque swaps, debt refinancing and restructuring, as well as halting or slowing down the pace of accumulation of new arrears. The aim is to clear all domestic arrears within the medium to long-term.

Monetary and financial sector policies

During the 8NDP period, monetary and financial sector policies will aim at maintaining price and financial system stability which are critical to promoting sustainable growth. Monetary policy will continue to rely on the forward-looking monetary policy framework anchored on the Policy Rate as a key signal of the policy stance.

To ensure financial system stability, the Bank of Zambia will strengthen both micro and macro-prudential regulations and supervision to mitigate the build-up in vulnerabilities and risks to the financial system. In addition, a Deposit Protection Scheme and Problem Bank Framework will be implemented.

The Government will also repeal and replace the Bank of Zambia Act of 1996 during the Plan period to strengthen central bank autonomy and enhance monetary policy credibility in line with the Constitutional (Amendment) Act No. 2 of 2016 and the adoption of the SADC Central Bank Model Law.

External sector policies

During the 8NDP period, the Government will continue to promote exports as a strategy for long-term economic growth. In addition to increasing traditional exports of commodities such as copper, widening the export base of non-traditional exports will be the focus to increase export earnings. This strategy will positively impact the country's international competitiveness, buttress the stability of the exchange rate and ensure current account sustainability. In this regard, focus will be on expanding export earnings from various sectors, especially mining, agriculture, manufacturing and tourism. Further, the Government will

continue facilitating and formalising trade with neighbouring countries. With regard to the exchange rate policy, a flexible system will be maintained while mitigating excessive volatility.

To maintain reserves to at least three months of import cover, the Government will, in addition to promoting increased exports, continue with the policy requiring all mining companies to pay their tax obligations in United States dollars. Further, the Bank of Zambia will continue to build up its stock of gold bullion as part of the interventions to increase foreign reserves, through the purchase of locally-mined gold.

This socio-economic profile highlights the efforts necessary in order to achieve effective resource allocation in the country's HIV and AIDS response. The epidemiology of HIV and AIDS in the country now follows, before the NASA exercise is addressed.

1.2 Zambia HIV and AIDS epidemiology

Zambia has an estimated 1.2 million People Living with HIV (PLHIV). According to the 2021 Zambia Demographic and Health Survey (ZDHS), 9.9 per cent of persons aged between 15 and 49 years are living with HIV with 13.2 per cent females and 6.3 per cent male. Prevalence of HIV among adults aged 15 years and above in Zambia was 11 per cent. HIV prevalence was 13.9 per cent among women and eight per cent among men (ZDHS, 2021). Accordingly, the annual incidence of HIV among adults aged between 15 and 49 years in Zambia is 0.34 per cent with 0.63 per cent among females and 0.05 per cent among males. Annual incidence of HIV among adults aged 15 years and above in Zambia was 0.31 per cent, which corresponds to approximately 28,000 new cases of HIV per year among adults. HIV incidence was 0.56 per cent among women and 0.06 per cent among men (ZAMPHIA, 2021) across the country.

Prevalence of viral load suppression (VLS) among adults aged 15 years and above living with HIV in Zambia was 86.2 per cent: 86.6 per cent among women and 85.5 per cent among men. Note that these estimates of VLS prevalence are among all adults living with HIV, regardless of their knowledge of HIV status or use of antiretroviral therapy (ART).

Table 3: HIV Prevalence, annual incidence and viral load suppression among Adults (15-49) and adults aged 15+ years in Zambia

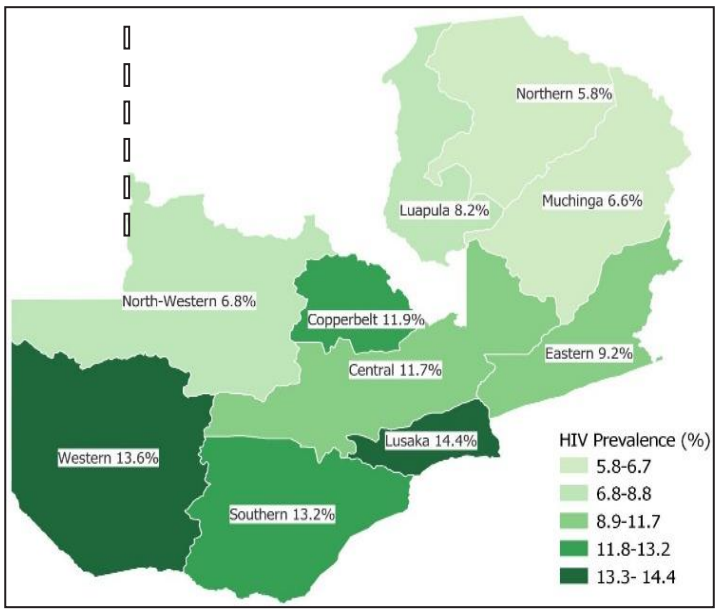
HIV Indicator Women		95% CI	Men	95% CI	Total	95% CI
Annual incidence (%)						
15-49	0.63	(0.24 - 1.02)	0.05	(0 - 0.15)	0.34	(0.14 - 0.53)
15+	0.56	(0.22 - 0.90)	0.06	(0 - 0.16)	0.31	(0.14 - 0.48)
Prevalence (%)						
15-49	13.2	(12.2 - 14.3)	6.3	(5.0 - 7.7)	9.9	(9.1 - 10.7)
15+	13.9	(12.8 - 15.1)	8	(7.0 - 9.0)	11	(10.3 - 11.8)
Viral load suppression (%)						
15-49	85.4	(80.7 - 90.0)	82	(77.3 - 86.7)	84.3	(80.7 - 88.0)
15+	86.6	(83.1 - 90.1)	85.5	(82.3 - 88.7)	86.2	(83.9 - 88.5)

Source: *ZAMPHIA, 2021*

There are regional variations in the HIV situation in Zambia. Among adults aged 15 years and above, HIV prevalence varied geographically across Zambia, ranging from 5.8 per cent to 14.4 per cent. Lusaka province has the highest HIV prevalence of 14.4 per cent, followed by Western (13.6%), Southern province is at 13.2 per cent , Copperbelt (11.9%), Central

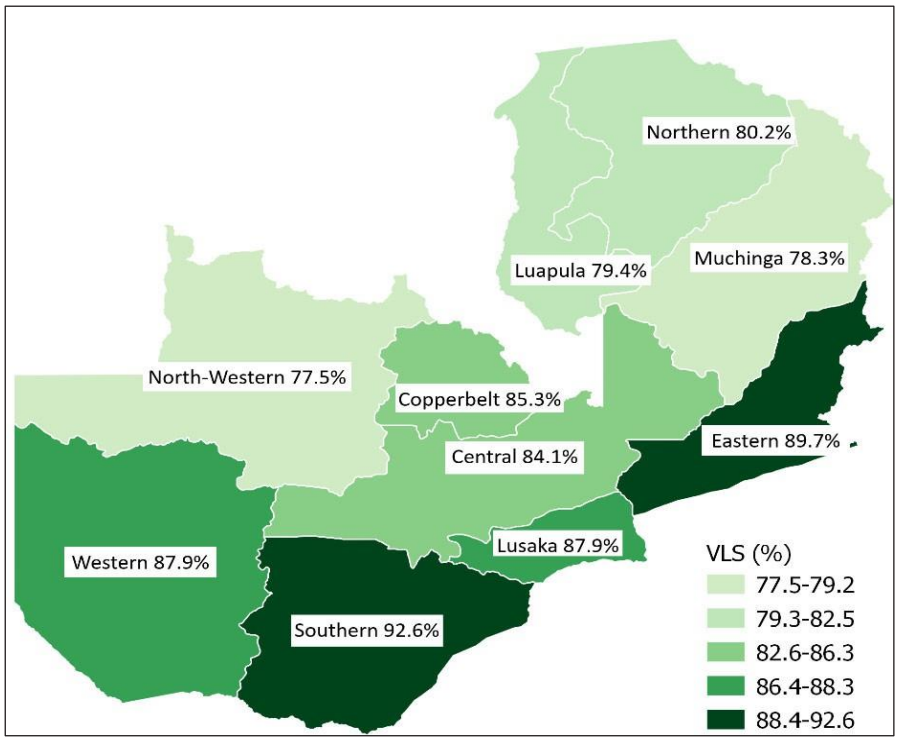
11.7 per cent , Eastern 9.2 per cent , Luapula 8.2 per cent, North-Western province 6.8 per cent , Muchinga and Northern provinces have the lowest prevalence rates, estimated at 6.6 per cent and 5.8 per cent, respectively as indicated in Figure 10 below.

Figure 10: HIV Prevalence by Province



There are regional variations in prevalence of VLS situation in Zambia. Among adults aged 15 years and above, living with HIV, prevalence of VLS varied geographically across Zambia, ranging from 77.5 per cent to 92.6 per cent. Southern province has the highest prevalence of VLS (92.6 %) followed by Eastern (89.7%), Lusaka and Western provinces are both at 87.9 per cent. Copperbelt is at 85.3 per cent, Central (84.1 %), Luapula 79.4 per cent, North-Muchinga and Northern provinces have the lowest of VLS rates, estimated at 78.3 per cent and 77.5 per cent respectively as indicated in Figure 11 below.

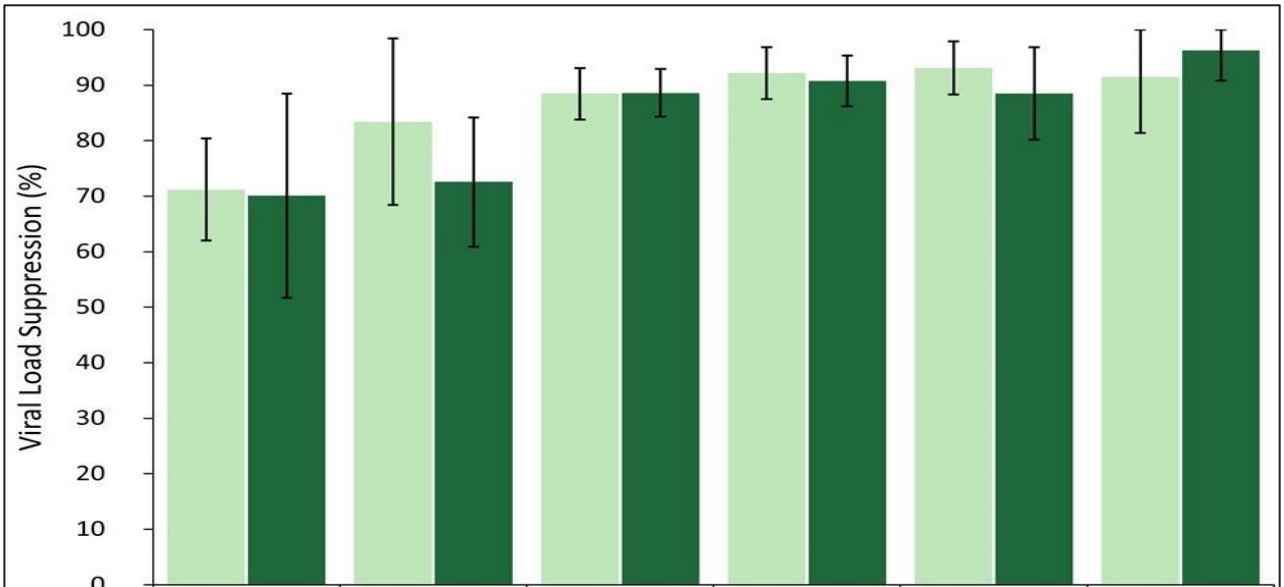
Figure 11: Viral load suppression among adults living with HIV, by province



Source: *ZAMPHIA, 2021*

Among adults living with HIV in Zambia, the prevalence of VLS ranged from 71.2 per cent among women aged 15-24 years to 93.1 per cent among women aged 55-64 years, and from 70.1 per cent among men aged 15-24 years to 96.3 per cent among men aged 65 years and above. VLS was similar for women and men across all age groups. The figure below illustrates what is announced.

Figure 12: Viral load suppression, by age and sex



Ages (years)	15-24	25-34	35-44	45-54	55-64	65+
Women	71.2%	83.4%	88.5%	92.2%	93.1%	(91.5%)
Men	70.1%	72.6%	88.6%	90.8%	88.5%	(96.3%)

The Joint United Nations Programme on HIV/AIDS (UNAIDS) set the 95-95-95 targets with the aim that by 2025, 95 per cent of all people living with HIV will know their HIV status; 95 per cent of all people with diagnosed HIV infection will receive sustained ART; and 95 per cent of all people receiving ART will have VLS.

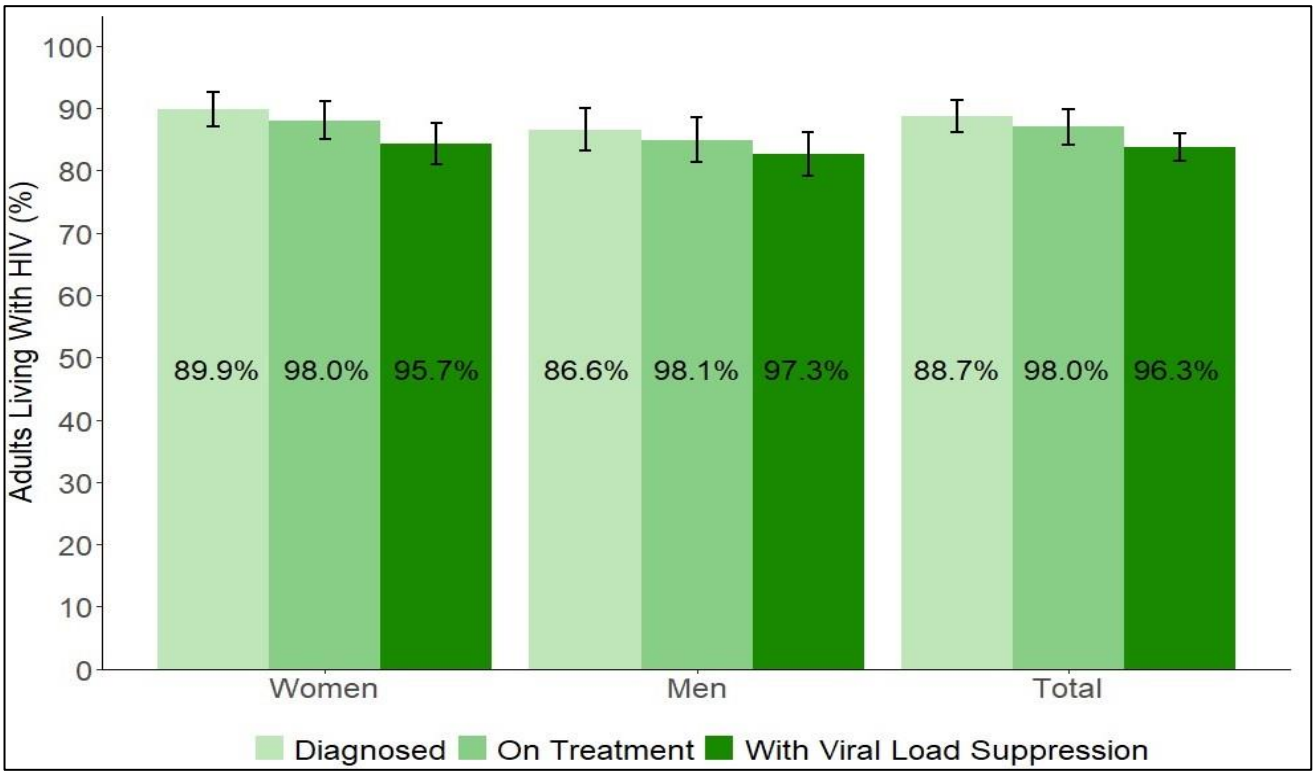
Diagnosed: In Zambia, 88.7 per cent of adults (15+ years) living with HIV were aware of their HIV status: 89.9 per cent of women and 86.6 per cent of men. Individuals were classified as aware if they reported their HIV-positive status or had a detectable antiretroviral (ARV) in their blood.

On Treatment: In Zambia, among adults living with HIV who were aware of their status, 98 per cent were on ART: 98 per cent of women and 98.1 per cent of men. Individuals were classified as being on ART if they reported current ART use or had a detectable ARV in their blood.

Viral Load Suppression: Among adults who were on ART, 96.3 per cent had VLS: 95.7 per cent of women and 97.3 per cent of men.

Percentages shown in the graph refer to the conditional 95-95-95 targets described in the text to the right. The heights of the bars represent the unconditional (overall) percentages for each indicator among all people living with HIV. Male, female, and total percentages apply to adults aged 15-64 years. Error bars represent 95 per cent confidence intervals (CIs).

Figure 13: Achievement of the 95-95-95 targets, by age and sex



Source: *ZAMPHIA, 2021*

Among all adults living with HIV, VLS prevalence was 86 per cent, suggesting that Zambia is well-positioned to achieve the UNAIDS goal of ending the AIDS epidemic by 2030.

Zambia has met the 2nd and 3rd 95 targets of people (15+ years) who know their HIV status receiving ART and having VLS. The country is approaching the overall 95-95-95 target of 86 per cent (95*95*95) with nearly 84 per cent of all adults achieving VLS with ART use.

While recognising the remarkable accomplishments of Zambia in controlling HIV at the national level, key gaps remain. Zambia has not yet reached the first 95 target among adults aged 15 years and above and VLS prevalence among men aged 15-34 years and women aged 15-24 years is lagging behind other age groups. Geographic variation in VLS prevalence indicates some provinces (Muchinga and North-western) are below targets.

Moving forward, Zambia is well-positioned to achieve the UNAIDS 95-95-95 targets by closing the programmatic gaps in diagnosis, treatment, and adherence. The country can ensure that all people benefit from these achievements by increasing diagnosis among people who do not yet know they are living with HIV and helping younger people achieve viral load suppression.

2.0 NASA STUDY DESIGN AND METHODOLOGY

2.1 NASA concepts

NASA is a comprehensive and systematic methodology to track the flow of resources for the AIDS response from the source, through the different agents, to the beneficiaries. The NASA resource tracking algorithm is designed to describe financial flows and expenditures, using the same categories in the global resource needs estimation. It has been designed as a core-tracking framework without substituting for other methods and tools already in use. The NASA framework is based on globally accepted standardised methods and definitions, which are compatible with, but more disaggregated than, the National Health Accounts (NHA) – now called System of Health Accounts (SHA).

NASA can, therefore, generate useful evidence to assist with the planning and financing of HIV services and can be used to measure the potential financial gap and thus to mobilise for additional resources. It is a very powerful tool for policy makers and all actors involved in the HIV/AIDS response, including governments, donors, persons affected by HIV and civil society more broadly. NASA provides useful insights on the extent of harmonisation and alignment of the resource envelope to the programmatic priorities. This is particularly important when future HIV funding is threatened by competing global priorities and the economic down turn while expectations to achieve more remain high.

National AIDS Spending Assessment (NASA) is a framework that calls for the embodiment and resource tracking of HIV and AIDS related activities occurring in all sectors (not only health sector) given the multi-sectoral nature of the response. Expenditures are in, but not limited to, education, social development, welfare and other non-healthcare delivery branches that are intimately related to the policy perception of the problem by Heads of State, Governments, National and International Authorities. The process follows a harmonised framework of several classifications around HIV and AIDS activities, interventions and programmatic areas. The framework was produced in 2006 and revised in 2009 to incorporate comments from the stakeholders. Further reviews have been conducted since then to capture lessons learnt in almost a decade of implementing NASA in various countries. The latest NASA classifications were produced in 2018 and they have been used in this study.[1]

2.2 NASA classifications

NASA classifications are summarised in three dimensions: financing, provision, and utilisation. The classification of the three dimensions and nine categories comprise the framework of the NASA system. These dimensions incorporate nine categories:

A) Financing HIV and AIDS services

i. Financing Entities (FE) are entities that provide money to financing agents (see Table 1.a, Annex 1).

ii. The funds are sourced from various pools (revenues), e.g. transfer from government domestic revenue, transfers distributed by government from foreign origin etc. (see Table 1.b, Annex 1).

iii. Financing Schemes (SCH) are the main types of financing arrangements through which people obtain health services. Health care financing schemes

[1] See UNAIDS (2018), NASA Data Consolidation Tool (DCT) and NASA RTT Software, Geneva.

include direct payments by households for services and goods and third-party financing arrangements e.g. through compulsory contributory health insurance schemes, transfer through social health insurance etc. (see Table 1.c, Annex 1).

iv. Financing Agents – Purchasers (FAP) are entities that pool financial resources to finance service provision programmes and also make programmatic decisions (purchaser-agent) [see Table 1.d, Annex 1].

B) Provision of HIV and AIDS services

1. Providers of Services (PS) are entities that engage in the production, provision, and delivery of HIV and AIDS services (see Table 1.e, Annex 1).
2. The health providers provide services using various Service Delivery Modalities (SDMs) e.g. inpatient care, outpatient care, community outreach programmes etc. (see Table 1.f, Annex 1).
3. Production Factors (PF)/resource costs are inputs (labour, capital, workshop facilities, promotion materials, travel etc.) that are used by providers to provide services [see Table 1.g, Annex 1].

C) Utilisation of HIV and AIDS services

1. AIDS Spending Categories (ASC) are HIV-related interventions and activities, what is done in order to reach the expected achievements in addressing the pandemic (see Table 1.h, Annex 1).
2. Beneficiary segments of the population (BP), e.g., men who have sex with men, injecting drug users, general population, pregnant women etc. (see Table 1.i, Annex 1).

NASA seeks to answer the following questions:

1. Where does the money come from? Who provides the funds? (Financial Entities)
2. Who pools the funds? (Revenues)
3. What mechanism allows payment? (Financing schemes)
4. Which entity manages the funds? Who makes the decision of what services or goods to purchase? (Financing Agents – Purchasers)
5. Who provides the services or the goods? (Services and goods providers)
6. How are the services provided? (Service Delivery Modalities))
7. What does a provider buy to produce the AIDS Spending Categories? (Production factors e.g. medical supplies, time of health providers (by paying salaries and other incentives), office rent, utilities, catering services, etc.
8. What does a provider deliver? (AIDS Spending Categories-ASC: e.g. Prevention services, treatment services, etc.)
9. Who are the recipients of the services and goods? (Beneficiaries of the services or target groups)

2.3 Rationale for conducting NASA in 2022

The 2001 United Nations General Assembly Special Session on HIV and AIDS urged countries to invest in monitoring and evaluation systems of their HIV and AIDS responses. This entails the institutionalisation of a monitoring system that enables implementers to routinely collect financial and health service delivery data on the HIV and AIDS response.

The NASA methodology produces information that can guide decision-making to determine the level of expenditure incurred in each programme area, to measure the potential financing gap, and to improve future allocative decisions and mobilise additional resources in an evidence-based planning process. Additionally, the NASA result informs the processes of developing or improving key national strategies such as sustainability plans and allocative or productive efficiency analyses, and permits monitoring of implementation of the National Strategic Framework.

This is particularly important when future HIV and AIDS financing is threatened by competing global priorities and economic downturns but expectations to achieve more remain high. NASA data allow for further examination of aspects of equity, efficiency, absorptive capacity and allocative efficiency and are critical for informing the sustainability discourse.

Zambia faces challenges related to timely financial reporting for HIV and AIDS services, resource mobilisation, allocation and absorptive capacity at all levels. At the same time, the size of the HIV and AIDS resource envelope is unpredictable and it is not easy to understand how these resources are used. Information on financing for the national response, as well as public, civil society and private sector spending, remains largely uncoordinated and with data deficiencies. The effective tracking of such resources is, therefore, an important policy issue for all stakeholders.

Tracking HIV and AIDS expenditure produces estimates of the flow of resources into a country's health system. To answer policy questions around financial sustainability, it is vital to understand and explain the financial flows; to demonstrate how the funds are dispersed to different economic agents and the channels used to access financing; to determine the level of expenditure incurred in each programme area and the targeted beneficiary populations; and to measure the potential financing gap.

Against such a background, Zambia NAC, in collaboration with UNAIDS, commissioned NASA for the period 2019 to 2021.

2.4 Objectives of NASA in Zambia

The primary objective for this exercise is to collect data on HIV and HIV/TB coinfection expenditures in Zambia from 2019 to 2021 using the National AIDS Spending Assessment methodology.

Specific objectives are:

1. To implement a methodology for systematic monitoring of HIV and HIV/TB coinfection financial flows at national and regional level using the NASA methodology in Zambia;
2. Build national level capacity for systematic monitoring of HIV and AIDS financing flows using the NASA methodology, with a view to a yearly fully-institutionalised NASA;
3. To conduct an HIV and HIV/TB coinfection spending assessment focusing on public and development partner (external) resources, and including private (both for-profit and not-for-profit) entities known to be contributing to HIV and TB activities;
4. To identify and measure the flow of resources for HIV and HIV/TB coinfection by the funding entity *(FE),* revenue *(REV),* financing scheme *(SCH),* financing agent-purchaser *(FAP)*, service provider *(PS),* the service delivery modality *(SDM),* function/ intervention *(ASC)*, cost components (factors of production, *PF*) and beneficiary populations *(BP)*;
5. To prepare a report of expenditure trends that will contribute to the country's next Global Fund Request for Funding and to their Sustainability Plan, including steps to

incorporate the NASA findings into relevant documents and processes, such as the National HIV/AIDS Strategic Framework (NASF) mid-term review, the sustainable financing plan, the investment case update, resource mobilisation strategies.

The NASA will answer the following questions:

- ✓ Who are the sources of funding for HIV and TB coinfection in Zambia?
- ✓ Are the funds adequate to achieve the NASF targets?
- ✓ Who are the agents/ manager of funding for HIV and TB?
- ✓ Who are the providers of HIV and TB services?
- ✓ What HIV and TB services are being provided and what is being spent on these?
- ✓ Is there need to reallocate towards interventions of greater impact, as per the Investment Case findings?
- ✓ Which activities are most dependent on external support and may need sustainability planning?
- ✓ What is the spending on HIV and TB across the provinces and does it match the provincial burden of disease?
- ✓ Who are the beneficiaries of the HIV and TB spending?
  What are the key cost drivers, the production factors, of the HIV and TB spending in Zambia?

2.5 Methodology and Scope

2.5.1 Methodology

The NASA methodology, as promoted by UNAIDS, has been applied with transactions being reconstructed from the transfer of resources between different economic agents following the money through the financing flows, buyers, providers and the description of its factors of the production function, so as to generate the intended intervention to benefit specific beneficiary populations. Where expenditure data are missing, costing methods have been used to estimate the expenditure. The most logical estimation approach has been applied, based on available data, but generally estimations have been used as little as possible.

NASA implementation occurred in the following phases:

a) Planning, mapping of actors and capacity building
b) Awareness-raising with key national HIV response and TB response stakeholders: government ministries, cooperating/development partners, private sector, NGOs and civil society – this was done by NAC and UNAIDS.
c) Mobilisation of funds for the project - this was done by NAC and UNAIDS.
   Establishment of the core steering committee comprising of NAC, government ministries, private sector, civil society and cooperating/development partners - this was done by NAC. A technical committee was set up for oversight of the operational phase of the exercise. The members of the technical committee are listed below:

#	Title	Names	Organization
1	Mr	Akapelwa Imwiko	Ministry of Finance and National Planning
2	Mrs	Onida Moyo	Ministry of Finance and National Planning

#	Title	Names	Organization
3	Dr	Patricia Bobo	Ministry of Health
4	Dr	Dean Phiri	Global Fund PMU
5	Mr	Michael Kachumi	CHAZ
6	Mr	Patrick Banda	Ministry of Health
7	Mr	Christopher Chikatula	Global Fund CCM Secretariat
8	Ms	Mildred L. Miti Kanyenge	Ministry of Community Development and Social Services
9	Mrs	Dieneke Huurne	GIZ
10	Mrs	Annie Kaleshe	NAC
11	Mr	Peter Ndemena	NAC
12	Mr	Audace Niyongere	UNAIDS
13	Ms	Lenganji Nanyangwe	SAT Zambia
14	Ms	Hilda Shakwelele	CHA
15	Mr	Chungu Fred	NZP+
16	Mr	Mwanza Felix	TALC
17	Mr	Sibusiso Malunga	KPC
18	Mr	Collen Zulu	USAID

d) Preparation of letters to institutions requesting access to financial expenditure records as well as the required letters of permission to access provinces, districts, health facilities, etc. NAC and MOH arranged for this.
e) Undertook a mapping of all actors involved in the HIV/TB response in Zambia at national and regional levels. NAC provided a list of NASA Cooperating Partners and Stakeholders:

i. Ministry of Finance and National Planning (Budgeting)
ii. Ministry of Health (Planning and Budgeting)
iii. CDC, USAID and other PEPFAR IPs
iv. Global Fund – PMU
v. CHAZ
vi. UNFPA
vii. UNICEF
viii. GIZ
ix. UNAIDS
x. Zambia Federation of Employers
xi. Manufacturers Association of Zambia
xii. Bankers Association of Zambia
xiii. Mining Association of Zambia

f) Orientation and training of the core team on the updated NASA guidelines, classifications and tools.
g) Reviewing and adjusting of the NASA data collection tools by an International consultant. The NASA classifications and vectors were revised in 2019, with some nomenclature revised and the number of vectors increased from six to nine. This

necessitated the adjustment of the data collection tools to ensure that they could be used under this new classification.

h) Planned for data collection (developed a plan). This was done by international and local consultants alongside NAC officers, who arranged all the logistics.

Sampling and data collection

The mapping of all actors, both at national and sub-national levels, were supported in identifying sampling frameworks from which the majority of respondents were included. All the funding sources and agent-purchasers were included, without sampling.

In the case of service providers, those with the largest portfolio of services and expenditure were purposively sampled by strata, so as to ensure that the different levels and sizes of providers were represented and that approximately 80 per cent of all the HIV expenditure in the country would be captured. This selection was informed by NAC and UNAIDS.

The financial transactions were reconstructed from the origin to the final user by identifying three dimensions and nine vectors:

- **FINANCING**:
  1. Financing entities (Sources) FE
  2. Financing scheme SCH
  3. Revenue of financing schemes REV
  4. Financing agent and purchaser (Agents) FAP

- **PROVISION:**
  1. Providers of services PS2)
  2. Production Factors PF

- **USE/CONSUMPTION:**
  1. AIDS Spending categories ASC
  2. Service delivery model SDM
  3. Intended Beneficiary Populations BP

The NASA data collection tools for financing entities, revenues, schemes, financing agents-purchasers, and providers were applied through face-to-face interviews. Service delivery modalities, production factors and beneficiaries were identified. The Data Consolidation Tool were utilised in this exercise.

The consultants led and undertook the data collection with rigorous quality control measures, so as to ensure the correct application of the tools and quality of the data collected. Twenty (20) data collectors were engaged for this exercise and were deployed in at least five provinces (Lusaka, Copperbelt, North-western, Northern and Southern provinces). For PEPFAR, data was downloaded from their Panorama website and cross-walked to NASA classifications.

The following is the list of data collectors engaged:

NO.	NAME	SEX	QUALIFICATION
1.	Jennipher Makondo	F	BA Computer Science
2.	Fatima Phiri	F	BA Nursing
3.	Lorraine Goma	F	BA Education
4.	Victoria Mwanza	F	BA Political Science
5.	Koniwayi Chingoma	F	Medical Student (7^{th} Year)
6.	Martha Chuma	F	MSc Education
7.	Rita Banda	F	BA Human Resources
8.	Gilbert Kalumbi	M	Accounts
9.	Mathews Lungu	M	BA Psychology
10.	Maurice Telebwe Luchen	M	BA Economics
11.	Mary Hamangaba	F	BA Demography
12.	Naminda Momba	F	MSc Economics
13.	Martin Chuma	M	BA Development Studies
14.	Maimbolwa Akufuna	F	BA Nursing
15.	Ziwase Mambo	F	BA Economics
16.	Thombi Nguluwe	F	BA Adult Education
17.	Muma Obino	M	BA Human Resource
18.	Madaliso Mbewe	F	BA Education
19.	Eliud Musonda	M	BA Commerce
20.	Cynthia Phiri	F	BA Development Studies
21.	Clara Kaloza	F	BA Library Studies

The data collectors were trained in the NASA methodology, the taxonomy, use of the data collection tools and also in the appropriate allocation of expenditure between the different categories. Training of the resource tracking team in the use of Resource Tracking Tool (RTT) software was provided by UNAIDS Geneva.

Quality control

Data processing was conducted in the field and the collected data was checked, cleaned and validated, before entry into the NASA RTT. The field supervisors, on a daily basis, checked the capturing of the transactions by all the data collectors. During data processing, transactions were traced by cross-checking the data collected from multiple sources, agents and providers. This process was designed to carefully and methodically eliminate any potential double-counting of resources and ensure that each transaction had all the vectors labelled correctly. Once collected, the data was entered into MS Excel and then exported to the NASA RTT following triangulation and verification. After data analysis, the findings were presented at a stakeholder meeting which was called to validate the preliminary findings. Validation included a clear explanation of the methods applied, estimations, assumptions, missing data and other limitations, and how the results could be interpreted or used.

Data analysis, validation and report writing

This phase focused on data entry, analysis, triangulation and report writing. All these activities were undertaken by the research team, with strict quality control and internal validity checks by the team leaders and senior consultants. Data was entered into MS Excel and then exported to the NASA RTT, after triangulation and verification. The team analysed the findings and prepared a PowerPoint presentation of the preliminary findings. The initial presentation was made to the stakeholder meeting, which validated the preliminary findings. The presentation included a clear explanation of the methods applied, estimations, assumptions, missing data and other limitations. The omissions and errors have since been addressed prior to drafting the technical report.

For quality assurance purposes, the draft report, with data sets, was submitted to UNAIDS Geneva for midterm and final review before submission and clearance by national authorities. The draft report was also submitted to NAC, UNAIDS, the Core Steering Team, donors and other key actors for comments and suggestions.

2.5.2 Scope of NASA

The following are the parameters of the NASA:

- Calendar years: 2019, 2020, 2021;
- HIV and TB/HIV coinfection interventions;
- Financial sources included: public, external, private (businesses and not-for-profit).
- Level of the assessment: national and sub-national; and
- All the variables have been collected in accordance with the NASA methodology of 2019 as outlined above.

2.5.3 Assumptions and Limitations

Beginning from the year 2020, the Ministry of Health changed its approach to planning from activity-based to output-based approach. The output-based approach aggregates costs at a much higher level. Under this approach, disaggregated data by intervention, activity or production factor can only be obtained at district level where the actual activities take place. It was not, however, possible to visit all the 116 districts and past attempts to obtain information remotely yielded a very low response rate. This issue was unknown and, therefore, not taken into account during the planning phase. Consequently, there were no resources to visit districts around the country. However, an attempt was made to sample some districts in the Southern Province. Admittedly, the sampled districts were not representative of the country. Further, MoH was undergoing two audits at the time and it was anticipated that the data from the audit would help to fill the gap. Unfortunately, though promised that the data would be made available for incorporation in the study, the data was never availed. Faced with this scenario, MoH expenditure for 2020 and 2021 was estimated by applying the ratio of HIV spending against total expenditure for the year 2017. 2019 was ignored, as MoH experienced uncharacteristically lower expenditure in that year. The detailed calculations of the estimates are attached in a separate Excel file.

An estimation of the Ministry of Health's human resource costs incurred in delivering integrated HIV services, but which are not specifically labelled as HIV, was included based on the same criteria applied in the previous NASA. For this estimation, MoH suggested that 9 per cent of their annual salary bill be attributed to HIV, based on the SHA allocative key. The detailed calculations are attached in the Excel file.

The general approach used for data collection was to collect data directly from the source as far as possible, rather than from the implementers providing services directly to beneficiaries. For example, Global Fund expenditure was obtained directly from the two Global Fund Principal Recipients and United States Government (USG) spending was obtained from PEPFAR directly. Any data obtained from implementers who were receiving funds from such sources were excluded to avoid double counting.

PEPFAR data was downloaded from their Panorama website and cross-walked to NASA classifications. The data did not indicate their implementing partners and, therefore. all the USG funds had to be classified under one service provider category (PS.99), which meant that they could not be specifically identified. Where the services were provided through Government facilities, the FAP was assumed to be the GRZ. The SDM was determined by the nature of the intervention (ASC) and the beneficiary population.

Similarly, Global Fund implementers were not indicated and classified under one service provider category.

Where details were not available on the beneficiaries of programme spending, the most obvious classification was selected, based on the AIDS Spending Categories. For example, administration costs of other organisations were assumed to be non-targeted; M&E activities were assumed to be non-targeted interventions; training received by health workers (trained health workers, peer educators, opinion leaders, etc.) was assumed to benefit the beneficiary population that receives the services that health workers were trained in, mostly PLHIV, unless the training related to above-site HR.

Expenditure data was provided and collected either in ZMW or USD by stakeholders. The following Bank of Zambia annual average exchange rates were applied to all currency conversions so that all figures could be presented in USD.

Average Exchange Rates for the Financial Years	2019	2020	2021
US$1.00	ZMW 12.8900	ZMW 18.3441	ZMW 20.0185

3. Main findings of NASA 2019-2021 and Analysis

Financial flows related to HIV and AIDS response in Zambia, 2019-2021The financial flows of funds from source to providers for Zambia for the years 2019 to 2021 are illustrated in figure 14, 15 and 16, respectively.

Figure 14: Financial flows (2019)

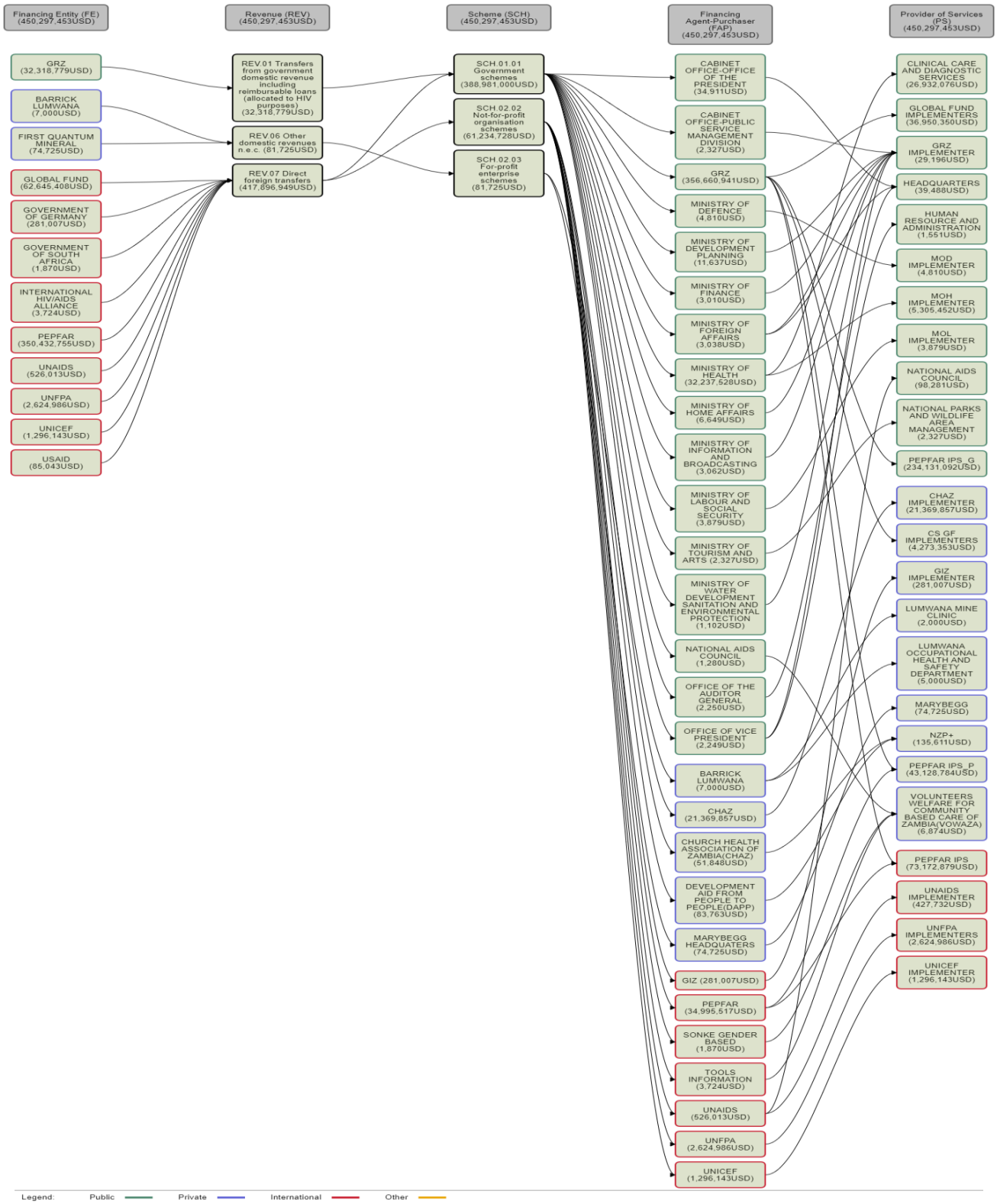


Figure 15: Financial flows (2020)

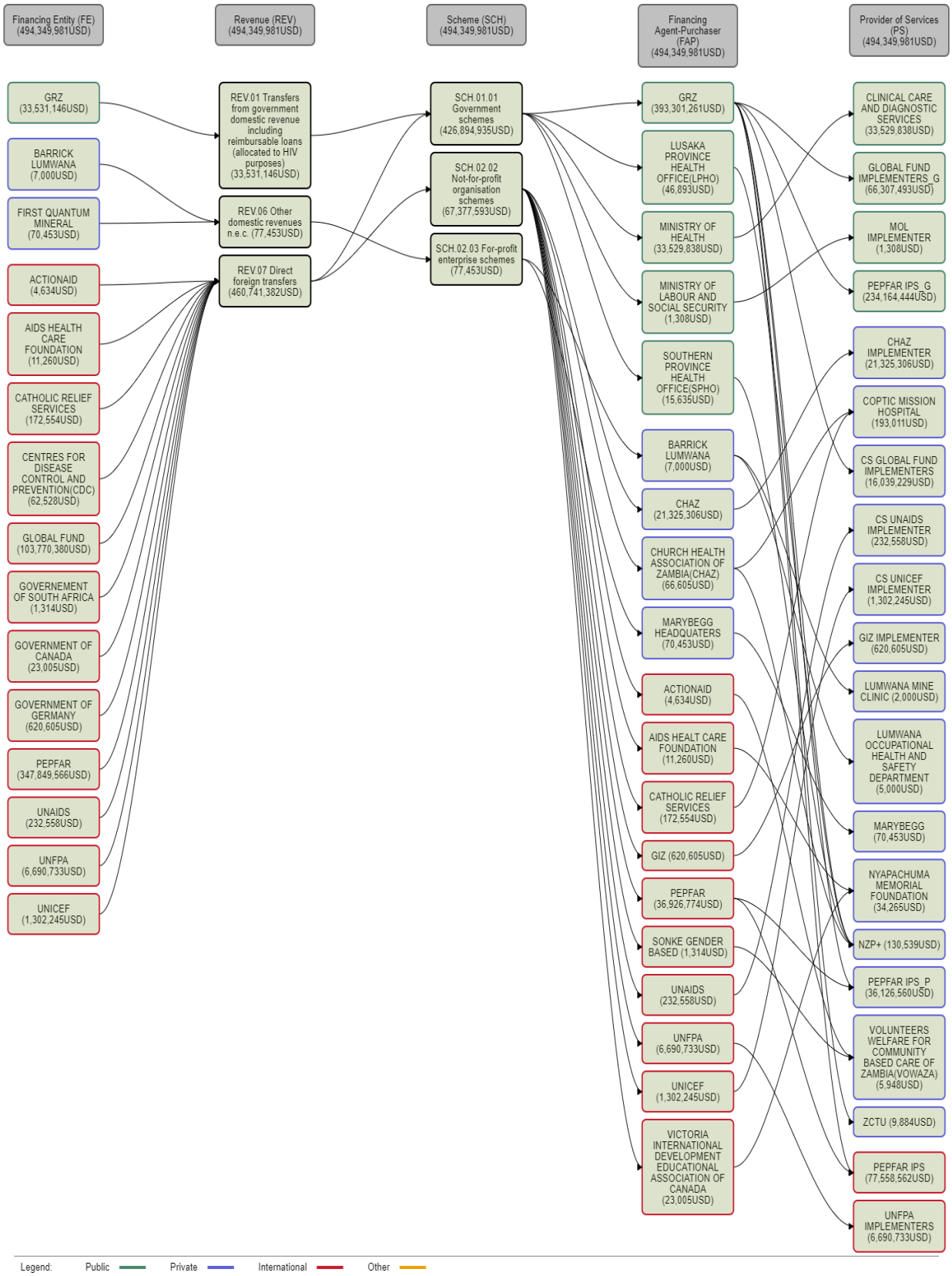
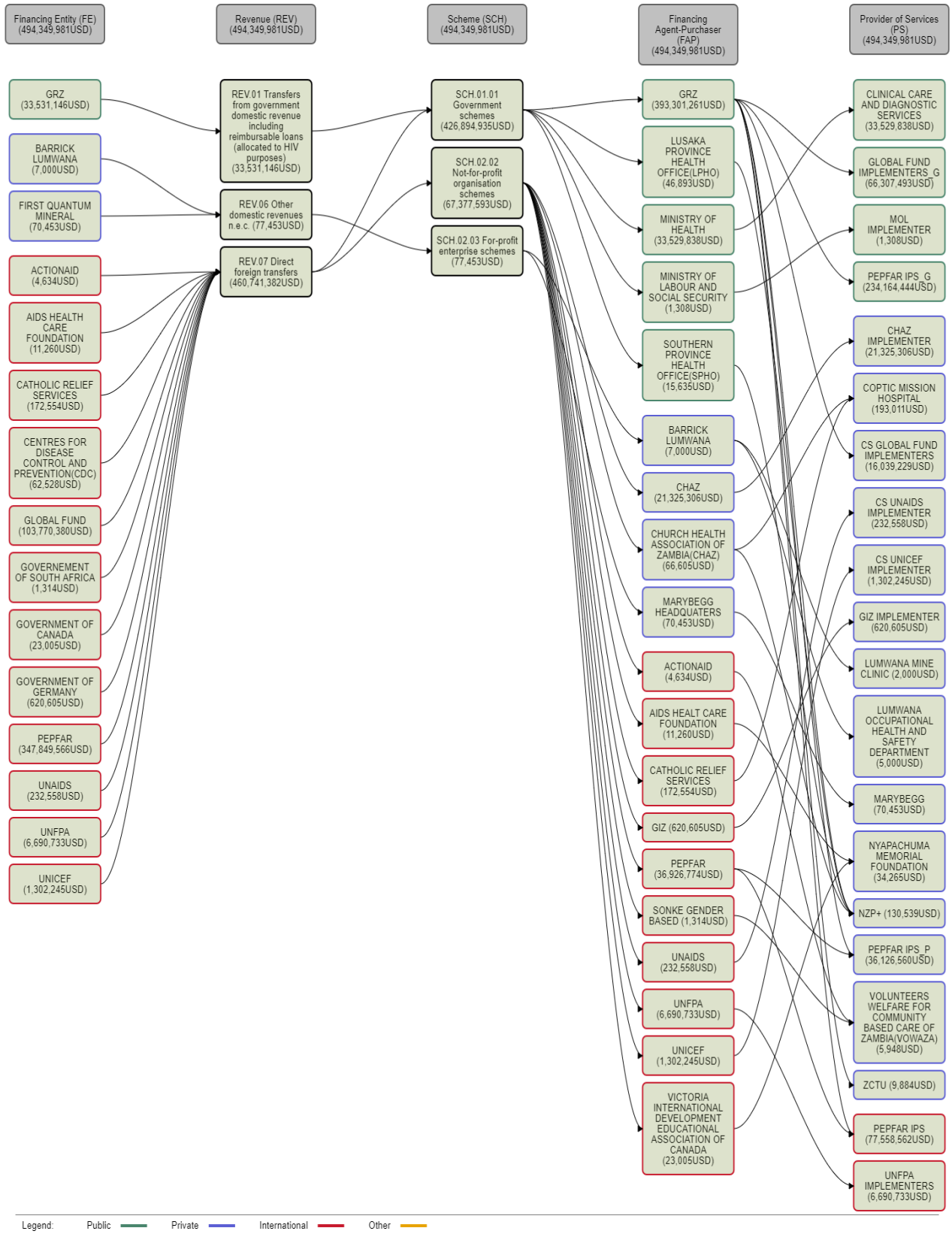


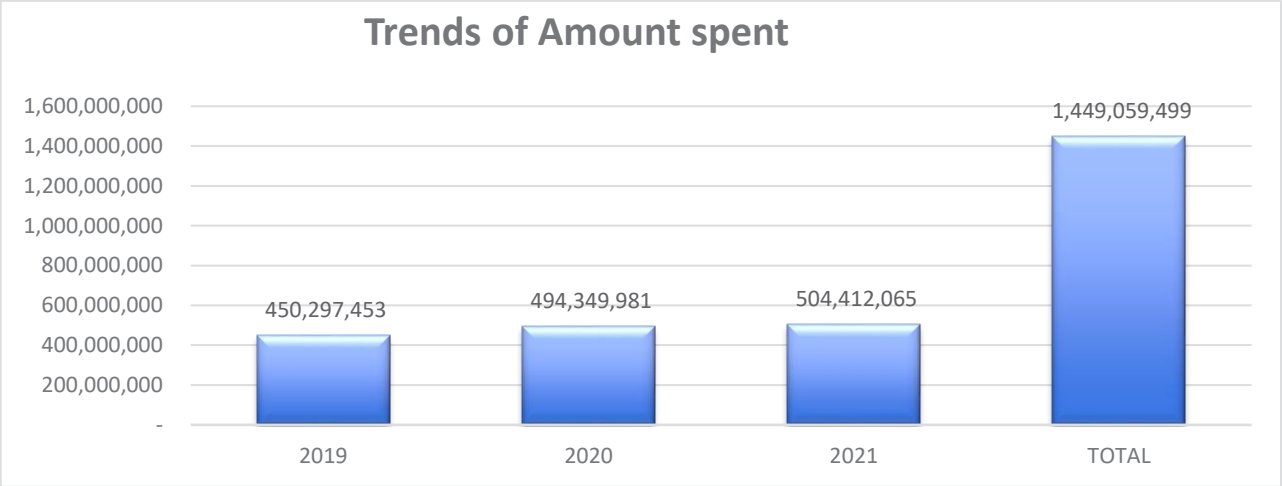
Figure 16: Financial flows (2021)



3.2 Main findings of the NASA study in Zambia (2019-2021)

3.2.1 Total HIV and AIDS spending in Zambia, 2019 – 2021

Figure 17: Trends in HIV and AIDS spending in Zambia, 2019 – 2021

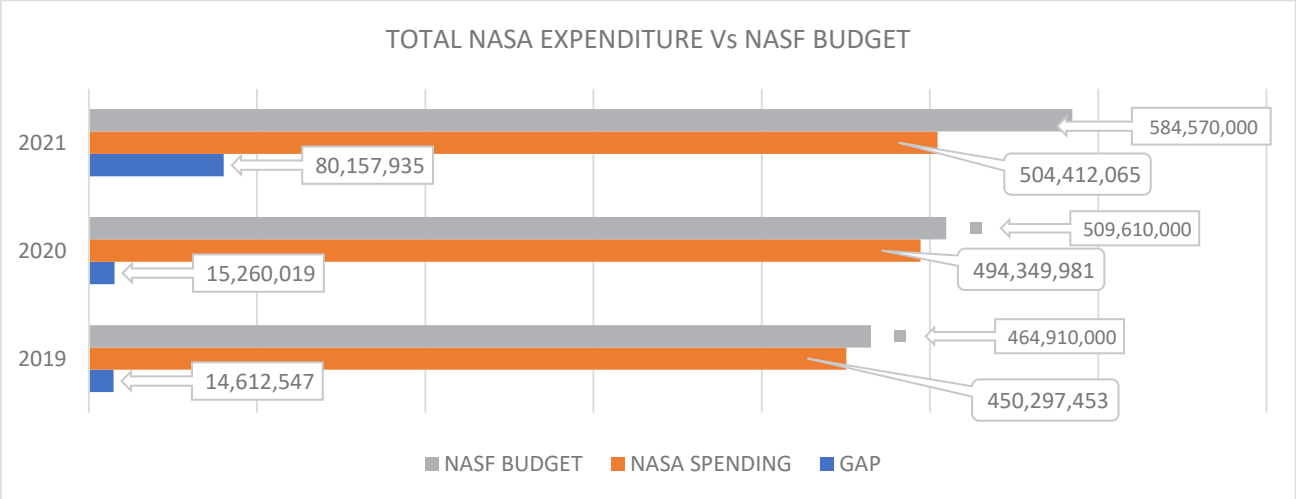


During the period of this NASA study (2019 to 2021), the total expenditure for the response to HIV and AIDS amounts to US$ 1, 449, 059, 499. The results show that total expenditure on HIV and AIDS interventions in Zambia increased moderately from US$450, 297, 453 in 2019; US$ 494, 349, 981 in 2020; and US$ 504, 412, 065 in 2021, representing an increase of 10 per cent between 2019 and 2020 and only two per cent between 2020 and 2021. The increase rate between 2019 and 2021 was 12 per cent.

3.2.2 Total HIV and AIDS spending in Zambia compared to NASF budget, 2019 – 2021

AIDS spending was estimated at US$450, 297, 453 in 2019; US$494, 349, 981 in 2020; and US$ 504, 412, 065 in 2021 while during the same period the NASF budget was US$ 464, 910, 000; US$ 509, 610, 000; and US$ 584, 570, 000, respectively as illustrated in the figure below:

Figure 18: Total NASA expenditure compared to NASF budget



The NASA expenditure for the three years compared to NASF budget shows that the financing gap was moderate in 2019 and 2020 but was substantial in 2021. In 2019 and 2020, the gap was **three per cent** of NASF budget whereas in 2021 the gap rose to **14 per cent** of NASF budget. With these figures, if the NASF budget is well estimated, we can safely say that the mobilisation of financing in Zambia was at a good level in 2019 and 2020 and that in 2021 more effort needed to have been made, in the mobilisation of financing, because the gap became quite significant.

3.2.3 HIV and AIDS Financing

3.2.3.1 *Financing entities (FE) spending*

Analysis of total funding

The following table shows that funding for the response to HIV and AIDS was mainly provided by the US Government **(74%)** followed by the Global Fund **(17%),** the Government of the Republic of Zambia **(8%)**, United Nations Population Fund (**1 %)** and other international and national donors **(1%).**

Table 4: HIV and AIDS Financing Entities (FE) spending breakdown (2019-2021)

FINANCING ENTITIES (FE)	2019	%	2020	%	2021	%	TOTAL	%
FE010101 Central government	32, 318, 779	7.18%	33, 531, 146	6.78%	46, 772, 515	9.27%	112, 622, 440	7.77%
FE0201 Domestic corporations	81, 725	0.02%	77, 453	0.02%	185, 059	0.04%	344, 237	0.02%
FE030105 Government of Canada	-	0.00%	23, 005	0.00%	-	0.00%	23, 005	0.00%
FE030109 Government of Germany	281, 007	0.06%	620, 605	0.13%	1, 369, 685	0.27%	2, 271, 297	0.16%
FE030124 Government of South Africa	1, 870	0.00%	1, 314	0.00%	-	0.00%	3, 184	0.00%
FE030130 Government of United States	350, 517, 798	77.84%	347, 912, 094	70.38%	368, 393, 826	73.03%	1, 066, 823, 718	73.62%
FE030207 The Global Fund to Fight AIDS. Tuberculosis and Malaria	62, 645, 408	13.91%	103, 770, 380	20.99%	83, 830, 885	16.62%	250, 246, 673	17.27%
FE030208 UNAIDS Secretariat	526, 013	0.12%	232,558	0.05%	514, 387	0.10%	1, 272, 958	0.09%
FE030209 United Nations Children's Fund (UNICEF)	1, 296, 143	0.29%	1, 302, 245	0.26%	1, 428, 910	0.28%	4, 027 ,298	0.28%
FE030212 United Nations Educational, Scientific and Cultural Organization (UNESCO)	-	0.00%	-	0.00%	51, 601	0.01%	51, 601	0.00%
FE030213 United Nations High Commissioner for Refugees (UNHCR)	-	0.00%	-	0.00%	50, 000	0.01%	50, 000	0.00%
FE030217 United Nations Population Fund (UNFPA)	2, 624, 986	0.58%	6, 690, 733	1.35%	1, 453, 448	0.29%	10, 769, 167	0.74%
FE030301 International HIV/AIDS Alliance	3, 724	0.00%	-	0.00%	-	0.00%	3, 724	0.00%
FE030302 ActionAid	-	0.00%	4, 634	0.00%	-	0.00%	4, 634	0.00%
FE030309 Caritas International/Catholic Relief Services	-	0.00%	172, 554	0.03%	361, 749	0.07%	534, 303	0.04%
FE030399 Other International not-for-profit organizations and foundations nec	-	0.00%	11, 260	0.00%	-	0.00%	11, 260	0.00%
TOTAL	450, 297, 453	100.00%	494, 349, 981	100.00%	504, 412, 065	100.00%	1, 449, 059, 499	100.00%

3.2.3.1.1 Financing entities (FE) spending: International Vs local Entities (2019-2021)

Table 5: Breakdown of financing entities (FE) spending: International Vs domestic Entities (2019-2021)

FINANCING ENTITIES	2019	%	2020	%	2021	%	TOTAL	%
International Sources	417 896 949	92.80 %	460 741 382	93.20 %	457 454 491	90.69 %	1 336 092 822	92.20 %
Government	32 318 779	7.18%	33 531 146	6.78%	46 772 515	9.27%	112 622 440	7.77%
Domestic corporations	81 725	0.02%	77 453	0.02%	185 059	0.04%	344 237	0.02%
TOTAL	450 297 453	100.0 0%	494 349 981	100.0 0%	504 412 065	100.0 0%	1 449 059 499	100.0 0%

Analysis of total funding (2019-2021)

Analysis of the data in the above table clearly shows that the response to HIV and AIDS during the period from 2019 to 2021 was mainly funded by international entities at **92 per cent**. The national contribution was **eight per cent** including Government financing at **7.77 per cent** and the private sector at **0.02 per cent.**

Analysis of trends by financing source

In 2020, spending on international financing increased by **10 per cent** and domestic funding increased by **four per cent.** In 2021, expenses of international financing decreased by **one per cent** and domestic funding increased by **40 per cent**. Between 2019 and 2021, spending on international funding increased by **9 per cent** as spending on domestic funding increased by **45 per cent**.

Analysis of shares in annual spending

In 2019, the shares in total expenditure show that international funding represented 93 per cent and local funding represented seven per cent.

In 2020, the shares in total expenditure show that international funding represented 93 per cent and local funding represented seven per cent.

In 2021, the shares in total expenditure show that international funding represented 91 per cent and local funding represented nine per cent.

The figure below illustrates this analysis:

Figure 19: Breakdown of funding (international/national)

Figure 19.a: Total spending (2019-2021)

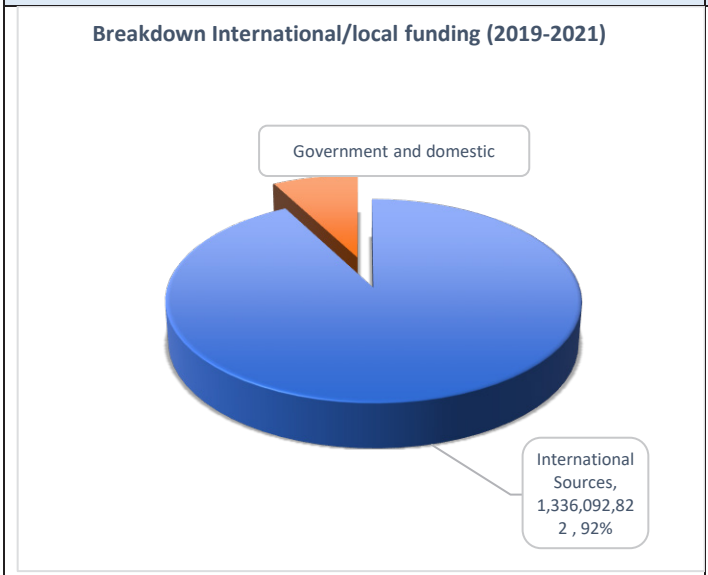


Figure 19.b: Year 2019

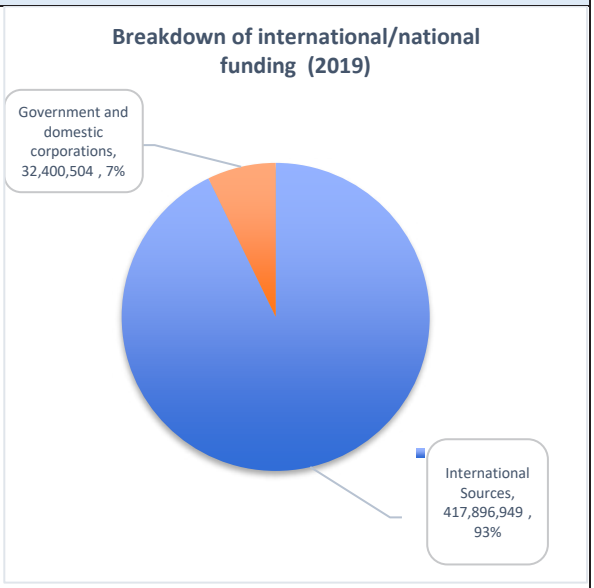


Figure 19.c: Year 2020

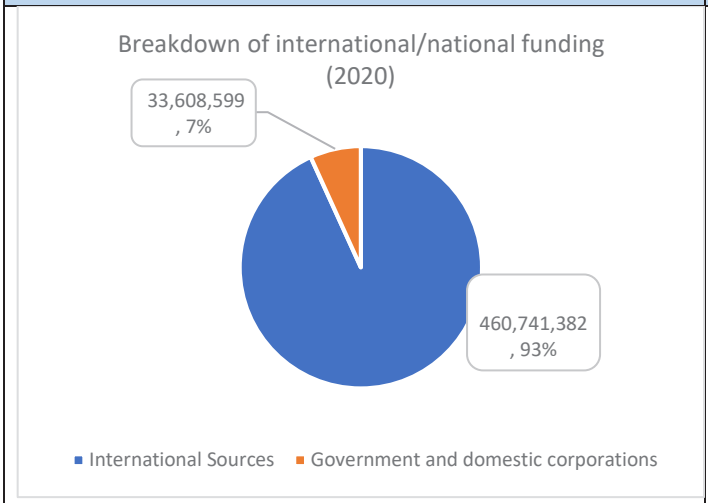
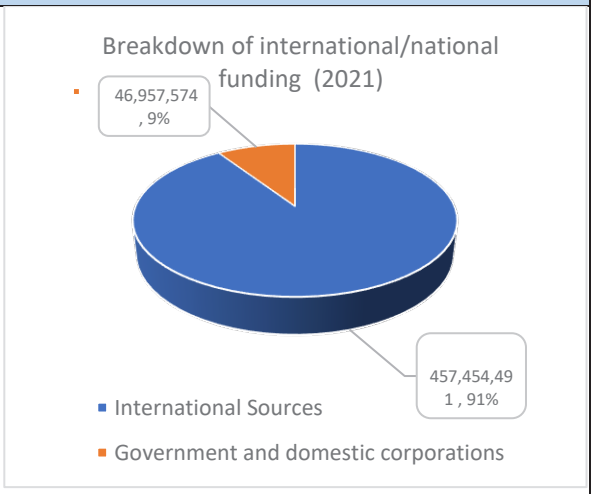


Figure 19.d: Year 2021



3.2.3.1.2 Breakdown of external financing

Table 6: Breakdown of external financing entities spending (2019-2021)

INTERNATIONAL FINANCING	2019	%	2020	%	2021	%	TOTAL	%
Government of United States	350, 517, 798	83.88%	347, 912, 094	75.51%	368, 393, 826	80.53%	1, 066, 823, 718	79.85%
The Global Fund to Fight AIDS. Tuberculosis and Malaria	62, 645, 408	14.99%	103, 770, 380	22.52%	83, 830, 885	18.33%	250, 246, 673	18.73%
United Nations Population Fund (UNFPA)	2, 624, 986	0.63%	6, 690, 733	1.45%	1, 453, 448	0.32%	10, 769, 167	0.81%
Other external partners	2, 108, 757	0.50%	2, 363, 541	0.51%	3, 776, 332	0.83%	8, 248, 630	0.62%
TOTAL	417, 896, 949	100%	460, 736, 748	100%	457, 454, 491	100%	1, 336, 088, 188	100.00%

Analysis of total spending (2019-2021)

External funding for the response includes funds from bilateral, the Global Fund, the United Nations and other international organisations. During the period 2019 to 2021, the main external donor was the United States Government (**80%** of external funding) followed by the Global Fund to Fight AIDS, Malaria and Tuberculosis (**19%** of external funding). UNFPA and other external partners accounted for **one per cent** of shares (comprising **0.81%** for UNFPA and **0.62%** for other external partners)**.**

Analysis of trends by type of external financing

Between 2019 and 2020, spending on total external financing increased by **10 per cent**. Between 2020 and2021, expenses decreased by **1%**. Between 2019 and 2021, spending increased by **nine per cent**.

Between 2019 and 2020, expenditure from the Government of the United States of America funding decreased by **one per cent**. Between 2020 and 2021, expenses increased by **six per cent**. Between 2019 and 2021, the increase in spending on American funding increased by **five per cent**.

Between 2019 and 2020, spending on Global Fund financing increased by **66 per cent**. Between 2020 and 2021, there was a **19 per cent** decrease and between 2019 and 2021, the increase in spending on GF funding was **34 per cent**.

Between 2019 and 2020, spending on UNFPA financing increased by **155 per cent**. Between 2020 and 2021, there was a **78 per cent** decrease and between 2019 and 2021, a decrease in spending on UNFPA funding was **45 per cent**.

Between 2019 and 2020, spending on other external partners financing increased by **12 per cent**. Between 2020 and 2021, there was a **60 per cent** increase and between 2019 and 2021, an increase in spending on Other external partners funding was **79 per cent**.

Analysis of shares in annual spending

In 2019, the shares in external financing show that the US Government represents **84 per cent** of the shares, the GF represents **15 per cent** of the shares, UNFPA and other external partners accounted for **one per cent** of shares (including **0.63 per cent** for UNFPA and **0.50 per cent** for other external partners)**.**

In 2020, the shares in external financing show that the US Government represents **75 per cent** of the shares, the GF represents **23 per cent** of the shares, UNFPA and other external partners accounted for **two per cent** of shares (including **1.45 per cent** for UNFPA and **0.51 per cent** for other external partners)**.**

In 2021, the shares in external financing show that the US Government represents **81 per cent** of the shares, the GF represents **18 per cent** of the shares, and the other partners represent **one per cent** of the shares (including **0.32 per cent** for UNFPA and **0.83 per cent** for other external partners)**.**

The figure below illustrates this analysis:

Figure 20: Breakdown of funding by types of international partners (2019, 2020 and 2021)

Figure 20.a: Total spending (2019-2021)

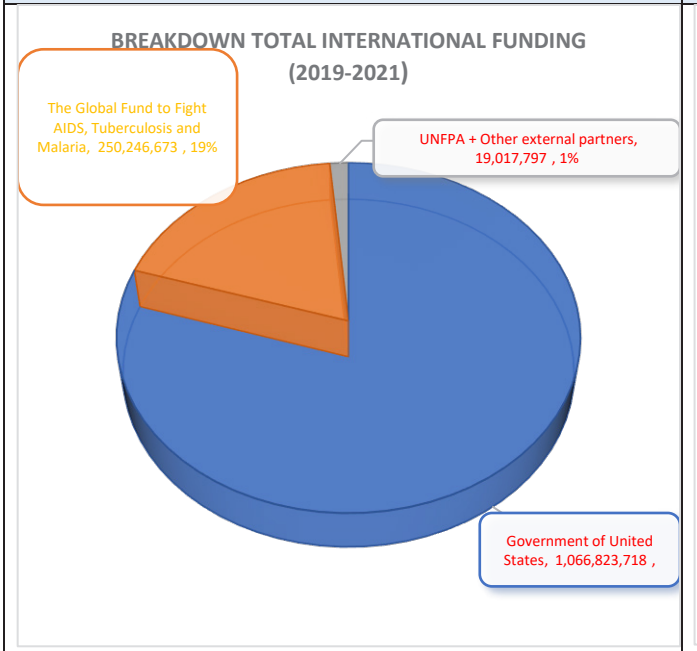


Figure 20.b: Year 2019 spending

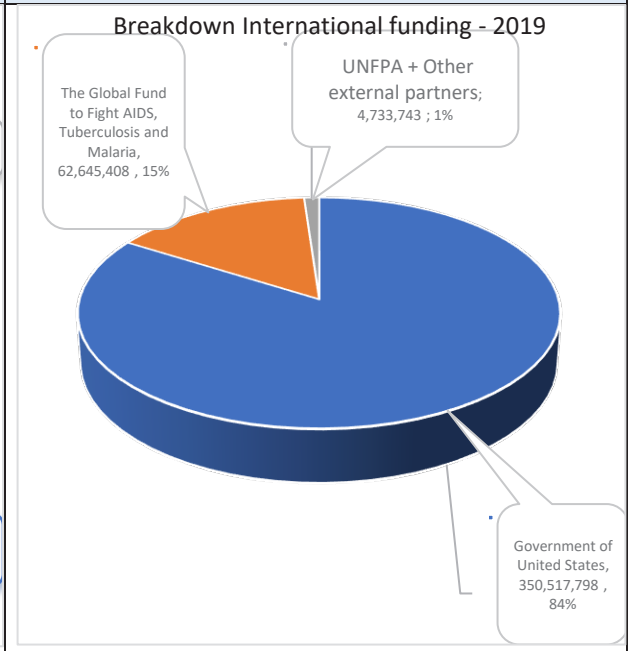


Figure 20.c: Year 2020 spending

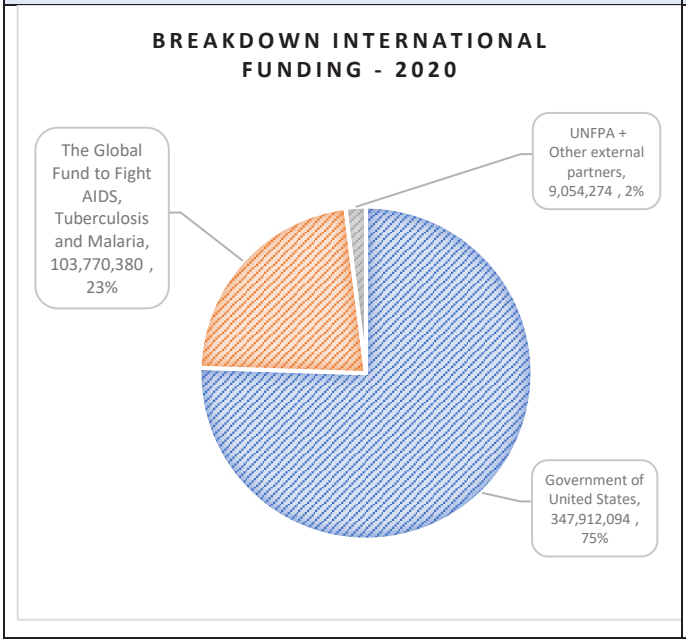
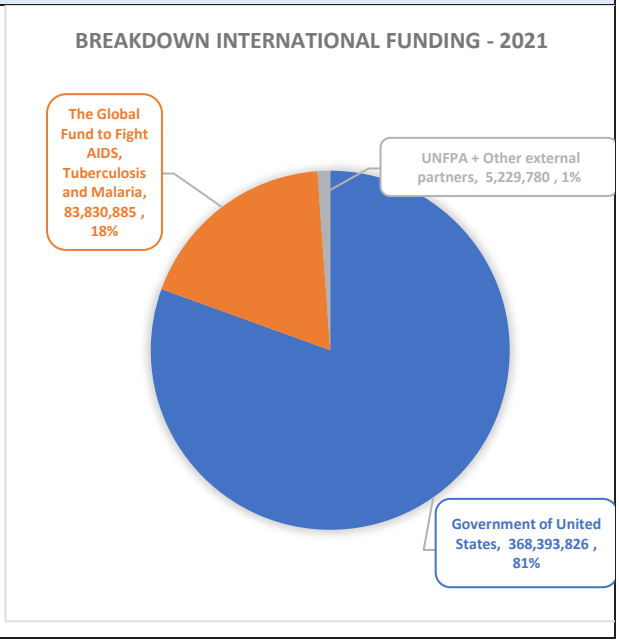


Figure 20.d: Year 2021 spending



3.2.3.3 HIV & AIDS revenues spending

NASA provides classifications on how the funds are pooled from the financing entities or sources. Although the financial flow is between the economic agents (FE, FAP and PS), resource tracking allows to identify what type of pools or resources are transferred and how the financing mechanism is organised, for guaranteeing access in accordance with the legal

provisions in force in the country. Examples of such pools or resources include: transfers from government domestic revenue, including reimbursable loans allocated to HIV purposes (REV.01); transfers distributed by government from foreign origin (REV.02); social insurance contributions (REV.03); direct foreign transfers (REV.07) etc. (see Table 1.b, Annex 1 for REV classifications).

Table 7: Breakdown of revenue spending (2019-2020)

REVENUES (REV)	2019	%	2020	%	2021	%	TOTAL	%
REV.01.01 Internal transfers and grants	32, 318 ,779	7.18%	33, 531, 146	6.78%	46, 772, 515	9.27%	112, 622, 440	7.77%
REV.06.02 Other revenues from corporations n.e.c.	81, 725	0.02%	77, 453	0.02%	185, 059	0.04%	344, 237	0.02%
REV.07.01.01 Direct bilateral financial transfers	350, 800, 675	77.90%	348, 557, 018	70.51%	369, 763, 511	73.31%	1, 069, 121, 204	73.78%
REV.07.01.02 Direct multilateral financial transfers	67, 092, 550	14.90%	112, 184, 364	22.69%	87, 690, 980	17.38%	266, 967, 894	18.42%
REV.07.99 Other direct foreign transfers n.e.c.	3, 724	0.00%	0	0.00%	0	0.00%	3, 724	0.00%
TOTAL	450, 297, 453	100.00%	494, 349, 981	100.00%	504, 412, 065	100.00%	1, 449, 059, 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, direct bilateral financial transfers entities accounted for the highest proportion of HIV and AIDS financing (74%), followed by direct multilateral financial transfers (18%) and internal transfers and grants (8%). Other classifications represent 0.02 per cent of shares.

Analysis of trends by type of revenue

In 2020, direct bilateral financial transfers decreased by **one per cent**. In 2021, expenses increased by **six per cent** and between 2019 and 2021, the increase in spending for direct financial transfers was **five per cent**.

In 2020, spending on direct multilateral financial transfers increased by **67 per cent**. In 2021, there was a **22 per cent** decrease and between 2019 and 2021, the increase in spending on direct multilateral financial transfers was **31 per cent**.

In 2020, spending on Internal transfers and grants increased by **four per cent**. In 2021, there was a **39 per cent** increase and between 2019 and 2021, the increase in spending on Internal transfers and grants was **45 per cent**.

Analysis of shares in annual spending

In 2019, the shares in revenues financing showed that direct bilateral financial transfers represented **78 per cent** of shares followed by direct multilateral financial transfers with **15 per cent** of shares and Internal transfers and grants with **seven per cent** of shares. Other classifications represented **0.02 per cent** of shares.

In 2020, the shares in revenues financing showed that direct bilateral financial transfers represent **70 per cent** of the shares followed by direct multilateral financial transfers with **23 per cent** of shares and internal transfers and grants with **seven per cent** of shares. Other classifications represented **0.02 per cent** of shares.

In 2021, the shares in revenues financing showed that direct bilateral financial transfers represented **73 per cent** of the shares followed by direct multilateral financial transfers with **17 per cent** of shares and internal transfers and grants with **nine per cent** of shares. Other classifications represented **0.04 per cent** of shares.

The figure below illustrates this analysis:

Figure 21: Breakdown of revenue spending

Figure 21.a: Total spending (2019-2021)

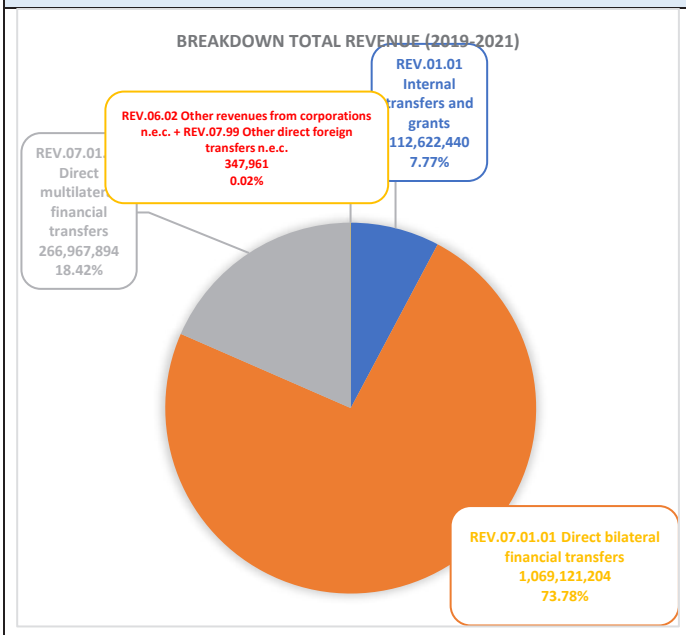


Figure 21.b: Year 2019

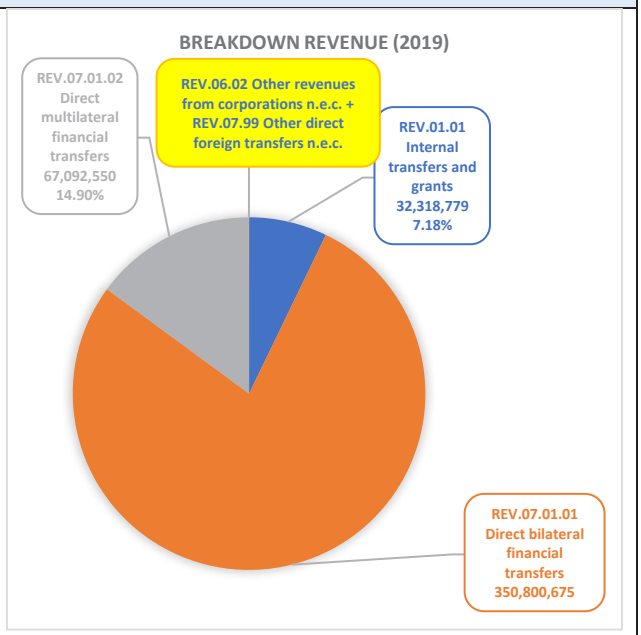


Figure 21.c: Year 2020

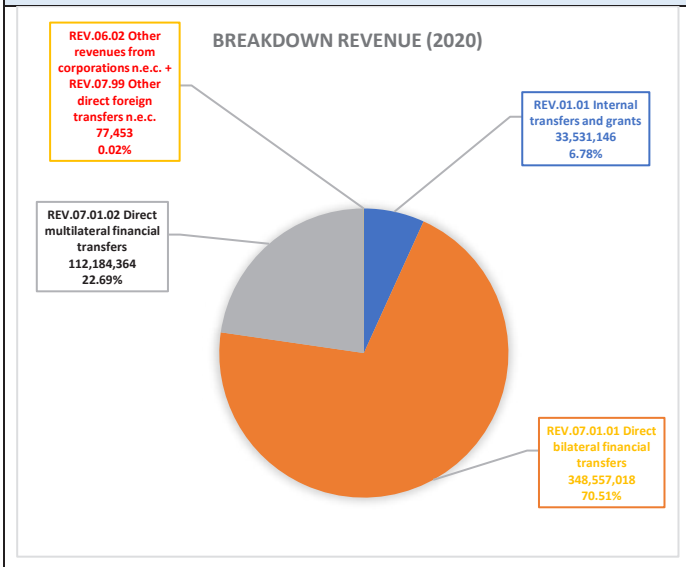
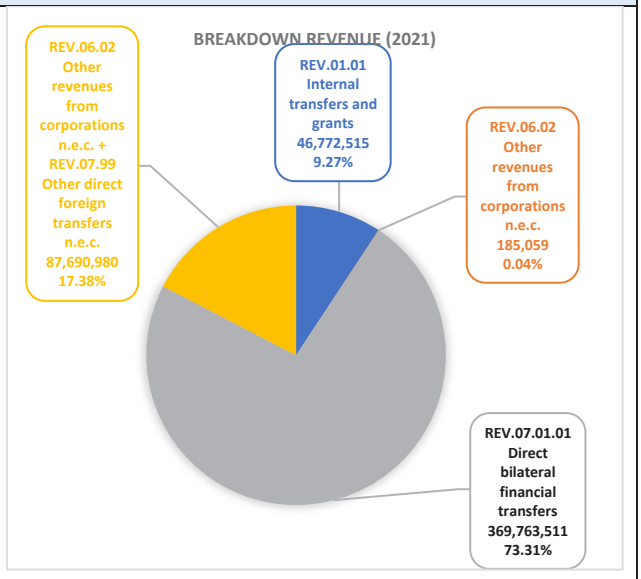


Figure 21.d: Year 2021



3.2.3.4 HIV and AIDS financing schemes spending

NASA classifies the schemes from which HIV and AIDS expenditures come from. Financing Schemes (SCH) are financing modalities through which the population has access to HIV and AIDS goods and services. SCHs mobilise and allocate resources within the system to

satisfy the needs of individuals and collective populations, both current and future. They are a set of rules or laws that regulate the modality of participation, the right to access health services and how to obtain and pool resources. Financing schemes are classified according to the following criteria: mode of participation, benefit entitlement, basic method for fund-raising and pooling. SCHs include direct payments by households for services and goods and third-party financing arrangements. An example of the third-party scheme is where the services are provided for free at the health facility but certain organisations have paid for the services e.g. the government or an international organisation.

Table 8: Breakdown of schemes spending (2019-2021)

SCHEMES	2019	%	2020	%	2021	%	TOTAL	%
SCH.01.01.01 Central government schemes	388, 981, 000	86.38%	426, 894, 935	86.35%	429, 826, 298	85.21%	1, 245, 702, 233	85.97%
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.02.02.02)	21, 509, 192	4.78%	21, 429, 550	4.33%	21, 251, 131	4.21%	64, 189, 873	4.43%
SCH.02.02.02 Resident foreign agencies schemes	39, 725, 536	8.82%	45, 948, 043	9.29%	53, 149, 577	10.54%	138, 823, 156	9.58%
SCH.02.03.99 For-profit enterprises not elsewhere classified (n.e.c.)	81, 725	0.02%	77 453	0.02%	185, 059	0.04%	344, 237	0.02%
TOTAL	450, 297, 453	100.00%	494, 349, 981	100.00%	504, 412, 065	100.00%	1, 449, 059, 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, central Government schemes were the most used **(86%),** followed by resident foreign agencies schemes **(10%)**. The third largest scheme used was not-for-profit organisation **(4%).** For-profit enterprises not elsewhere classified accounted for **0.02 per cent** of shares (see figure 22.a).

Analysis of trends by type of scheme

In 2020, spending on central Government schemes increased by **10 per cent.** In 2021, expenses increased by **one per cent** and between 2019 and 2021, the increase in spending for resident and central Government schemes was **11 per cent**.

In 2020, spending on resident foreign agencies schemes increased by **16 per cent**. In 2021, there was a **16 per cent** increase and between 2019 and 2021, the increase in spending on resident foreign agencies schemes was **34 per cent**.

In 2020, spending on not-for-profit organisation schemes did not increase. In 2021, expenses decreased by **one per cent** and between 2019 and 2021, the decrease in spending for not-for-profit organisation schemes was **one per cent.**

In 2020, spending on for-profit enterprises schemes, not elsewhere classified, decreased by **five per cent**. In 2021, there was a **139 per cent** increase and between 2019 and 2021, the increase in spending on for-profit enterprises schemes, not elsewhere classified schemes, was **126 per cent**.

Analysis of shares in annual spending

In 2019, the shares in financing schemes showed that central Government schemes represent **86 per cent** of the shares, followed by resident foreign agencies schemes with **nine per cent**. The third largest scheme was not-for-profit organisation scheme with **five per**

cent of shares and for-profit enterprises scheme, not elsewhere classified, which accounted for **0.02 per cent** (see figure 22.b).

In 2020, the shares in financing schemes showed that central Government schemes represented **86 per cent** of the shares, followed by resident foreign agencies schemes with **nine per cent**. The third largest scheme was not-for-profit organisation scheme with **five per cent** of shares and for-profit enterprises schemes, not elsewhere classified, which accounted for **0.02 per cent** (see figure 22.c).

In 2021, the shares in financing schemes showed that central Government schemes represented **85 per cent** of the shares, followed by resident foreign agencies schemes with **11 per cent**. The third largest scheme was not-for-profit organisation with **four per cent** of shares and for-profit enterprises schemes, not elsewhere classified, which accounted for **0.04 per cent** (see figure 22.d). The figure below illustrates this analysis:

Figure 22: Breakdown of schemes spending

Figure 22.a: Total spending (2019-2021)

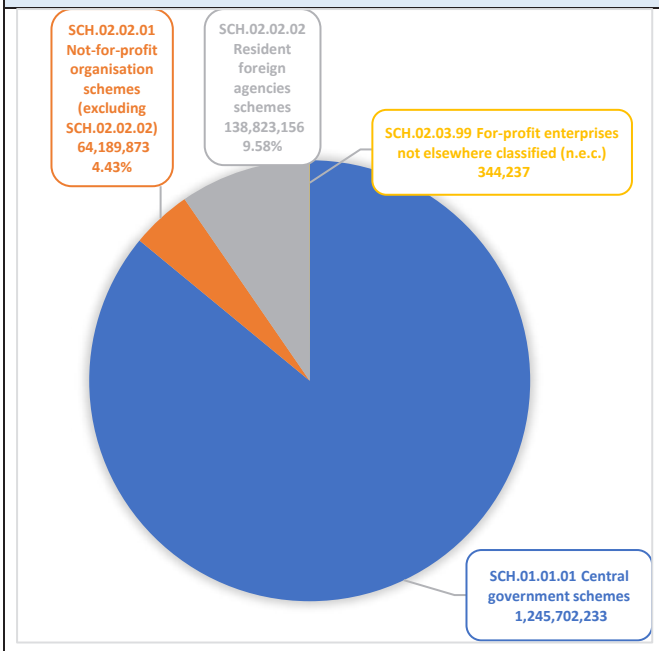


Figure 22.b: Year 2019

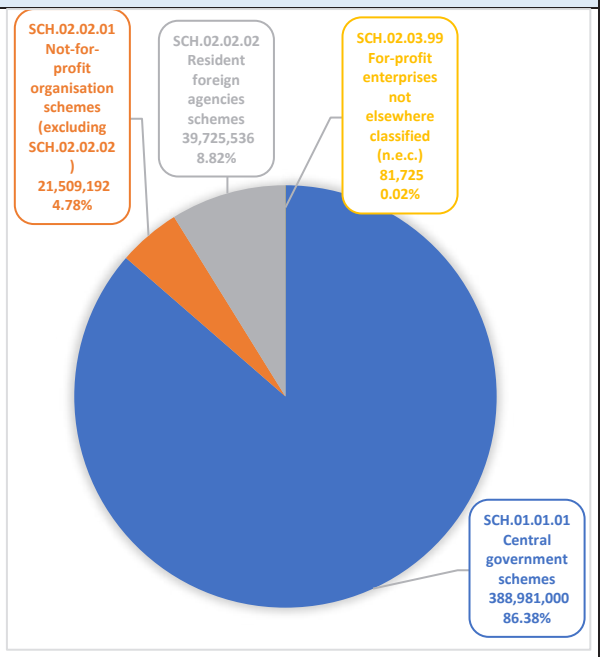


Figure 6.c: Year 2020

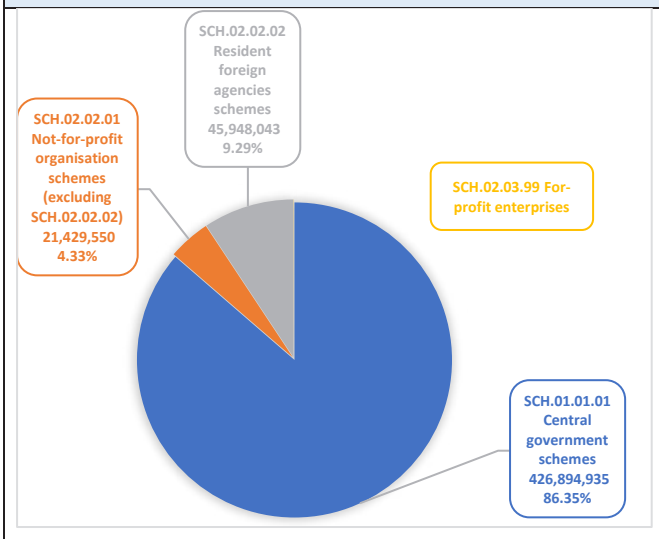
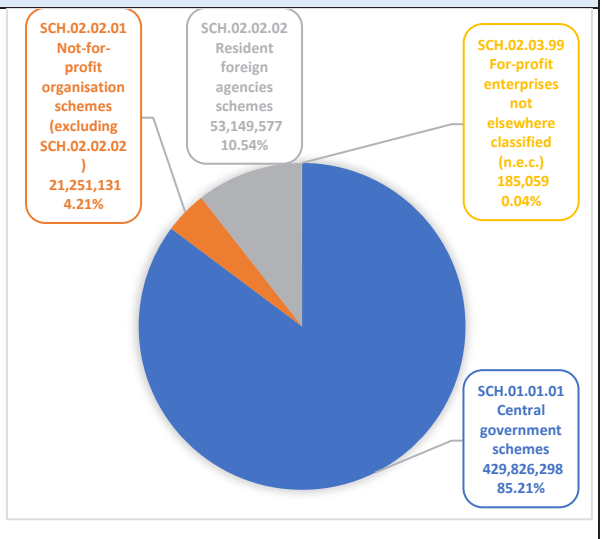


Figure 6.d: Year 2021



3.2.3.5 *HIV and AIDS financing agents – purchasers spending*

A health-care financing agent or purchaser is an institutional unit that mobilises and pools funds and makes decisions to allocate and make payments to providers for the services rendered. Financing agents are mainly involved in the management of one or more financing schemes.

Table 9: Financing agent-purchaser spending breakdown (2019-2021)

Financing Agent Purchaser	2019	%	2020	%	2021	%	TOTAL	%
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	388, 898, 469	86.36%	426, 893, 627	86.35%	429, 823, 201	85.21%	1, 245, 615, 297	85.96%
FAP.01.01.01.02 Ministry of Education (or equivalent sector entity)	-	0.00%		0.00%	2, 098	0.00%	2, 098	0.00%
FAP.01.01.01.04 Ministry of Defence (or equivalent sector entity)	4, 810	0.00%		0.00%		0.00%	4, 810	0.00%
FAP.01.01.01.05 Ministry of Finance (or equivalent sector entity)	3, 010	0.00%		0.00%		0.00%	3, 010	0.00%
FAP.01.01.01.06 Ministry of Labour (or equivalent sector entity)	3, 879	0.00%	1, 308	0.00%	999	0.00%	6, 186	0.00%
FAP.01.01.01.08 Other ministries (or equivalent sector entities)	69, 552	0.02%		0.00%		0.00%	69, 552	0.00%
FAP.01.01.01.10 National AIDS Commission	1, 280	0.00%		0.00%		0.00%	1, 280	0.00%
FAP.02.05 Not-for-profit institutions (other than social insurance)	21, 505, 468	4.78%	21, 391, 911	4.33%	20, 729, 021	4.11%	63, 626, 400	4.39%
FAP.02.06 Corporations other than providers of health services (nonparastatal)	81, 725	0.02%	77, 453	0.02%	185, 059	0.04%	344, 237	0.02%
FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles	35, 276, 524	7.83%	37, 547, 379	7.60%	49, 652, 832	9.84%	122, 476, 735	8.45%
FAP.03.02.07 UNAIDS Secretariat	526, 013	0.12%	232, 558	0.05%	514, 387	0.10%	1, 272, 958	0.09%
FAP.03.02.08 United Nations Children's Fund (UNICEF)	1, 296, 143	0.29%	1, 302, 245	0.26%	1, 428, 910	0.28%	4, 027, 298	0.28%
FAP.03.02.11 United Nations Educational, Scientific and Cultural Organization (UNESCO)	-	0.00%		0.00%	51, 601	0.01%	51, 601	0.00%
FAP.03.02.12 United Nations High Commissioner for Refugees (UNHCR)	-	0.00%		0.00%	100, 000	0.02%	100, 000	0.01%
FAP.03.02.16 United Nations Population Fund (UNFPA)	2, 624, 986	0.58%	6, 690, 733	1.35%	1, 453, 448	0.29%	10, 769, 167	0.74%
FAP.03.02.99 Other Multilateral entities n.e.c.	-	0.00%		0.00%	108, 760	0.02%	108, 760	0.01%
FAP.03.03.01 International HIV/AIDS Alliance	5, 594	0.00%	1, 314	0.00%		0.00%	6, 908	0.00%
FAP.03.03.02 ActionAID	-	0.00%	4, 634	0.00%		0.00%	4, 634	0.00%
FAP.03.03.09 Caritas Internationalis/Catholic Relief Services	-	0.00%	172, 554	0.03%		0.00%	172, 554	0.01%
FAP.03.03.99 Other International not-for-profit organizations n.e.c.	-	0.00%	34, 265	0.01%	361, 749	0.07%	396, 014	0.03%
TOTAL	450, 297, 453	100.00%	494, 349, 981	100.00%	504, 412, 065	100.00%	1, 449, 059, 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, the analysis of expenditure by financing agent-purchaser type showed that the resources for funding the response to HIV and AIDS had mainly been managed by the public sector **(86%),** followed by international purchasing organisations **(10%)** and the private sector **(4%)** (see figure 23.a).

Analysis of trends by type of financing agent-purchaser

In 2020, the funds managed by public sector increased by **9 per cent.** In 2021, expenses increased by **one per cent** and between 2019 and 2021, spending increased by **11 per cent**.

In 2020, the funds managed by international purchasing organisations increased by **16 per cent**. In 2021, funds managed by this sector increased by **17 per cent** and between 2019 and 2021, the funds managed by this sector increased by **35 per cent**.

In 2020, the funds managed by private sector decreased by **one per cent**. In 2021, funds managed by this sector decreased by **3%** and between 2019 and 2021, the funds managed by this sector decreased by **three per cent**.

Analysis of shares in annual spending

In 2019, the shares showed that funds managed by public sector represented **86 per cent** of the shares followed by international purchasing organizations with **nine per cent** of shares and Private sector with **five per cent** of shares (see figure 23.b).

In 2020, the shares showed that funds managed by public sector represent **87 per cent** of the shares followed by international purchasing organizations with **nine per cent** of shares and Private sector with **four per cent** of shares (see figure 23.c).

In 2021, the shares show that funds managed by public sector represent **85 per cent** of the shares followed by international purchasing organizations with **one per cent** of shares and Private sector with **four per cent** of shares (see figure 23.d).

The figure below illustrates this analysis:

Figure 23: Breakdown of spending by type of FAP

Figure 23.a: Total spending (2019-2021)

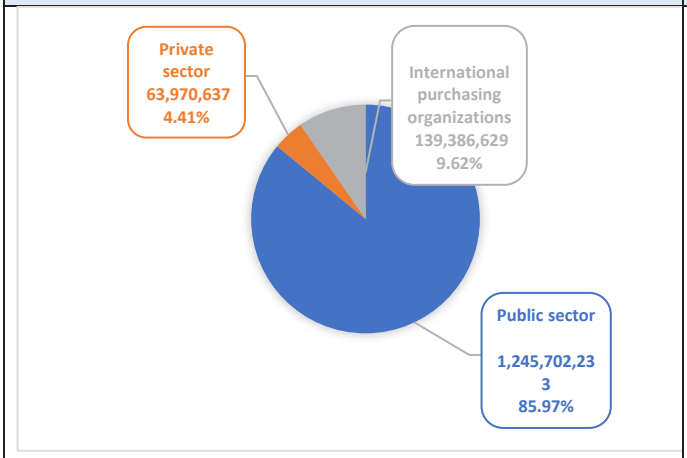


Figure 23.b: Year 2019

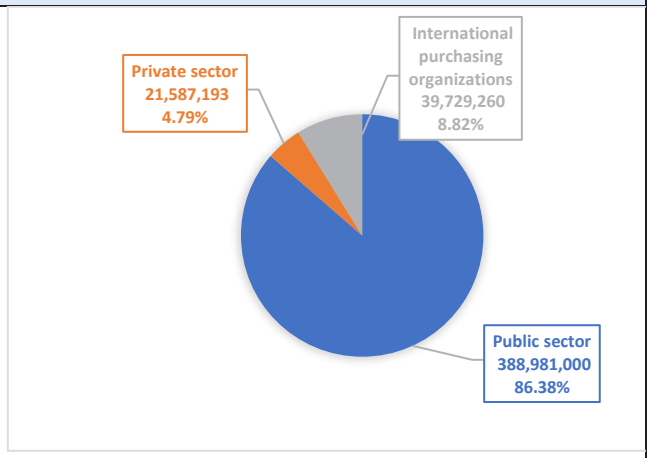


Figure 23.C: Year 2020

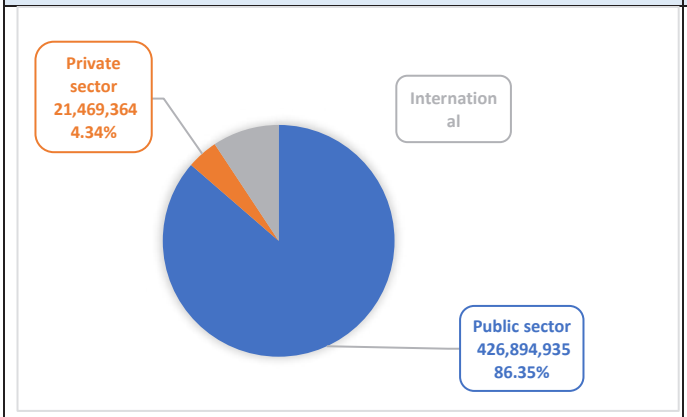
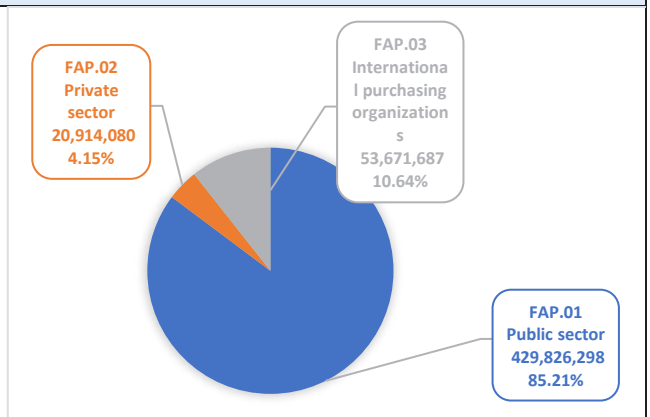


Figure 23.d: Year 2021



3.2.4 Provision of HIV and AIDS services

3.2.4.1 Providers of services spending

Table 10: Distribution of expenditure by type of service provider (2019-2021)

PROVIDERS OF SERVICES	2019	%	2020	%	2021	%	TOTAL	%
PS.01 Public sector providers	303 498 502	67.40%	334 003 083	67.56%	367 185 698	72.79%	1 004 687 283	69.33%
PS.01.01 Governmental organisations	303 460 617	67.39%	334 003 083	67.56%	367 088 523	72.78%	1 004 552 223	69.32%
PS.01.98 Public sector providers not disaggregated	37 885	0.01%		0.00%		0.00%	37 885	0.00%
PS.01.02 Parastatal organizations		0.00%		0.00%	97 175	0.02%	97 175	0.01%
PS.02 Private sector providers	69 277 211	15.38%	76 097 603	15.39%	65 618 753	13.01%	210 993 567	14.56%
PS.02.01 Non-profit providers	69 270 211	15.38%	76 090 603	15.39%	65 607 204	13.01%	210 968 018	14.56%

PS.02.02 Profit-making private sector providers	7 000	0.00%	7 000	0.00%	11 549	0.00%	25 549	0.00%
PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices	77 521 740	17.22%	84 249 295	17.04%	71 607 614	14.20%	233 378 649	16.11%
PS.03.01 Bilateral agencies		0.00%		0.00%	176 954	0.04%	176 954	0.01%
PS.03.02 Multilateral agencies		0.00%	6 690 733	1.35%		0.00%	6 690 733	0.46%
PS.03.99 Bilateral, multilateral entities, international NGOs and foundations – in country offices n.e.c.	77 521 740	17.22%	77 558 562	15.69%	71 430 660	14.16%	226 510 962	15.63%
TOTAL	450 297 453	100.00%	494 349 981	100.00%	504 412 065	100.00%	1 449 059 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, the analysis of expenditure by type of entities who provided the goods and services showed that the public sector provided **69 per cent** of shares, followed by bilateral, multilateral entities, international NGOs and foundations with **16 per cent** of shares and private sector providers (non-profit providers and profit-making private sector providers) with **15** per cent of shares. (see figure 24.a)

As observed, very few resources were executed by civil society organisations compared to other actors. It is important to strengthen these organisations for a better contribution to the national HIV and AIDS response.

Analysis of trends by type of service provider

In 2020, the services provided by the public sector increased by **10 per cent**. In 2021, spending on this type of providers increased by **10** per cent and between 2019 and 2021, expenditure increased by **21 per cent**.

In 2020, the services provided by bilateral, multilateral entities, international NGOs and foundations increased by **nine per cent.** In 2021, spending on this type of providers decreased by **15 per cent** and between 2019 and 2021, expenditure decreased by **eight per cent**.

In 2020, the services provided by private sector providers (non-profit providers and profit-making private sector providers) increased by **10 per cent**. In 2021, spending on this type of providers decreased by **14 per cent** and between 2019 and 2021, expenditure decreased by **five per cent**.

Analysis of shares in annual spending

In 2019, the shares show that services provided by public sector took the largest share, at **67 per cent** of shares followed by bilateral, multilateral entities, international NGOs and foundations with **17 per cent** of shares and private sector providers (non-profit providers and profit-making private sector providers) with 1**5 per cent** of shares. (see figure 24.b).

In 2020, the shares show that services provided by provided by Public sector took the largest share, at **68 per cent** of shares followed by bilateral, multilateral entities, international NGOs and foundations with **17 per cent** of shares, civil society organisations (private non-profit faith-based) provided **15 per cent** of shares. (see figure 24.c).

In 2021, the shares show that services provided by the public sector took the largest share, at **73 per cent** of shares, followed by bilateral, multilateral entities, international NGOs and foundations with **14 per cent** of shares. Private sector providers (non-profit providers and profit-making private sector providers) provided **13 per cent** of shares (see figure 24.d).

The figure below illustrates this analysis

Figure 24: Shares in providers of services spending

Figure 24.a: Total spending (2019-2021)

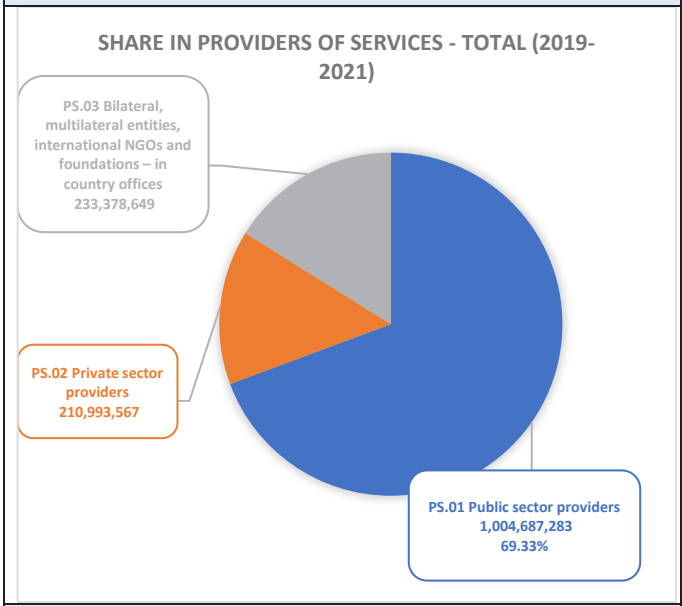


Figure 24.b: Year 2019

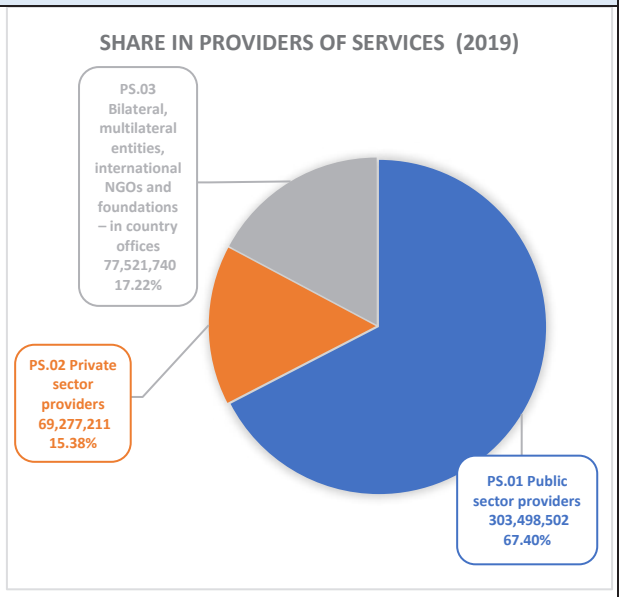


Figure 24.C: Year 2020

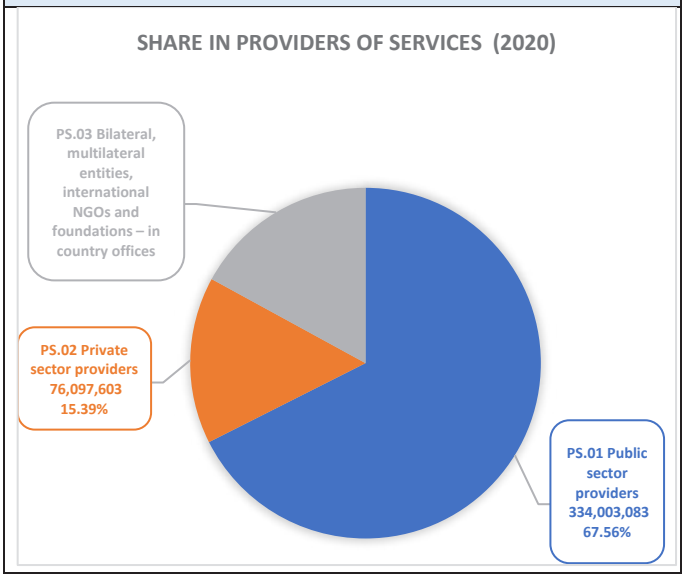
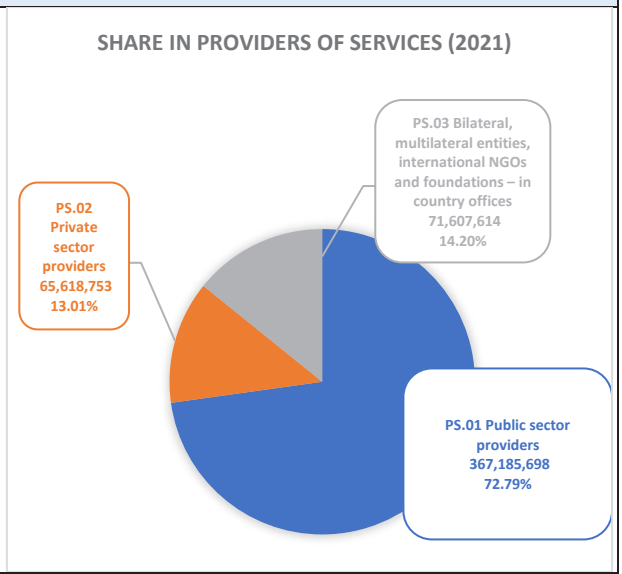


Figure 24.d: Year 2021



3.2.4.2 Service delivery modality spending

Table 11: Breakdown of SDM spending (2019-2021)

Service Delivery Modalities (SDM)	2019	%	2020	%	2021	%	TOTAL	%
SDM.01 Facility-based service modalities	273, 137, 210	60.66%	289, 049, 217	58.47%	410, 999, 692	81.48%	973, 186, 119	67.16%
SDM.02 Home and community-based service modalities	38, 450, 236	8.54%	38, 034, 172	7.69%	33, 854, 852	6.71%	110, 339, 260	7.61%
SDM.03 Non applicable (ASC which does not have a specific SDM)	113, 404, 077	25.18%	148, 585, 594	30.06%	59, 535, 260	11.80%	321, 524, 930	22.19%
SDM.98 Modalities not disaggregated	25, 303, 603	5.62%	18, 680, 998	3.78%	22, 262	0.00%	44, 006, 863	3.04%
SDM.99 Modalities n.e.c.	2, 327	0.00%		0.00%		0.00%	2, 327	0.00%
TOTAL	**450, 297, 453**	**100.00%**	**494, 349, 981**	**100.00%**	**504, 412, 065**	**100.00%**	**1, 449, 059, 499**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, of the total HIV and AIDS spending in Zambia, facility-based service modalities took the largest share, at **67 per cent** followed by non applicable (ASC which does not have a specific SDM), at **22 per cent.** The third largest expenditure was on home and community-based service modalities with **eight per cent** of share. Modalities not disaggregated took the fourth place with for **three per cent** of share**.** (see figure 25.a).

Analysis of trends by type of service modalities category

In 2020, expenditure on facility-based service modalities increased by **six per cent**. In 2021, expenditure on this category increased by **42 per cent** and between 2019 and 2021, expenditure increased by **50 per cent**.

In 2020, expenditure on Non-targeted interventions category increased by **31 per cent**. In 2021, expenditure decreased by **26 per cent** and between 2019 and 2021, expenditure decreased by **three per cent**.

In 2020, expenditure on non-applicable (ASC which does not have a specific SDM) category increased by **31 per cent**. In 2021, expenditure on this category decreased by **60 per cent** and between 2019 and 2021, expenditure decreased by **48 per cent**.

In 2020, expenditure on home and community-based service modalities decreased by **one per cent**. In 2021, expenditure decreased by **11 per cent** and between 2019 and 2021, expenditure decreased by **12 per cent**.

In 2020, expenditure modalities not disaggregated decreased by **26 per cent**. In 2021, expenditure decreased by **100 per cent** and between 2019 and 2021, expenditure decreased by **100 per cent**.

Analysis of shares in annual spending

In 2019, the shares show that facility-based service modalities took the highest share, at **61 per cent,** followed by non-applicable (ASC which does not have a specific SDM), at **25 per cent.** The third largest expenditure was on home and community-based service modalities with **nine per cent** of share. Modalities not disaggregated took the fourth place with for **six per cent** of share (see figure 25.b),

In 2020, the shares show that facility-based service modalities took the highest share, at **58 per cent**. This was followed by non-applicable (ASC which does not have a specific SDM), at **30 per cent.** The third largest expenditure was on home and community-based service

modalities with **eight per cent** of share. modalities not disaggregated took the fourth place with for **four per cent** of share (see figure 25.c)

In 2021, the shares show that facility-based service modalities took the highest share, at **81 per cent**. This was followed by non-applicable (ASC which does not have a specific SDM), at **12 per cent.** The third largest expenditure was on home and community-based service modalities with **seven per cent** of share. (see figure 25.d)

Figure 25: Share of service delivery modality spending (2019- 2021)

Figure 25.a: Total spending (2019-2021)

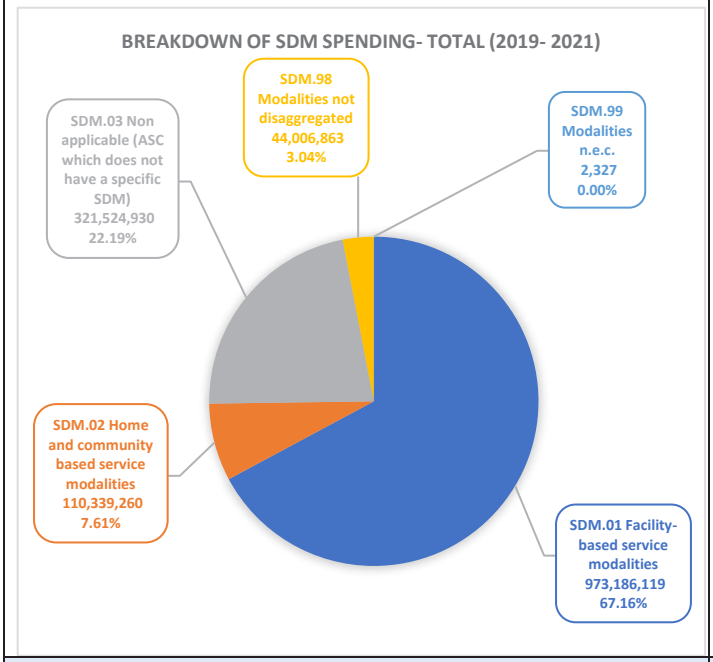


Figure 25.b: Year 2019

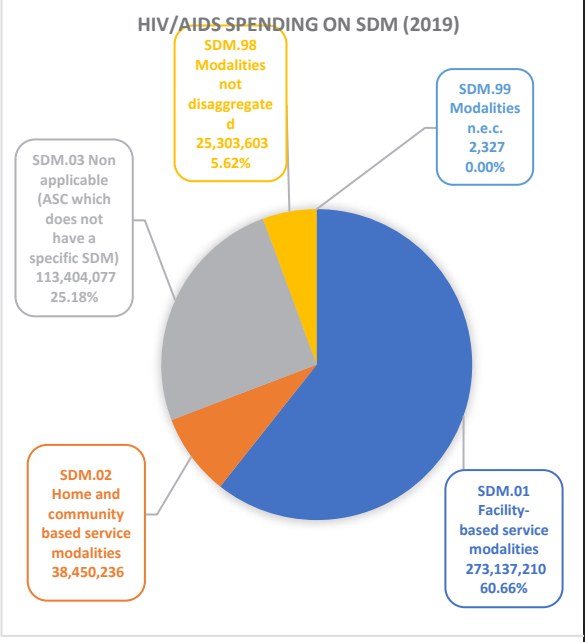


Figure 25.c: Year 2020

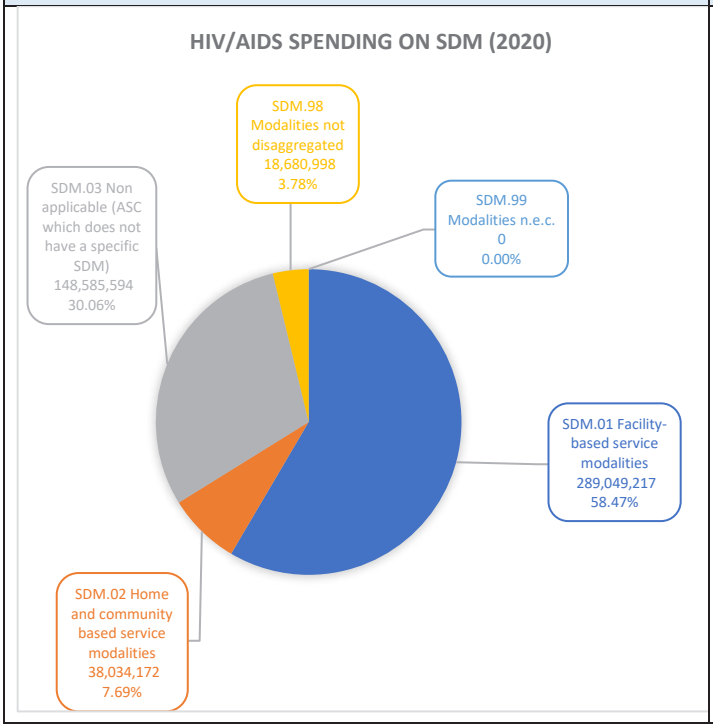
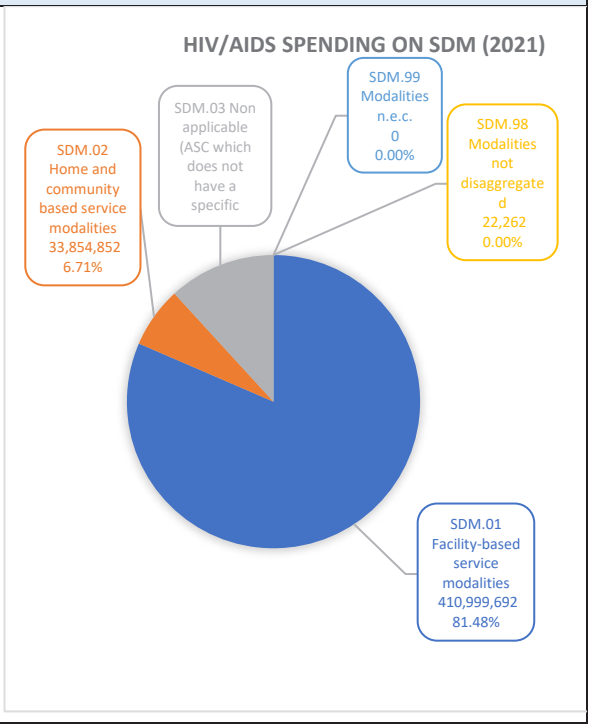


Figure 25.d: Year 2021



3.2.4.3 *Production factors of HIV and AIDS spending*

Production factors are critical inputs required to deliver planned services and goods to the beneficiaries. Production factors comprise capital and recurrent expenditure. Capital expenditure is the value of the non-financial assets acquired. Recurrent expenditure is expenditure on goods and services consumed within the current year that needs to be made recurrently to sustain the production of services.

In NASA classification, recurrent expenditure includes, among other things, salaries and wages, medicines, and administrative and consulting services. Capital expenditure includes buildings, vehicles, IT equipment, and laboratory and other medical equipment.

The table below shows the breakdown of current expenses, capital expenses and expenses on production factors not disaggregated.

Table 12: Breakdown of production factors spending (2019-2021)

PRODUCTION FACTORS - PF	2019	%	2020	%	2021	%	TOTAL	%
PF.01 Current direct and indirect expenditures	**431, 875, 506**	95.91%	**464, 379, 379**	93.94%	**466, 957, 396**	92.57%	**1, 363, 212, 280**	94.08%
PF.01.01 Personnel costs	126, 020, 643	27.99%	147, 108, 106	29.76%	135, 441,158	26.85%	408, 569, 906	28.20%
PF.01.02 Other operational and programme management current expenditures	25, 335, 888	5.63%	22, 027, 543	4.46%	23, 089, 842	4.58%	70, 453, 273	4.86%
PF.01.03 Medical products and supplies	175, 288, 244	38.93%	158, 580, 400	32.08%	196, 361, 890	38.93%	530, 230, 534	36.59%
PF.01.04 Contracted external services	30, 842, 157	6.85%	30, 857, 956	6.24%	38, 916, 965	7.72%	100, 617, 078	6.94%
PF.01.05 Transportation related to beneficiaries	502	0.00%		0.00%	879	0.00%	1 381	0.00%
PF.01.07 Financial support for beneficiaries	654, 463	0.15%	424, 151	0.09%	1, 244, 849	0.25%	2, 323, 463	0.16%
PF.01.08 Training- Training related per diems/transport/other costs	14, 973, 223	3.33%	13, 509, 189	2.73%	9, 518, 449	1.89%	38, 000, 861	2.62%
PF.01.09 Logistics of events, including catering services	17, 156, 364	3.81%	37, 079, 365	7.50%	792, 806	0.16%	55, 028, 535	3.80%
PF.01.10 Indirect costs	19, 374, 088	4.30%	19, 718, 849	3.99%	19, 205, 729	3.81%	58, 298, 666	4.02%
PF.01.98 Current direct and indirect expenditures not disaggregated	16, 480, 742	3.66%	31, 804, 915	6.43%	40, 009, 526	7.93%	88, 295, 183	6.09%
PF.01.99 Current direct and indirect expenditures n.e.c.	5, 749, 192	1.28%	3, 268, 905	0.66%	2, 375, 303	0.47%	11, 393, 400	0.79%
PF.02 Capital expenditures	**15, 573, 273**	3.46%	**13, 042, 743**	2.64%	**9, 417, 287**	1.87%	**38, 033, 303**	2.62%
PF.02.01 Building	3, 299, 279	0.73%	2, 110, 808	0.43%	179, 878	0.04%	5, 589, 965	0.39%
PF.02.02 Vehicles	817, 671	0.18%	235, 789	0.05%	341	0.00%	1, 053, 801	0.07%
PF.02.03 Other capital investment	11, 456, 323	2.54%	10, 696, 146	2.16%	9, 237, 068	1.83%	31, 389, 537	2.17%
PF.98 Production factors not disaggregated	**2, 848, 674**	0.63%	**16, 927, 859**	3.42%	**28, 037, 383**	5.56%	**47, 813, 916**	3.30%
TOTAL	450, 297, 453	100.00%	494, 349, 981	100.00%	504, 412, 065	100.00%	1, 449, 059, 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, the analysis of expenditure show that current expenditures accounted for the largest share of spending for the entire period (94%), followed by production factors not disaggregated (3.30%) and capital expenditures (2.62%).

The above table shows that 37 per cent of expenses relate to purchases of medical products and supplies. This is excellent in a context where Zambia would like to achieve viral suppression thereby accelerating the country's efforts in meeting the 95-95-95 Fast Track targets and ending AIDS as a public health threat. It should also be noted that human resource expenditures are significant (28%). Further, it is also important to point out that very few resources (3%) from 2019 to 2021 were directed towards capital expenditures (information technology, laboratory and other medical equipment, non-medical equipment).

Analysis of trends

In 2020, current expenditure increased by eight per cent. In 2021, spending increased by one per cent and between 2019 and 2021, current expenditure increased by eight per cent.

In 2020, capital expenditure decreased by 16 per cent. In 2021, spending decreased by 28 per cent and between 2019 and 2021, capital expenditure decreased by 40 per cent.

In 2020, production factors not disaggregated increased by 494 per cent. In 2021, spending increased by 66 per cent and between 2019 and 2021, expenditure increased by 884 per cent.

Analysis of shares in annual spending

In 2019, the shares show that current expenditures represented 96 per cent of the shares followed by capital expenditures with three per cent of shares and production factors not disaggregated with one per cent of shares.

In 2020, the shares show that current expenditure represented 94 per cent of the shares followed by production factors not disaggregated with three per cent of shares and capital expenditures with three per cent of shares.

In 2021, the shares show that current direct and indirect expenditures represented 93 per cent of the shares followed by production factors not disaggregated with six per cent of shares and capital expenditures with one per cent of shares.

The figure below illustrates this analysis:

Figure 26: Share of production factors spending (2019- 2021)

Figure 26.a: Total spending (2019-2021)

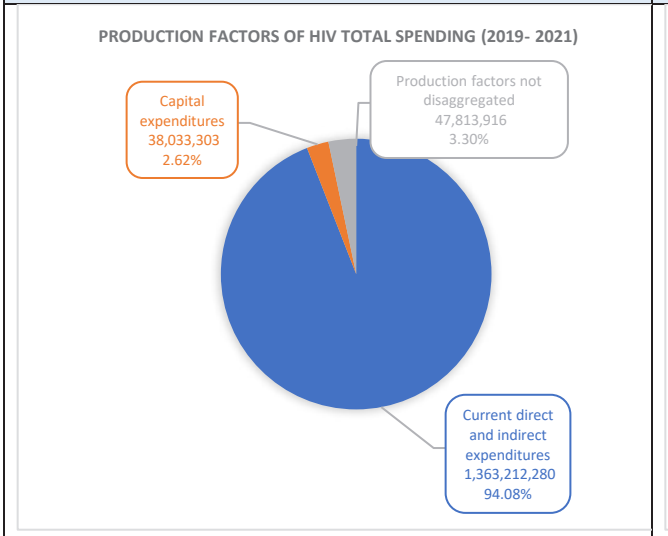


Figure 26.b: Year 2019

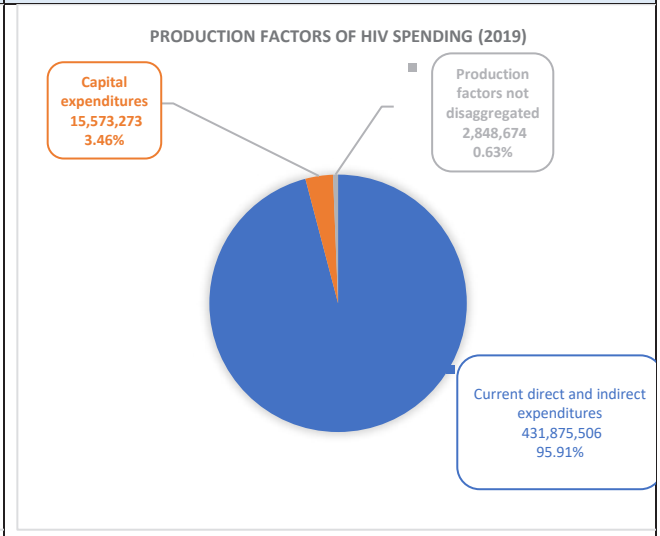


Figure 26.C: Year 2020

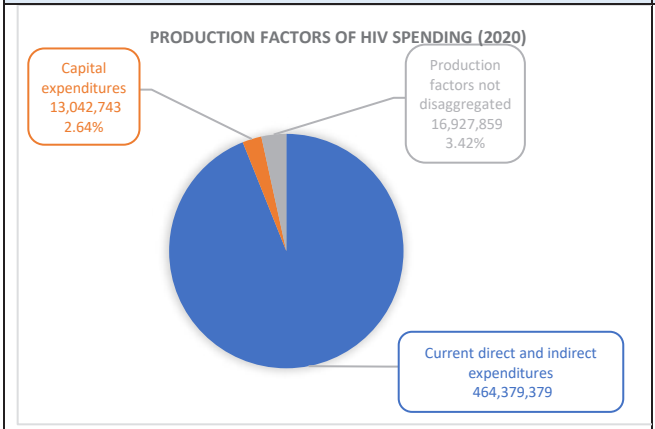
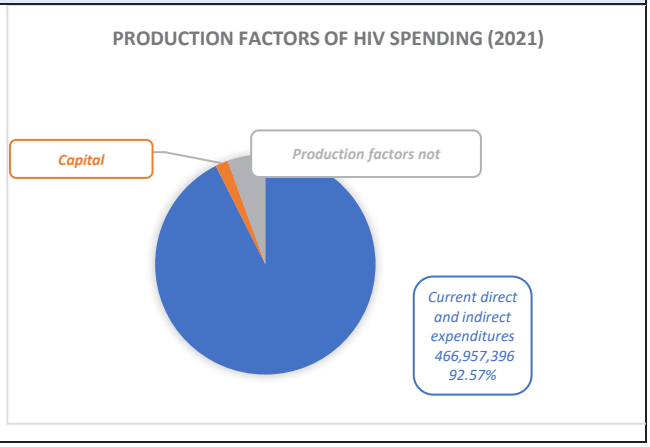


Figure 26.d: Year 2021



3.2.5 *Utilisation of HIV and AIDS services*

3.2.5.1 *AIDS spending categories expenditures*

NASA uses the term “AIDS spending categories” to define all HIV-related interventions and activities in the HIV and AIDS response. AIDS spending categories include prevention, care and treatment, and other health and non-health services related to HIV and AIDS.

This section presents the broader programme areas and a breakdown of each category. It is important to note that in the NASA 2019 classifications, the HIV testing and counselling programme was separated into a new programme area. Previously, voluntary testing and counselling was considered part of prevention, and provider-initiated testing and counselling was part of treatment. In the new framework, all forms of HIV testing and counselling are combined.

Table 13: Breakdown of AIDS spending categories expenditure (2019-2021)

AIDS SPENDING CATEGORIES (ASC)	2019	%	2020	%	2021	%	TOTAL	%
ASC.01 Prevention	48, 928, 466	10.87%	64, 770, 973	13.10%	61, 348, 668	12.16%	175, 048, 107	12.08%
ASC.02 HIV testing and counselling (HTC)	28, 339, 089	6.29%	21, 473, 042	4.34%	20, 587, 326	4.08%	70, 399, 457	4.86%
ASC.03 HIV Care and Treatment	246, 755, 326	54.80%	254,879,856	51.56%	305,421,029	60.55%	807, 056, 211	55.70%
ASC.04 Social protection and economic support (for PLHIV, their families. for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	12, 870, 495	2.86%	4, 640, 516	0.94%	7, 457, 177	1.48%	24, 968, 188	1.72%
ASC.05 Social Enablers (excluding the efforts for KPs above)	399, 639	0.09%	-	0.00%	-	0.00%	399, 639	0.03%
ASC.06 Programme enablers and systems strengthening	112, 726, 091	25.03%	113, 357, 074	22.93%	108,380,772	21.49%	334, 463, 936	23.08%
ASC.07 Development synergies	216, 489	0.05%	34, 847, 965	7.05%	896, 915	0.18%	35, 961 ,369	2.48%
ASC.08 HIV-related research (paid by earmarked HIV funds)	61, 858	0.01%	380, 555	0.08%	320, 179	0.06%	762, 592	0.05%
TOTAL	**450, 297, 453**	**100%**	**49, 349,981**	**100%**	**504,412,065**	**100%**	**1,449,059,499**	**100%**

Analysis of total spending (2019-2021)

From 2019 to 2021, of the total HIV and AIDS spending in Zambia, care and treatment took the highest share, at **56 per cent** followed by programme enablers and systems strengthening, at **23 per cent.** The third largest expenditure was on prevention with **12 per cent** of share. HIV with testing and counselling (HTC) accounted for **5 per cent** of share. Development synergies accounted for **3 per cent** of shares while social protection and economic support accounted for **2 per cent** of shares. The remaining sub-categories (social enablers, research) combined accounted for **0.08 per cent** of the total HIV and AIDS spending. (See figure 27.a).

Analysis of trends by type of Aids Spending Category

In 2020, expenditure on care and treatment category increased by 3 per cent. In 2021, expenditure on this category increased by 20 per cent and between 2019 and 2021, expenditure increased by 24 per cent.

In 2020, expenditure on programme enablers and systems strengthening category increased by one per cent. In 2021, expenditure decreased by 4 per cent and between 2019 and 2021, expenditure decreased by 4 per cent.

In 2020, expenditure on prevention category increased by 32 per cent. In 2021, expenditure on this category decreased by 5 per cent and between 2019 and 2021, expenditure increased by 25 per cent.

In 2020, expenditure on HIV testing and counselling (HTC) category decreased by **24 percent**. In 2021, expenditure decreased by **4 per cent** and between 2019 and 2021, expenditure decreased by **27 per cent**.

In 2020, expenditure on development synergies category increased by **15, 997 per cent**. In 2021, expenditure decreased by **97 per cent** and between 2019 and 2021, expenditure increased by **314 per cent**.

In 2020, expenditure on social protection and economic support category decreased by **64 per cent**. In 2021, expenditure decreased by **61 per cent** and between 2019 and 2021, expenditure decreased by **42 per cent**.

In 2020, expenditure on HIV-related research category increased by **515 per cent**. In 2021, expenditure decreased by **16 per cent** and between 2019 and 2021, expenditure increased by **418 per cent**.

In 2020, expenditure on social enablers category increased by **100 per cent**. In 2021, expenditure did not increase or decrease and between 2019 and 2021, expenditure decreased by **100 per cent**.

Analysis of shares in annual spending

In 2019, the shares show that care and treatment took the highest share, at **55 per cent**. This was followed by programme enablers and systems strengthening at **25 per cent**. The third largest expenditure was on prevention with **11 per cent** of annual shares. HIV testing and counselling (HTC) tool the fourth place in shares with **six per cent** of shares and social protection and economic support accounted for **three per cent.** Other sub-categories (social enablers, development synergies, HIV-related research) accounted for **0.15 percent** of shares (see figure 27.b).

In 2020, the shares show that care and treatment took the highest share, at **52 per cent**. This was followed by programme enablers and systems strengthening, at **23 per cent.** The third largest expenditure was on prevention with **13 per cent** of annual shares. Development synergies took fourth place in shares with **seven per cent** of share**,** HIV testing and counselling (HTC) took fifth place in shares with **four per cent** and social protection and economic support accounted for **one per cent .** HIV related research accounted for **0.08 per cent** of shares (see figure 27.c)

In 2021, the shares show that care and treatment took the highest share, at **61 per cent**. This was followed by programme enablers and systems strengthening, at **21 per cent.** The third largest expenditure was on prevention with **12 per cent** of annual shares. HIV testing and counselling took fourth place in shares with **four per cent** of share, social protection and economic support took the fifth place in shares, with **1.48 per cent.** Development synergies took sixth place in shares with **0.18 per cent.** Other sub-categories (social enablers, HIV-related research) accounted for **0.06 per cent** of shares (see figure 27.d)

The figure below illustrates what is announced in the previous text.

Figure 27: Share of ASC expenditure by chapter of interventions (2019-2021)

Figure 27.a: Total spending (2019-2021)

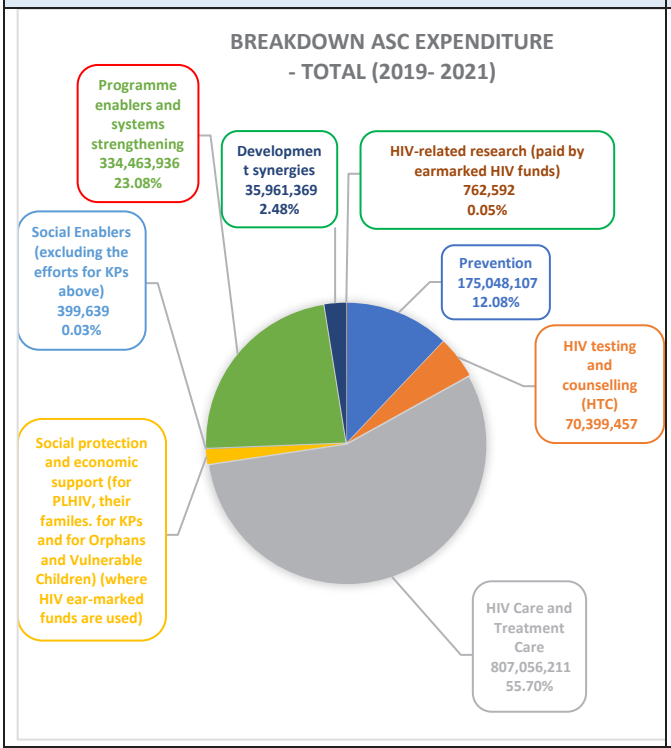


Figure 27.b: Year 2019

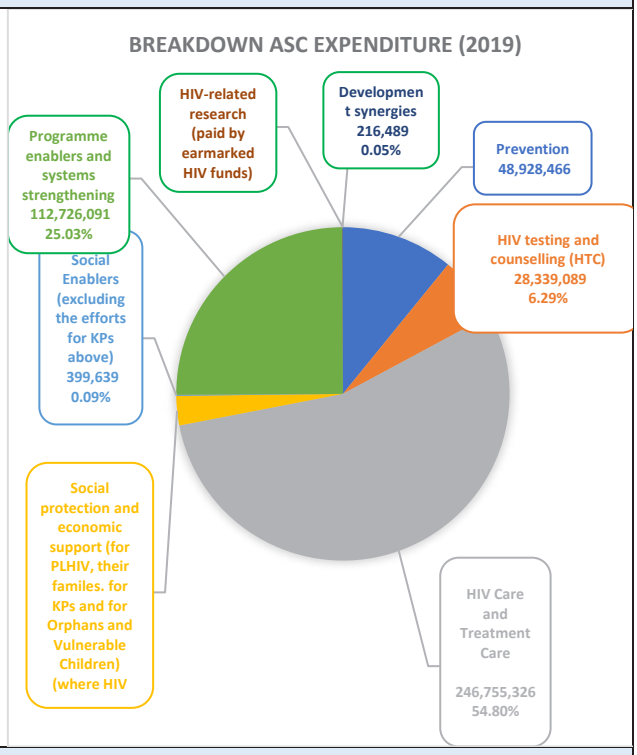


Figure 27.c: Year 2020

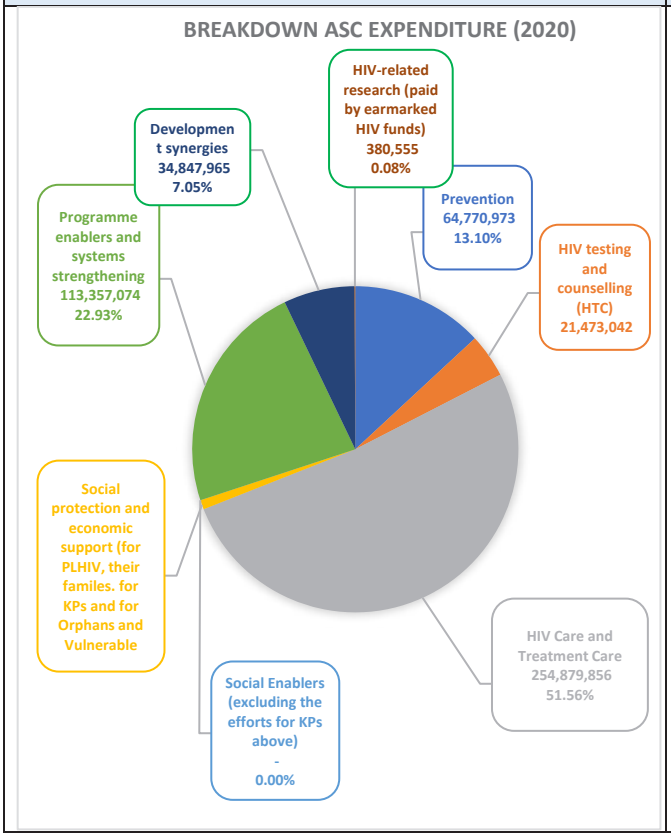
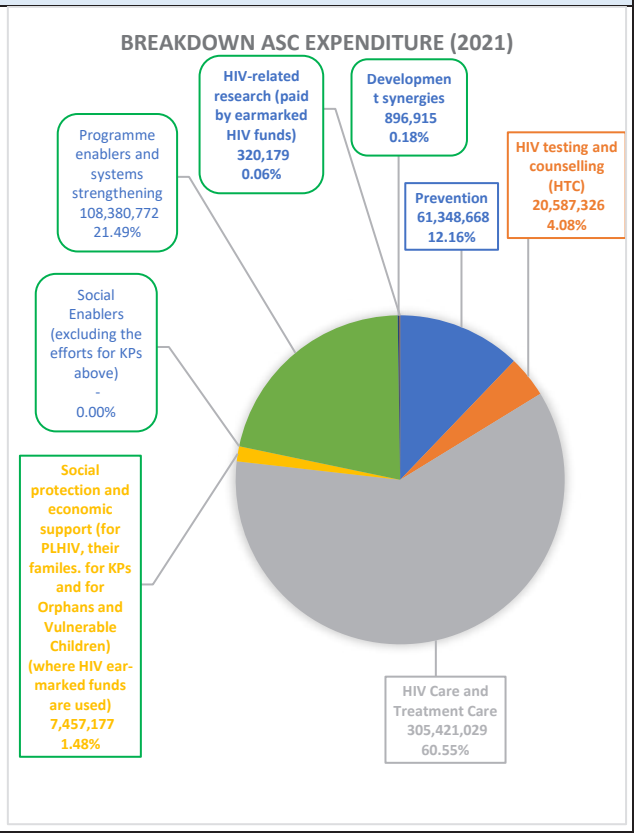


Figure 27.d: Year 2021



Breakdown of prevention expenditure

Table 14: Breakdown of prevention spending (2019-2021)

PREVENTION INTERVENTIONS	2019	%	2020	%	2021	%	TOTAL	%
ASC.01.01 Five Pillars of Prevention	**25, 050, 942**	**51.20%**	**31, 452, 334**	**48.56%**	**51, 815, 603**	**84.46%**	**108, 318, 879**	**61.88%**
ASC.01.01.01.01 Condom promotion and distribution as part of dedicated programmes for AGYW - only if earmarked HIV funds are spent	1, 280	0.00%		0.00%	150, 000	0.24%	151, 280	0.09%
ASC.01.01.01.02 Youth-friendly SRH services for AGYW - only if earmarked HIV funds are spent		0.00%	620 605	0.96%	1, 421, 360	2.32%	2, 041, 965	1.17%
ASC.01.01.01.03 Behaviour change communication (BCC) as part of programmes for AGYW and their male partners - only if earmarked HIV funds are spent	4, 038, 258	8.25%	2, 966, 509	4.58%	3, 112, 510	5.07%	10, 117, 277	5.78%
ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent	2, 746, 293	5.61%	2, 245, 792	3.47%	12, 251, 147	19.97%	17, 243, 232	9.85%
ASC.01.01.01.98 Programmatic activities for AGYW not disaggregated by type	144, 873	0.30%	356, 054	0.55%	47, 153	0.08%	548, 080	0.31%
ASC.01.01.01.99 Other activities for AGYW n.e.c.	91, 288	0.19%	383, 143	0.59%	1, 013, 813	1.65%	1, 488, 244	0.85%
ASC.01.01.02.01.01 Condom and lubricant programmes as part of programmes for sex workers		0.00%	23, 068	0.04%		0.00%	23, 068	0.01%
ASC.01.01.02.01.04 Community empowerment including prevention of violence against sex workers and legal support - only if earmarked HIV funds are spent	1, 064, 896	2.18%	922, 604	1.42%		0.00%	1, 987, 500	1.14%
ASC.01.01.02.02.03 Behaviour change communication (BCC) as part of programmes for MSM	393, 530	0.80%	625, 704	0.97%		0.00%	1, 019, 234	0.58%
ASC.01.01.02.03.03 Behaviour change communication (BCC) as part of programmes for TG	28, 024	0.06%	424, 319	0.66%		0.00%	452, 343	0.26%
ASC.01.01.02.04.03 Behaviour change communication (BCC) as part of programmes for PWID	82, 841	0.17%		0.00%	114, 247	0.19%	197, 088	0.11%
ASC.01.01.02.05.03 Interpersonal communication on HIV prevention as part of programmes for inmates (prisoners)	3, 568	0.01%	8, 837	0.01%		0.00%	12, 405	0.01%
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	636, 644	1.30%	33, 420	0.05%	5, 096, 577	8.31%	5, 766, 641	3.29%
ASC.01.01.03.01 Provision of free condoms for HIV prevention (excluding for KPs and AGYW)		0.00%	3, 447, 168	5.32%		0.00%	3, 447, 168	1.97%

PREVENTION INTERVENTIONS	2019	%	2020	%	2021	%	TOTAL	%
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated		0.00%	616, 814	0.95%	716, 235	1.17%	1, 333, 049	0.76%
ASC.01.01.04.01 Voluntary medical male circumcision (VMMC) programmes	1, 310, 260	2.68%		0.00%	130, 917	0.21%	1, 441, 177	0.82%
ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	13, 027, 414	26.63%	14, 699, 731	22.69%	16, 028, 413	26.13%	43, 755, 558	25.00%
ASC.01.01.05.01 PrEP as part of programmes for AGYW		0.00%		0.00%	1, 263, 453	2.06%	1, 263, 453	0.72%
ASC.01.01.05.98 PrEP not disaggregated by key population	974, 264	1.99%	3, 024, 604	4.67%	10, 469, 778	17.07%	14, 468, 646	8.27%
ASC.01.01.05.99 PrEP not elsewhere classified n.e.c.	507, 509	1.04%	1, 053, 962	1.63%		0.00%	1, 561, 471	0.89%
ASC.01.02 Other prevention activities	**23, 877, 524**	48.80%	**33, 318, 639**	51.44%	**9, 533, 065**	15.54%	**66, 729, 228**	**38.12%**
ASC.01.02.01.01 Safe infant feeding practices (including substitution of breastmilk)	1, 184	0.00%		0.00%	74, 615	0.12%	75, 799	0.04%
ASC.01.02.01.98 PMTCT not disaggregated by activity	987, 983	2.02%		0.00%	664, 473	1.08%	1, 652, 456	0.94%
ASC.01.02.02 Social and behavioural change communication (SBCC) for populations other than key populations	10, 038	0.02%	572, 769	0.88%	289, 861	0.47%	872, 668	0.50%
ASC.01.02.03 Community mobilisation for populations other than key populations	8, 597, 091	17.57%	6, 121, 036	9.45%	3, 240, 641	5.28%	17, 958, 768	10.26%
ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	3, 147, 866	6.43%	257, 505	0.40%		0.00%	3, 405, 371	1.95%
ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type	61, 271	0.13%		0.00%		0.00%	61, 271	0.04%
ASC.01.02.04.99 Other programmatic activities for vulnerable and accessible populations n.e.c		0.00%	2, 377	0.00%		0.00%	2, 377	0.00%
ASC.01.02.05.01 Prevention activities implemented in school		0.00%	1, 629, 962	2.52%	51, 601	0.08%	1, 681, 563	0.96%
ASC.01.02.05.98 Prevention activities for children and youth not disaggregated by type	1, 024, 705	2.09%	955, 928	1.48%	875, 846	1.43%	2, 856, 479	1.63%
ASC.01.02.05.99 Prevention activities for children and youth n.e.c		0.00%	101, 796	0.16%		0.00%	101, 796	0.06%
ASC.01.02.06.98 Programmatic activities for PLHIV and SDC not disaggregated by type		0.00%	21, 863	0.03%		0.00%	21, 863	0.01%
ASC.01.02.07 Prevention and wellness programmes in the workplace	53, 878	0.11%	9, 884	0.02%	22, 262	0.04%	86, 024	0.05%
ASC.01.02.98 Prevention activities not disaggregated	9, 959, 810	20.36%	23, 645, 519	36.51%	4, 313, 766	7.03%	37, 919, 095	21.66%
ASC.01.02.99 Other prevention activities n.e.c.	33, 698	0.07%		0.00%		0.00%	33, 698	0.02%
TOTAL	**48, 928, 466**	**100.00%**	**64, 770, 973**	**100.00%**	**61, 348, 668**	**100.00%**	**175, 048, 107**	**100.00%**

Analysis of total spending (2019-2021)

Expenditure on the five pillars of prevention

From 2019 to 2021, the five pillars of prevention accounted for 62 per cent of prevention expenditure, followed by other prevention activities, at 38 per cent of share (see figure 28.a).

Within the category of the five pillars of prevention, voluntary medical male circumcision (VMMC) took the highest share (25%) of all prevention spending. This was followed by cash transfers, social grants and other economic empowerment as part of programmes for AGYW, at 10 per cent of shares. The third largest expenditure was on PrEP not disaggregated by key population which accounted for eight per cent. The fourth largest expenditure was on behaviour change communication (BCC) as part of programmes for AGYW and their male partners with six per cent of shares. The fifth largest expenditure was on condom activities (for HIV prevention) not disaggregated with three per cent of shares. The sixth largest expenditure was on provision of free condoms for HIV prevention with two per cent of shares. The remaining sub-categories combined accounted for six per cent of the total HIV and AIDS spending. (See table 14).

Expenditure on other prevention activities

Within the category of Other Prevention activities, prevention activities not disaggregated took the highest share (22%) of prevention spending followed by spending on community mobilisation for populations other than key populations (10%). Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations accounted for two per cent of prevention shares. Prevention activities for children and youth, not disaggregated by type, accounted for two per cent of shares. The remaining sub-categories combined accounted for six per cent of the total HIV and AIDS spending. (see table 14)

Analysis of trends for principal prevention categories

Between 2019 and 2020, expenditure on the sub-category of five pillars of prevention increased by 26 per cent. Between 2020 and 2021, expenditure on this category increased by 65 per cent. Between 2019 and 2021, expenditure increased by 107 per cent.

Between 2019 and 2020, expenditure on sub-category of Other Prevention activities increased by 40 per cent. Between 2020 and 2021, expenditure on this sub-category decreased by 71 per ecnt and between 2019 and 2021, expenditure decreased by 60 per cent.

Analysis of shares in annual spending

In 2019, the shares show that five pillars of prevention took the highest share, at 51 per cent. This was followed by Other Prevention activities at 49 per cent. (see figure 28.b).

In 2020, the shares show that Other Prevention activities took the highest share, at 51 per cent. This was followed by five pillars of prevention at 49 per cent. (see figure 28.c),

In 2021, the shares show that five pillars of prevention took the highest share, at 84 per cent. This was followed by Other Prevention activities at 16 per cent. (see figure 28.d).

The figure below illustrates what is announced in the previous text:

Figure 28: Share of prevention expenditure by chapter of intervention

Figure 28.a: Total spending (2019-2021)

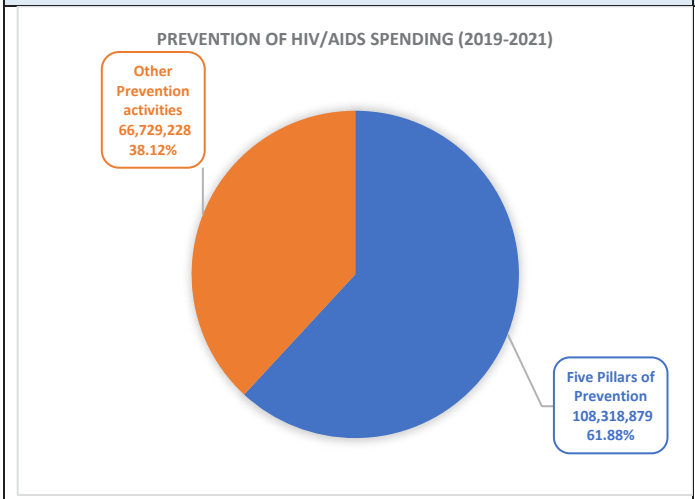


Figure 28.b: Year 2019

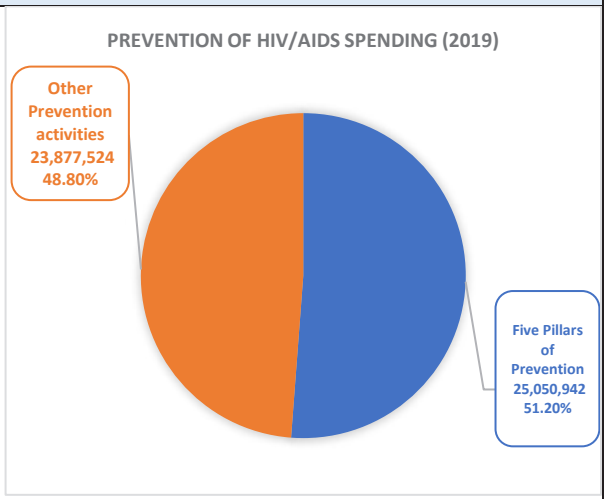


Figure 28.c: Year 2020

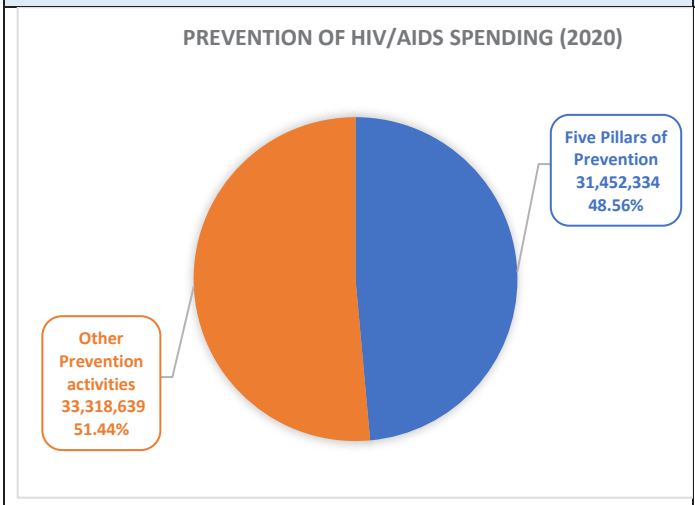
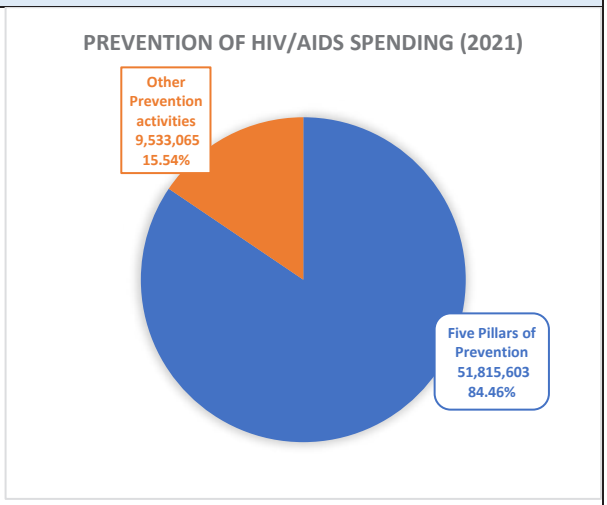


Figure 28.d: Year 2021



HIV care and treatment expenditure

Table 15: Breakdown of HIV care and treatment spending (2019-2021)

HIV Care and Treatment	2019	%	2020	%	2021	%	TOTAL	%
ASC.03.01 Anti-retroviral therapy	96, 562, 643	39.13%	78, 444, 114	30.78%	112, 798, 083	36.93%	287, 804, 840	35.66%
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring	1, 169, 965	0.47%	27, 892	0.01%	130, 216	0.04%	1, 328, 073	0.16%
ASC.03.03 Specific ART-related laboratory monitoring	54, 878, 863	22.24%	35, 373, 926	13.88%	47, 830, 382	15.66%	138, 083, 171	17.11%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	5, 624, 159	2.28%	16, 651, 668	6.53%	5, 536, 573	1.81%	27, 812, 400	3.45%
ASC.03.05 Psychological treatment and support service	353, 550	0.14%	3, 741, 246	1.47%	7, 534, 601	2.47%	11, 629, 397	1.44%
ASC.03.98 Care and treatment services not disaggregated	88, 166, 146	35.73%	120, 641, 010	47.33%	131, 591, 174	43.09%	340, 398, 330	42.18%

HIV Care and Treatment	2019	%	2020	%	2021	%	TOTAL	%
TOTAL	246, 755, 326	100%	254, 879, 856	100%	305, 421, 029	100%	807, 056, 211	100%

Analysis of total spending (2019-2021)

From 2019 to 2021, care and treatment services not disaggregated accounted for **42 per cent** of total expenditure followed by Anti-retroviral therapy, at **36 per cent** of share. The third largest expenditure was on specific ART-related laboratory monitoring with **17 per cent** of share. The fourth is co-infections and opportunistic infections with **three per cent** of share. Psychological treatment and support service accounted for **1.44 per cent** and adherence and retention on ART – support accounted for **0.16 per cent** of share (see figure 29.a).

Given that an estimated **1.3 million** people were living with HIV in Zambia in 2019 and the country had a high HIV prevalence rate of **11.2 per cent,** care and treatment was a major cornerstone and strategy of the national response. Financing for care and treatment should be adequate and managed effectively to ensure that the more than **1.2 million** people on antiretroviral therapy continue to receive treatment. Spending on care and treatment in 2019, 2020 and 2021 was below the cost estimate proposed by the NASF for the same years. This was estimated at **129 million** in 2019, **128 million** in 2020 and **130 million** in 2021 while, for the same period, expenditures were estimated at **450 million, 494 million** and **504 million US** dollars.

Trend analysis from 2019 to 2021

Between 2019 and 2020, spending on care and treatment services not disaggregated increased by 37 per cent. Between 2020 and 2021, spending increased by nine per cent and between 2019 and 2021, expenditure increased by 49 per cent.

Between 2019 and 2020, spending on Anti-retroviral therapy decreased by 19 per cent. Between 2020 and 2021, spending increased by 44 per cent and between 2019 and 2021, expenditure increased by 17 per cent.

Between 2019 and 2020, specific ART-related laboratory monitoring decreased by **36 per cent.** Between 2020 and 2021, spending increased by **35 per cent** and between 2019 and 2021, expenditure decreased by **13 per cent**.

Between 2019 and 2020, spending on co-infections and opportunistic infections (prevention and treatment for PLHIV and KPs) increased by **196 per cent.** Between 2020 and 2021, spending decreased by **67 per cent** and between 2019 and 2021, expenditure decreased by **two per cent**.

Between 2019 and 2020, spending on psychological treatment and support services increased by **958 per cent.** Between 2020 and 2021, spending decreased by **101 per cent** and between 2019 and 2021, expenditure decreased by **2031 per cent**.

Between 2019 and 2020, spending on psychological treatment and support service increased by **958 per cent.** Between 2020 and 2021, spending decreased by **101 per cent** and between 2019 and 2021, expenditure decreased by **2031 per cent**.

Between 2019 and 2020, spending on adherence and retention on ART - support (including nutrition and transport) and monitoring decreased by **98 per cent.** Between 2020 and 2021, spending increased by **367 per cent** and between 2019 and 2021, expenditure decreased by **89 per cent**.

Analysis of shares in annual spending

In 2019, the shares show that Anti-retroviral therapy represented **39 per cent** of the shares, followed by care and treatment services not disaggregated with **36 per cent** of shares. The third largest expenditure was on specific ART-related laboratory monitoring with **22 per cent** of shares. The fourth largest expenditure was on co-infections and opportunistic infections with **two per cent** of shares. The fifth largest expenditure was on adherence and retention on ART - support (including nutrition and transport) and monitoring with **0.47 per cent** of shares and the sixth expenditure was psychological treatment and support service with **0.14 per cent** of share (see figure 29.b).

In 2020, the shares show that care and treatment services not disaggregated represented **47 per cent** of the shares followed by Anti-retroviral therapy with **31 per cent** of shares. The third largest expenditure was on specific ART-related laboratory monitoring with **14 per cent** of shares. The fourth largest expenditure was on Co-infections and opportunistic infections with **seven per cent** of shares. The fifth largest expenditure was on psychological treatment and support service with **one per cent** of shares and the sixth expenditure was on adherence and retention on ART - support (including nutrition and transport) and monitoring with **0.01 per cent** of share (see figure 29.c).

In 2021, the shares show that care and treatment services not disaggregated represented **43 per cent** of the shares followed by Anti-retroviral therapy with **37 per cent** of shares. The third largest expenditure was on specific ART-related laboratory monitoring with **16 per cent** of shares. The fourth largest expenditure was psychological treatment and support service **with 2.47 per cent** of shares. The sixth largest expenditure was co-infections and opportunistic infections (prevention and treatment for PLHIV and KPs) with **1.81 per cent** of shares. The seventh largest expenditure was adherence and retention on ART - support (including nutrition and transport) and monitoring with **0.04 per cent** of share (see figure 29.d).The figure below illustrates this analysis:

Figure 29: Share of HIV care and treatment spending

Figure 29.a: Total spending (2019-2021)

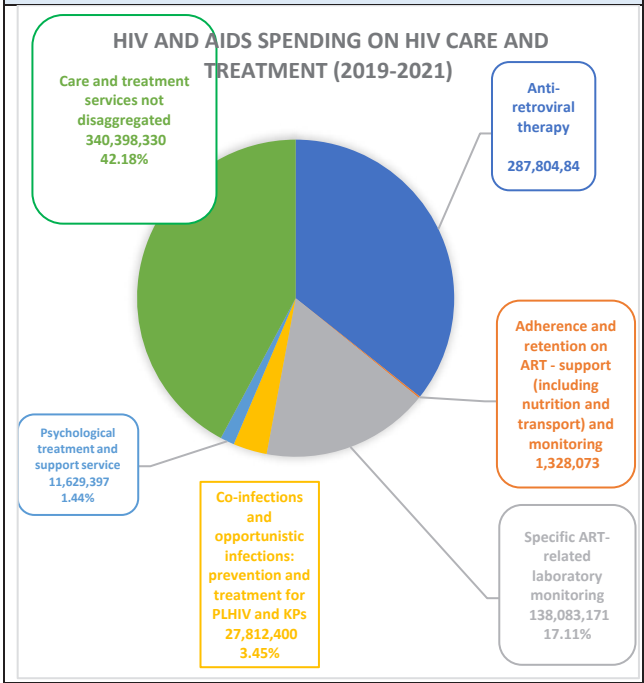


Figure 29.b: Year 2019

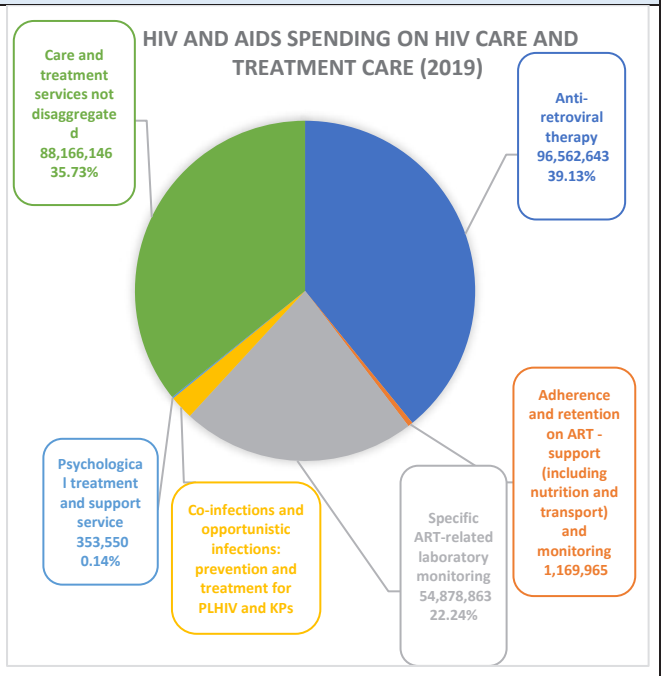


Figure 29.c: Year 2020

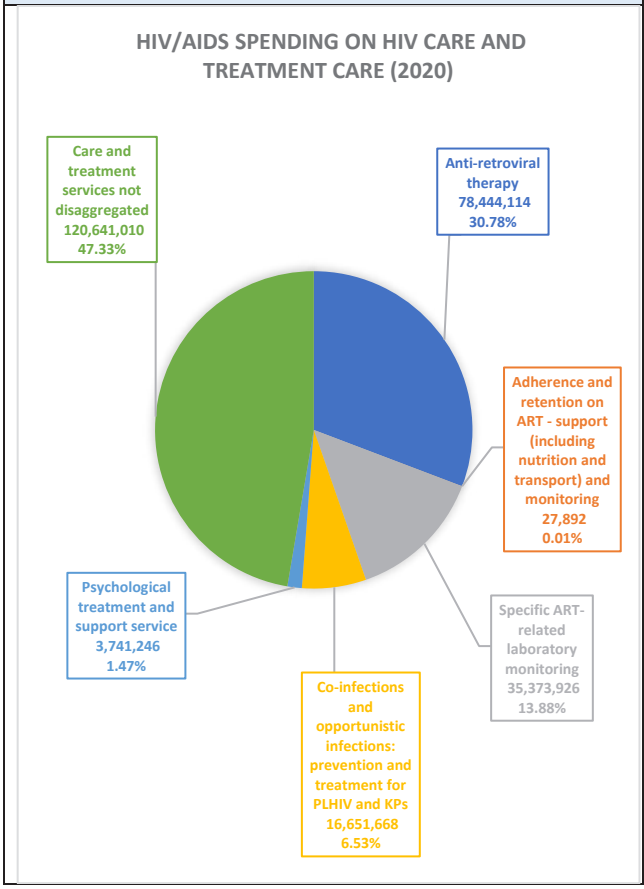
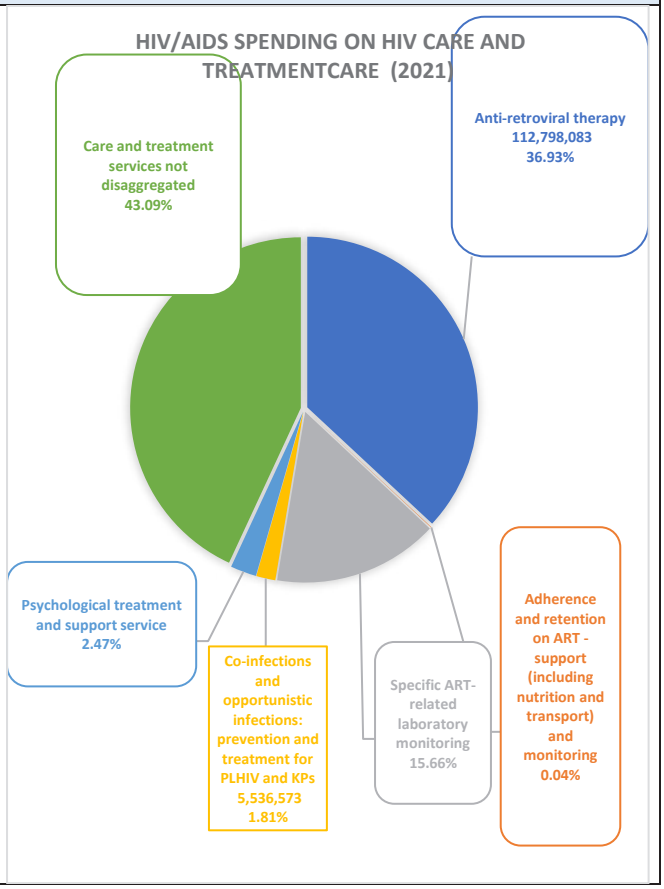


Figure 29.d: Year 2021



Testing and counselling expenditure

Table 16: Breakdown of HIV testing and counselling spending (2019-2021)

HIV testing and counselling (HTC)	2019	%	2020	%	2021	%	TOTAL	%
ASC.02.01 HIV testing and counselling for sex workers	924, 177	3.26%	339, 531	1.58%		0.00%	1, 263, 708	1.80%
ASC.02.02 HIV testing and counselling for MSM	363, 707	1.28%	339, 531	1.58%		0.00%	703, 238	1.00%
ASC.02.03 HIV testing and counselling for TG	28, 024	0.10%	251, 158	1.17%		0.00%	279, 182	0.40%
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)		0.00%		0.00%	1, 753, 797	8.52%	1, 753, 797	2.49%
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	3, 944, 108	13.92%	751, 969	3.50%		0.00%	4, 696, 077	6.67%
ASC.02.09 Voluntary HIV testing and counselling for general population	3, 598, 424	12.70%	17, 985, 980	83.76%	16, 358, 919	79.46%	37, 943, 323	53.90%
ASC.02.98 HIV testing and counselling activities not disaggregated	18, 483, 368	65.22%	556, 090	2.59%	153, 204	0.74%	19, 192, 662	27.26%
ASC.02.99 Other HIV counselling and testing activities n.e.c.	997, 281	3.52%	1, 248, 783	5.82%	2, 321, 406	11.28%	4, 567, 470	6.49%
TOTAL	**28, 339, 089**	**100.00%**	**21, 473, 042**	**100.00%**	**20, 587, 326**	**100.00%**	**70, 399, 457**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, voluntary HIV testing and counselling for general population accounted for **54 per cent** of total expenditure, followed by HIV testing and counselling activities not disaggregated, at **27 per cent** of share. The third largest expenditure was on HIV testing and counselling for vulnerable and accessible populations with **seven per cent** of share. The fourth is Other HIV counselling and testing activities n.e.c. with **six per cent** of share and the fifth is HIV testing and counselling for pregnant women (part of PMTCT programme), which accounted for **two per cent** of share. HIV testing and counselling for MSM accounted for **one per cent** of share and HIV testing and counselling for Transgender accounted for **0.4 per cent** of share (see figure 30.a).

Trend analysis from 2019 to 2021

Between 2019 and 2020, voluntary HIV testing and counselling for general population total spending increased by **400 per cent**. Between 2021 and 2020, spending decreased by **nine per cent** and between 2019 and 2021, expenditure increased by **355 per cent**.

Between 2019 and 2020, expenditure on HIV testing and counselling activities not disaggregated decreased by **97 per cent.** Between 2020 and 2021, spending decreased by **72 per cent** and between 2019 and 2021, expenditure decreased by **99 per cent**.

Between 2019 and 2020, expenditure on HIV testing and counselling for vulnerable and accessible populations decreased by **81 per cent.** Between 2020 and 2021, spending increased by **1, 000 per cent** and between 2019 and 2021, expenditure decreased by **100 per cent**.

Between 2019 and 2020, expenditure on other HIV counselling and testing activities n.e.c. increased by **25 per cent.** Between 2020 and 2021, spending increased by **86 per cent** and between 2019 and 2021, expenditure increased by **133 per cent**.

In 2019 and 2020, there was no expenditure registered on the HIV testing and counselling for pregnant women (part of PMTCT programme)**.** In 2021, there was expenditure but no base of comparison.

Between 2019 and 2020, expenditure on HIV testing and counselling for MSM decreased by **seven per cent.** Between 2020 and 2021, spending decreased by **100 per cent** and between 2019 and 2021, expenditure decreased by **100 per cent**.

Between 2019 and 2020, expenditure on HIV testing and counselling for TG increased by **796 per cent.** Between 2020 and 2021, spending decreased by **100 per cent** and between 2019 and 2021, expenditure decreased by **100 per cent**.

Analysis of shares in annual spending

In 2019, the shares show that spending on HIV testing and counselling activities not disaggregated represented **65 per cent** of shares followed by testing and counselling for vulnerable and accessible populations with **14 per cent** of shares. The third largest expenditure was on voluntary HIV testing and counselling for general population with **13 per cent** of shares. The fourth largest expenditure was on other HIV counselling and testing activities n.e.c. with **four per cent** of share. The fifth largest expenditure was on HIV testing and counselling for MSM with **one per cent** of share. The sixth largest expenditure was on HIV testing and counselling for TG with **0.10 per cent** of share (see figure 30.b).

In 2020, the shares show that spending on Voluntary HIV testing and counselling for general population represented **84 per cent** of shares, followed by other HIV counselling and testing activities n.e.c. with **six per cent** of shares. The third largest expenditure was on HIV testing and counselling for vulnerable and accessible populations with **four per cent** of shares. The fourth largest expenditure was on HIV testing and counselling activities not disaggregated with **three per cent** of share. HIV testing and counselling for sex workers with HIV testing and counselling for MSM took the fifth largest with **two per cent** of share, each. The sixth largest expenditure was on HIV testing and counselling for TG with **one per cent** of share (see figure 30.c).

In 2021, the shares show that spending on voluntary HIV testing and counselling for general population represented **79 per cent** of shares, followed by other HIV counselling and testing activities n.e.c. with **11 per cent** of shares. The third largest expenditure was on HIV testing and counselling for pregnant women (part of PMTCT programme) with **nine per cent** of shares. The fourth largest expenditure was on HIV testing and counselling activities not disaggregated with **one per cent** of share. Other sub-categories (HIV testing and counselling for sex workers; HIV testing and counselling for MSM; HIV testing and counselling for TG; and HIV testing and counselling for vulnerable and accessible populations), accounted for **zero per cent** (see figure 30.d).

The figure below illustrates this analysis:

Figure 30: Share of HIV testing and counselling spending

Figure 30.a: Total spending (2019-2021)

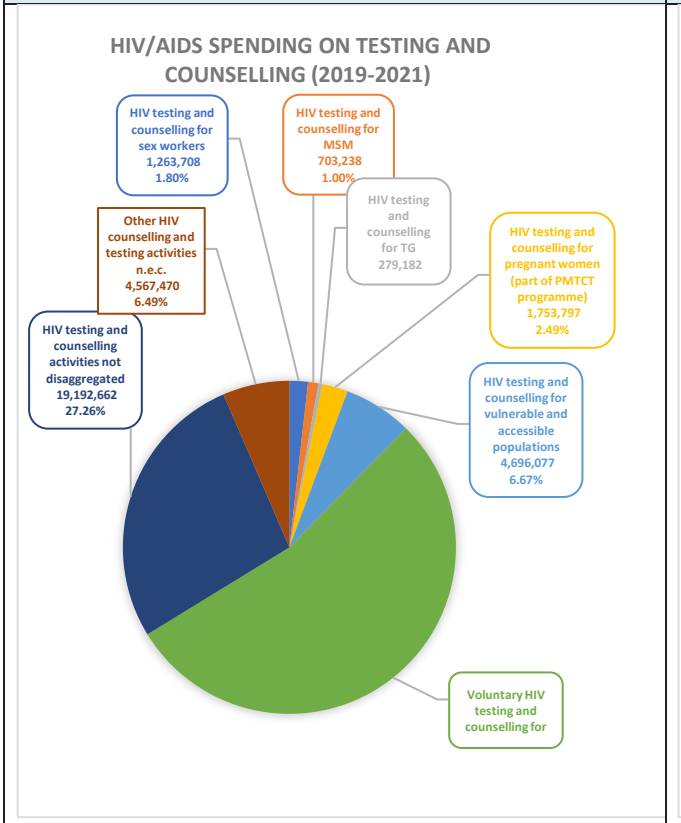


Figure 30.b: Year 2019

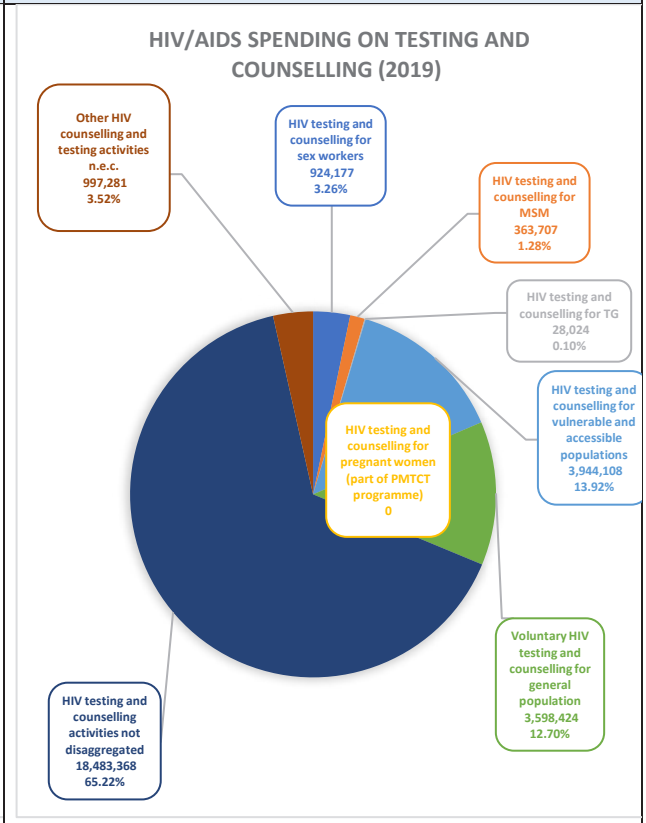


Figure 30.c: Year 2020

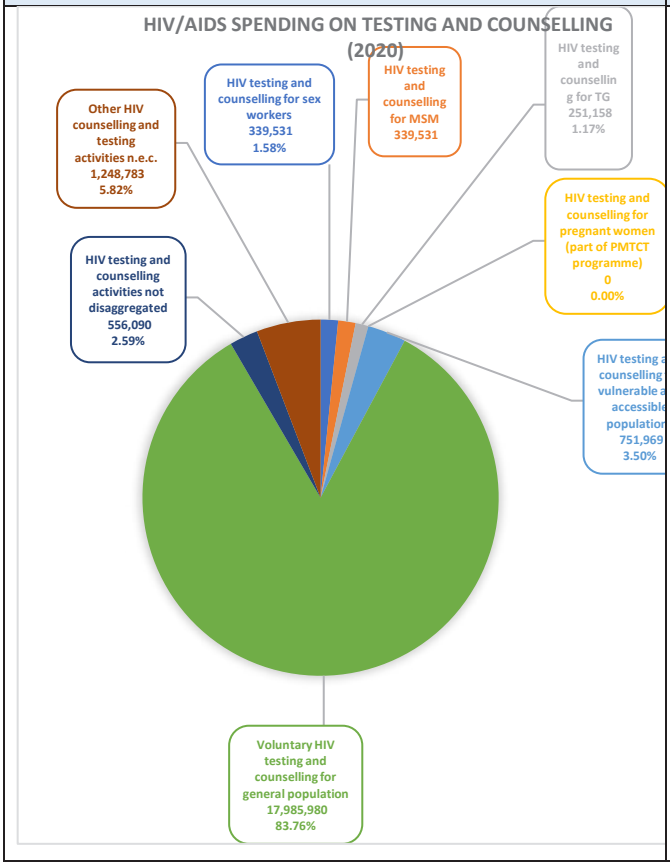
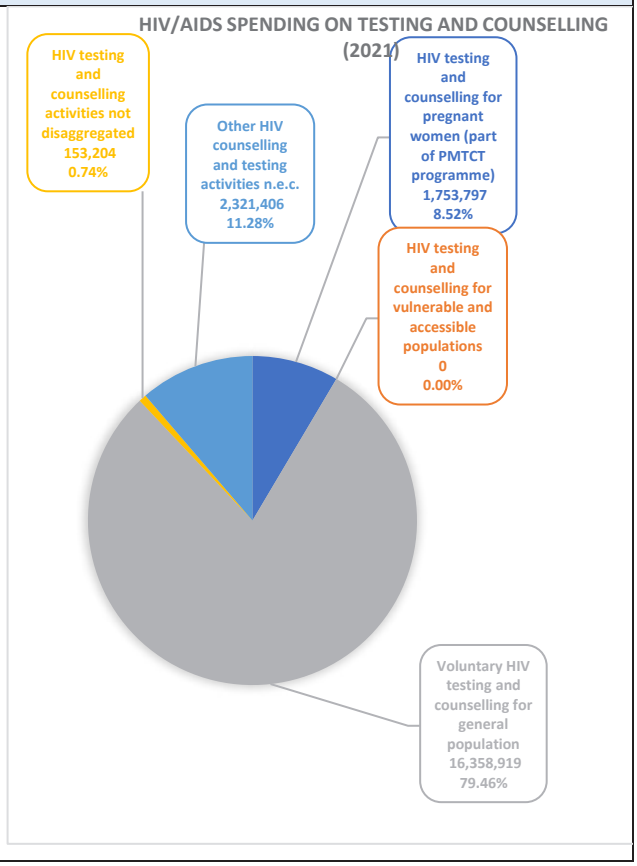


Figure 30.d: Year 2021



Programme enablers and systems strengthening expenditure (2019-2021)

Table 17: Breakdown of programme enablers and systems strengthening spending (2019-2021)

Programme enablers and systems strengthening	2019	%	2020	%	2021	%	TOTAL	%
ASC.06.01 Strategic planning, coordination and policy development	3, 341, 265	2.96%	1, 963, 731	1.73%	1, 158, 795	1.07%	6, 463, 791	1.93%
ASC.06.02 Building meaningful engagement for representation in key governance, policy reform and development processes	1, 607, 400	1.43%	2, 791, 410	2.46%		0.00%	4, 398, 810	1.32%
ASC.06.03 Programme administration and management costs (above service-delivery level)	57, 887, 937	51.35%	56, 507, 328	49.85%	52, 162, 675	48.13%	166, 557, 940	49.80%
ASC.06.04 Strategic information	7, 425, 387	6.59%	11, 551, 682	10.19%	15, 176, 022	14.00%	34, 153, 091	10.21%
ASC.06.05 Public Systems Strengthening	11, 948, 397	10.60%	17, 835, 331	15.73%	11, 700, 441	10.80%	41, 484, 169	12.40%
ASC.06.06 Community system strengthening	24, 416	0.02%	362, 328	0.32%	3, 714, 474	3.43%	4, 101, 218	1.23%
ASC.06.07 Human resources for health (above-site programmes)	28, 514, 523	25.30%	22, 243, 988	19.62%	24, 346, 984	22.46%	75, 105, 494	22.46%
ASC.06.98 Programme enablers and systems strengthening not disaggregated	1, 976, 766	1.75%	101, 276	0.09%	1, 893, 811	1.75%	3, 971, 853	1.19%
TOTAL	**112, 726, 091**	**100.00%**	**113, 357, 074**	**100.00%**	**108, 380, 772**	**100.00%**	**334, 463, 936**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, programme administration and management costs took the largest spending, at **50 per cent** of total expenditure, followed by human resources for health, at **22 per cent** of share. The third largest expenditure was on public systems strengthening with **12 per cent** of share. The fourth is strategic information with **10 per cent** of share and the fifth is HIV Strategic planning, coordination and policy development, which accounted for **two per cent** of share. Building meaningful engagement for representation in key governance, policy reform and development processes accounted for **1.32 per cent** of share, community system strengthening accounted for **1.23 per cent** of share and programme enablers and systems strengthening not disaggregated accounted for **1.19 per cent** of share (see figure 31.a).

Programme coordination, administration and management expenditures represented **26 per cent** of total expenditures for the period from 2019 to 2021 and **50 per cent** of programme enablers and systems strengthening expenditures. This cost did not include human resources costs. Better management of recurrent costs is required.

Trend analysis from 2019 to 2021

Between 2019 and 2020, programme administration and management costs spending decreased by **two per cent**. Between 2021 and 2020, spending decreased by **eight per cent** and between 2019 and 2021, expenditure increased by **10 per cent**.

Between 2019 and 2020, expenditure on human resources for health decreased by **22 per cent.** Between 2020 and 2021, spending increased by **nine per cent** and between 2019 and 2021, expenditure decreased by **15 per cent**.

Between 2019 and 2020, expenditure on public systems strengthening increased by **49 per cent.** Between 2020 and 2021, spending decreased by **34 per cent** and between 2019 and 2021, expenditure decreased by **two per cent**.

Between 2019 and 2020, expenditure on strategic planning, coordination and policy development decreased by **41 per cent.** Between 2020 and 2021, spending decreased by **41 per cent** and between 2019 and 2021, expenditure decreased by **65 per cent**.

Between 2019 and 2020, expenditure on building meaningful engagement for representation in key governance, policy reform and development processes increased by **74 per cent.** Between 2020 and 2021, spending decreased by **100 per cent** and between 2019 and 2021, expenditure decreased by **100 per cent**.

Between 2019 and 2020, expenditure on community system strengthening increased by **1, 384 per cent.** Between 2020 and 2021, spending increased by **925 per cent** and between 2019 and 2021, expenditure increased by **15, 133 per cent**.

Between 2019 and 2020, expenditure on programme enablers and systems strengthening not disaggregated decreased by **95 per cent.** Between 2020 and 2021, spending increased by **1, 770 per cent** and between 2019 and 2021, expenditure decreased by **four per cent**.

Analysis of shares in annual spending

In 2019, the shares show that spending on programme administration and management costs took the largest spending, at **51 per cent** of share followed by human resources for health, at **25 per cent** of share. The third largest expenditure was on public systems strengthening, with **11 per cent** of share. The fourth was strategic information with **seven per cent** of share and the fifth was HIV strategic planning, coordination and policy development, which accounted for **three per cent** of share. Programme enablers and systems strengthening not disaggregated accounted for **1.75 per cent** of share; building meaningful engagement for representation in key governance, policy reform and development processes accounted for **1.43 per cent** of share; and community system strengthening accounted for **0.02 per cent** of share (see figure 31.b).

In 2020, the shares show that spending on programme administration and management costs took the largest spending, at **50 per cent** of share, followed by human resources for health, at **20 per cent** of share. The third largest expenditure was on public systems strengthening, with **16 per cent** of share. The fourth was strategic information, which accounted for **10 per cent** of share. Spending on building meaningful engagement for representation in key governance, policy reform and development processes represented **2.46 per cent** of share and the fifth was strategic planning, coordination and policy development, which accounted for **1.73 per cent** of share. Community system strengthening accounted for **0.32 per cent** of share, programme enablers and systems strengthening not disaggregated accounted for **0.09 per cent** of share. (see figure 31.c).

In 2021, the shares show that spending on programme administration and management costs took the largest spending, at **48 per cent** of share, followed by human resources for health, at **22 per cent** of share. The third largest expenditure was on strategic information, with **14 per cent** of share. The fourth was public systems strengthening, with **11 per cent** of share and the fifth was community system strengthening, which accounted for **three per cent** of share. Programme enablers and systems strengthening not disaggregated accounted for **1.75 per cent** of share. Strategic planning, coordination and policy development accounted for **1.07 per cent** of share. Building meaningful engagement for representation in key governance, policy reform and development processes accounted for **0 per cent** of share (see figure 31.d).

The figure below illustrates this analysis:

Figure 31: Share of programme enablers and systems strengthening spending

Figure 31.a: Total spending (2019-2021)

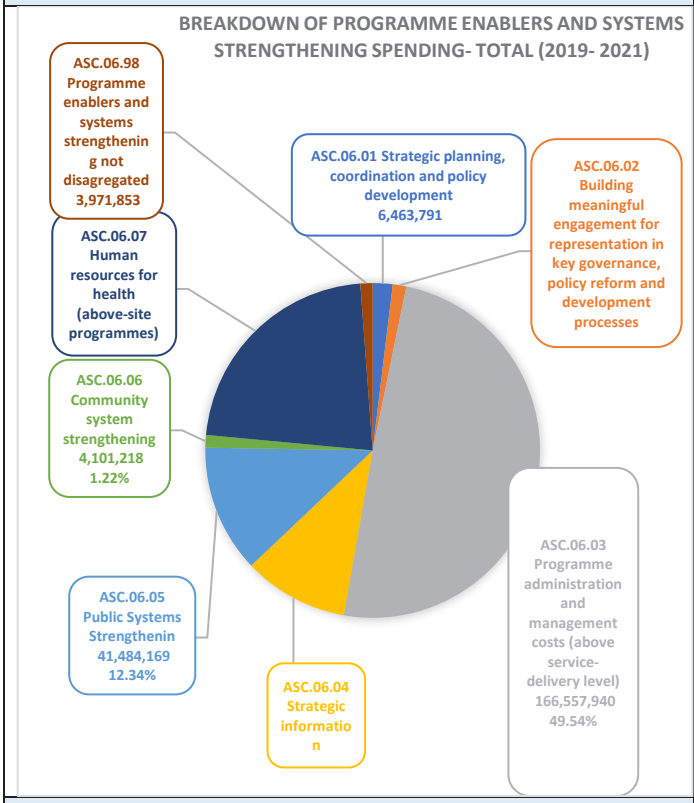


Figure 31.b: Year 2019

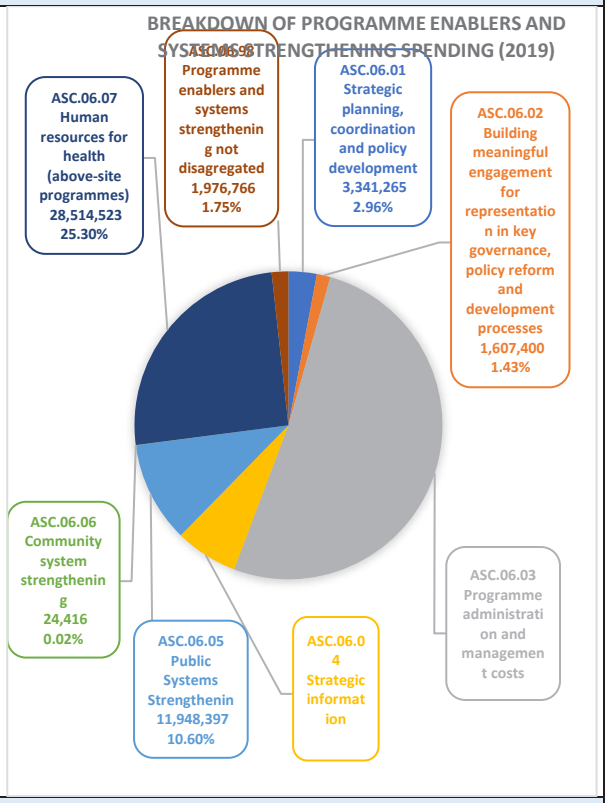


Figure 31.c: Year 2020

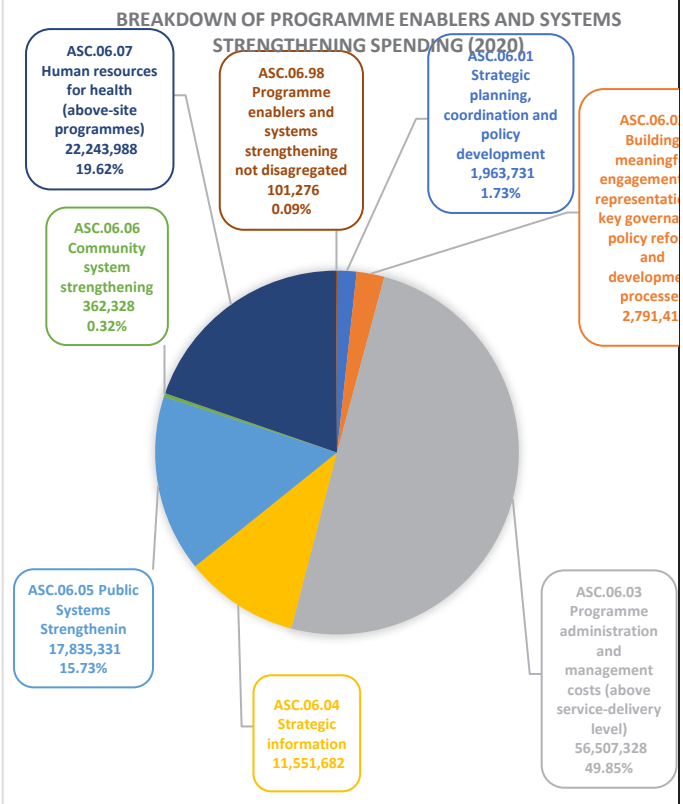
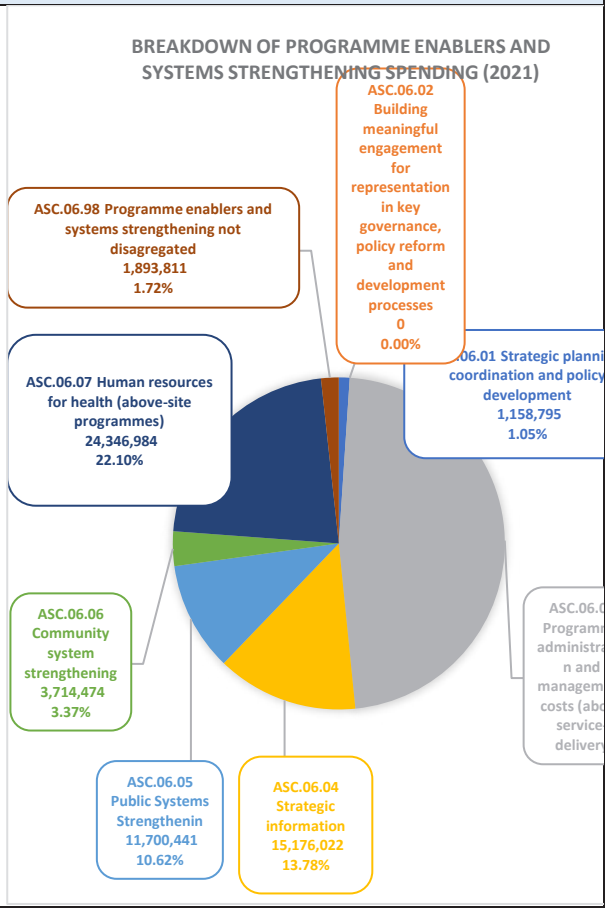


Figure 31.d: Year 2021



Development synergies

Table 18: Development synergies spending (2019-2021)

Development synergies	2019	%	2020	%	2021	%	TOTAL	%
ASC.07.02 Reducing gender based violence	216, 489	100.00%	891, 643	2.56%	896, 915	100.00%	2, 005, 047	5.58%
ASC.07.98 Development synergies not disaggregated		0.00%	33, 956, 322	97.44%		0.00%	33, 956, 322	94.42%
TOTAL	**216, 489**	**100.00%**	**34, 847, 965**	**100.00%**	**896, 915**	**100.00%**	**35, 961, 369**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, development synergies not disaggregated took the largest spending, at **94 per cent** of share, followed by reducing gender-based violence, at **six per cent** of share. (see figure 32.a).

Trend analysis from 2019 to 2021

Between 2019 and 2020, trend on development synergies not disaggregated shows that the denominator was **zero** in 2019 (there were no expenses) and, therefore, the calculation of the evolution is not possible.

Between 2021 and 2020, spending decreased by **100 per cent** and between 2019 and 2021, the denominator is **zero** in 2019 (there were no expenses) and, therefore, the calculation of the evolution is not possible.

Between 2019 and 2020, expenditure on reducing gender-based violence increased by **312 per cent.**

Between 2020 and 2021, spending increased by **one per cent** and between 2019 and 2021, expenditure increased by **314 per cent**.

Analysis of shares in annual spending

In 2019, the shares show that spending on reducing gender-based violence took the largest share, at **100 per cent**. Development synergies not disaggregated accounted for **zero per cent** of share. (see figure 32.b).

In 2020, the shares show that spending on development synergies not disaggregated took the largest share, at **97 per cent** followed by reducing gender-based violence with **three per cent** of share (see figure 32.c).

In 2021, the shares show that spending on reducing gender-based violence took the largest share, at **100 per cent**. Development synergies not disaggregated accounted for **zero per cent** of share (see figure 32.d)

.The figure below illustrates this analysis:

Figure 32: Share of development synergies spending

Figure 32.a: Total spending (2019-2021)

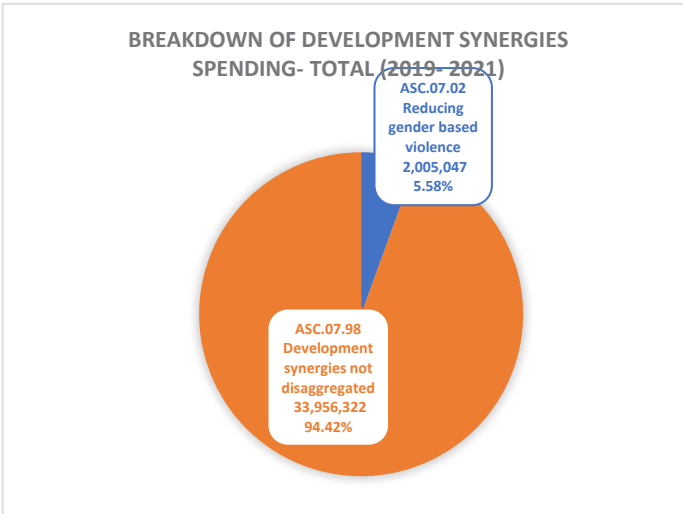


Figure 32.b: Year 2019

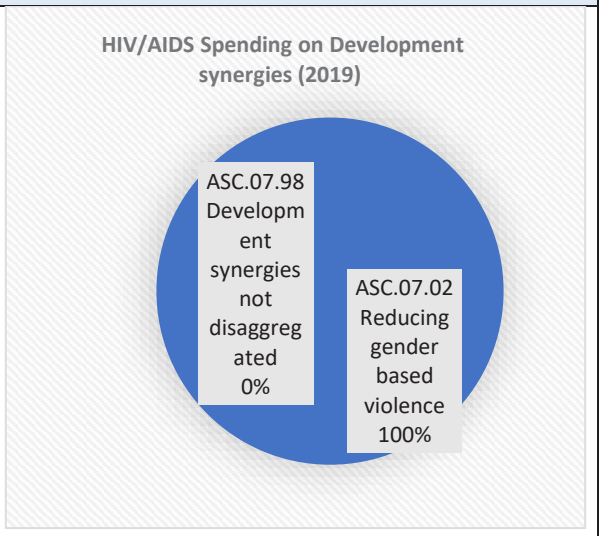


Figure 32.c: Year 2020

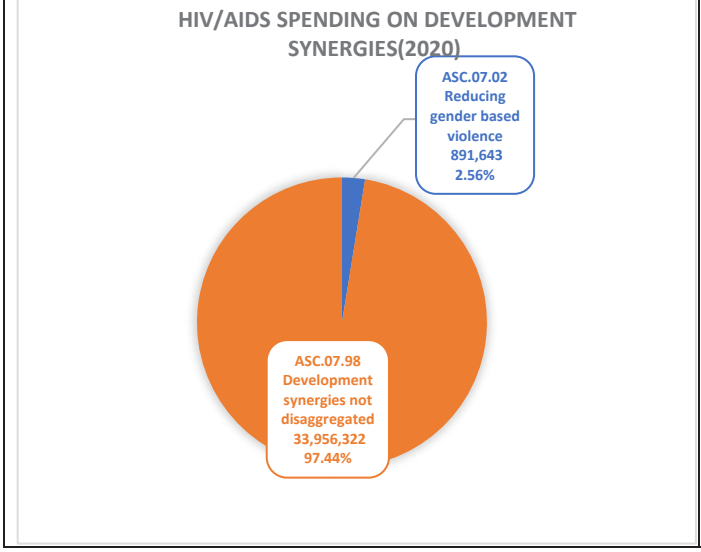
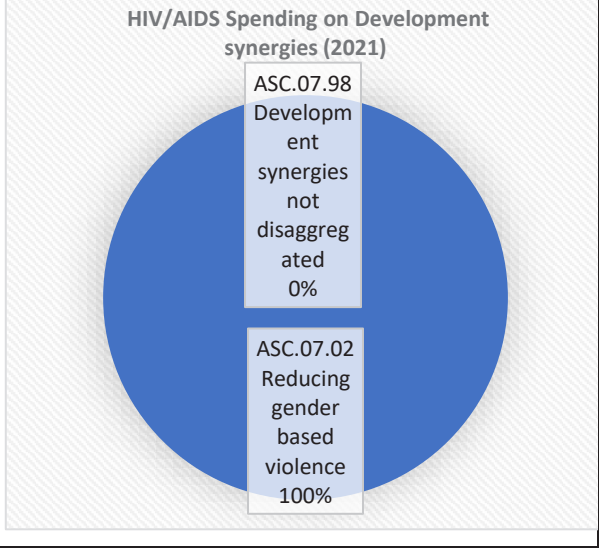


Figure 32.d: Year 2021



HIV related research

Table 19: Breakdown of HIV related research spending (2019-2021)

HIV-related research (paid by earmarked HIV funds)	2019	%	2020	%	2021	%	TOTAL	%
ASC.08.03 Epidemiological research	61, 858	100.00%	60, 484	15.89%	50, 035	15.63%	172, 377	22.60%
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type		0.00%	320, 071	84.11%	270, 144	84.37%	590, 215	77.40%
TOTAL	**61, 858**	**100.00%**	**380, 555**	**100.00%**	**320, 179**	**100.00%**	**762, 592**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, HIV and AIDS-related research activities not disaggregated by type took the largest spending, at 77 per cent of share, followed by Epidemiological research, at 23 per cent of share. (See figure 33.a).

Trend analysis from 2019 to 2021

Between 2019 and 2020, trend on HIV and AIDS-related research activities not disaggregated by type shows that the denominator is zero in 2019 (there were no expenses) and, therefore, the calculation of the evolution is not possible.

Between 2020 and 2021, spending decreased by 16 per cent and between 2019 and 2021, the denominator is zero in 2019 (there were no expenses) and, therefore, the calculation of the evolution is not possible.

Between 2019 and 2020, expenditure on Epidemiological research decreased by two per cent. Between 2020 and 2021, spending decreased by 17 per cent and between 2019 and 2021, expenditure decreased by 19 per cent.

Analysis of shares in annual spending

In 2019, the shares show that spending on Epidemiological research took the largest share, at 100 per cent. HIV and AIDS-related research activities not disaggregated by type accounted for zero per cent of share. (see figure 33.b).

In 2020, HIV and AIDS-related research activities not disaggregated by type took the largest spending, at 84 per cent of share, followed by Epidemiological research at 16 per cent of share (see figure 33.c).

In 2021, HIV and AIDS-related research activities not disaggregated by type took the largest spending, at 84 per cent of share, followed by Epidemiological research at 16 per cent of share (see figure 33.d).

The figure below illustrates this analysis:

Figure 33: Share of HIV related research spending

Figure 33.a: Total spending (2019-2021)

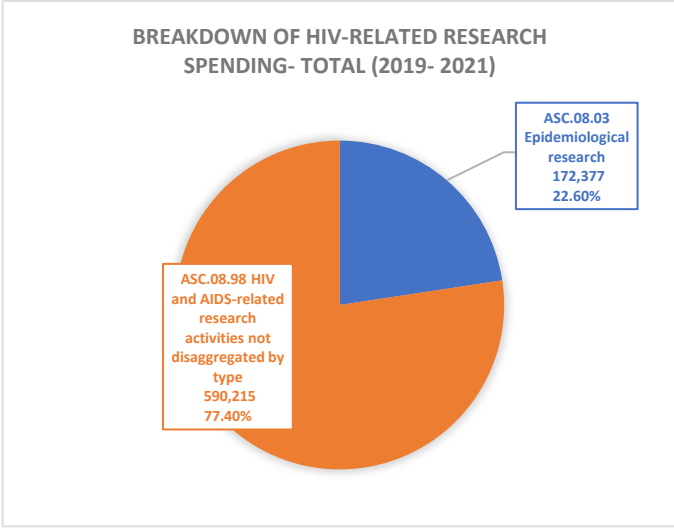


Figure 33.b: Year 2019

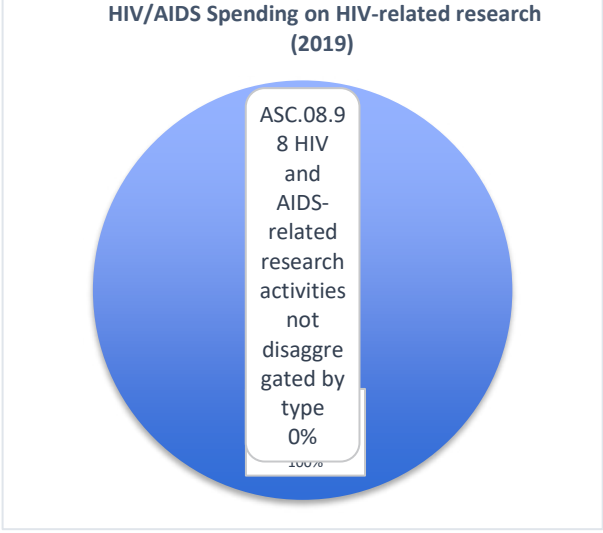


Figure 33.c: Year 2020

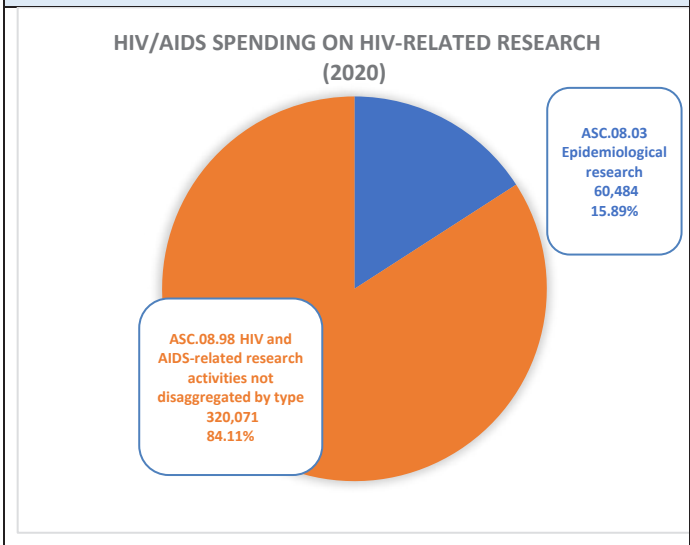
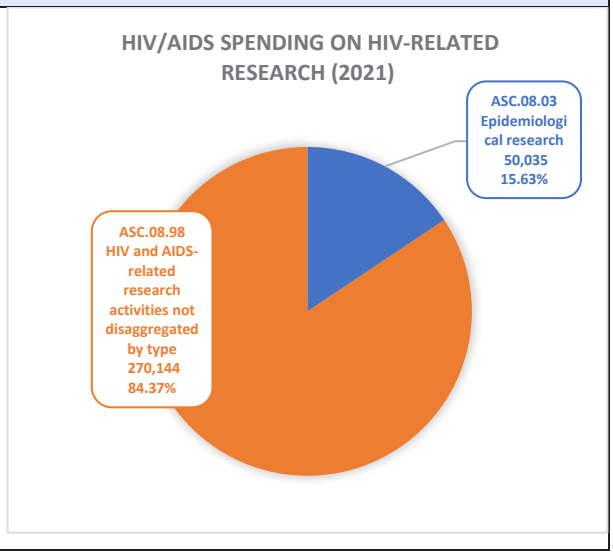


Figure 33.d: Year 2021



3.2.5.2 Beneficiary population spending

Table 20: Breakdown of beneficiary population spending (2019- 2021)

Beneficiary Populations	2019	%	2020	%	2021	%	TOTAL	%
BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)	246 842 890	54.82%	254 901 719	51.56%	306 625 657	60.79%	808 370 266	55.79%
BP.02 Key populations	4 769 869	1.06%	5 992 776	1.21%	17 418 603	3.45%	28 181 248	1.94%
BP.03 Vulnerable, accessible and other target populations	32 821 917	7.29%	15 113 099	3.06%	28 692 410	5.69%	76 627 426	5.29%
BP.04 General population	50 349 602	11.18%	69 756 793	14.11%	42 044 161	8.34%	162 150 556	11.19%
BP.05 Non-targeted interventions	113 404 077	25.18%	148 585 594	30.06%	109 597 866	21.73%	371 587 536	25.64%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	2 109 098	0.47%		0.00%	33 369	0.01%	2 142 467	0.15%
TOTAL	**450 297 453**	**100.00%**	**494 349 981**	**100.00%**	**504 412 065**	**100.00%**	**1 449 059 499**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, people living with HIV (regardless of having a medical or clinical diagnosis of AIDS) accounted for 56 per cent of total expenditure, followed by non-targeted interventions at 26 per cent of share. The third largest expenditure was on vulnerable, accessible and other target populations with five per cent of share. The fourth was key populations with two per cent of share and the fifth was specific targeted populations, not elsewhere classified, which accounted for 0.15 per cent of share (see figure 34.a).

As can be shown, the epidemic vectors (key populations) did not even benefit from three per cent of the total expenditure. Resource allocation should increasingly be evidence-based.

Trend analysis from 2019 to 2021

Between 2019 and 2020, spending on people living with HIV increased by **three per cent**. Between 2021 and 2020, spending increased by **20 per cent** and between 2019 and 2021, expenditure increased by **24 per cent**.

Between 2019 and 2020, expenditure on non-targeted interventions increased by **31 per cent.** Between 2020 and 2021, spending decreased by **26 per cent** and between 2019 and 2021, expenditure decreased by **three per cent**.

Between 2019 and 2020, expenditure on vulnerable, accessible and other target populations decreased by **54 per cent.** Between 2020 and 2021, spending increased by **90 per cent** and between 2019 and 2021, expenditure decreased by **13 per cent**.

Between 2019 and 2020, expenditure on key populations increased by **26 per cent.** Between 2020 and 2021, spending increased by **191 per cent** and between 2019 and 2021, expenditure decreased by **265 per cent**.

Between 2019 and 2020, expenditure on specific targeted populations not elsewhere classified decreased by **100 per cent.** Between 2020 and 2021, there was no spending in 2020 and between 2019 and 2021, expenditure decreased by **98 per cent**.

Analysis of shares in annual spending

In 2019, the shares show that spending on people living with HIV represented **55 per cent** of shares followed by non-targeted interventions with **25 per cent** of shares. The third largest expenditure was on general population with **11 per cent** of shares. The fourth largest expenditure was on vulnerable, accessible and other target populations with **seven per cent** of share. The fifth largest expenditure was on key populations, with **one per cent** of share. The sixth largest expenditure was on specific targeted populations not elsewhere classified, with **0.47 per cent** of share (see figure 34.b).

In 2020, the shares show that spending on people living with HIV represented **52 per cent** of shares followed by non-targeted interventions, with **30 per cent** of shares. The third largest expenditure was on general population with **14 per cent** of shares. The fourth largest expenditure was on vulnerable, accessible and other target populations, with **three per cent** of share. The fifth largest expenditure was on key populations, with **one per cent** of share. Specific targeted populations not elsewhere classified accounted for **zero per cent** of share (see figure 34.c).

In 2021, the shares show that spending on people living with HIV represented **61 per cent** of shares, followed by non-targeted interventions, with **22 per cent** of shares. The third largest expenditure was on general population, with **eight per cent** of shares. The fourth largest expenditure was on vulnerable, accessible and other target populations, with **six per cent** of share. The fifth largest expenditure was on key populations, with **three per cent** of share. The sixth largest expenditure was on specific targeted populations, not elsewhere classified, with **0.0 per cent%** of share (see figure 34.d).

The figure below illustrates this analysis:

Figure 34: Breakdown of beneficiary population spending (2019- 2021)

Figure 34.a: Total spending (2019-2021)

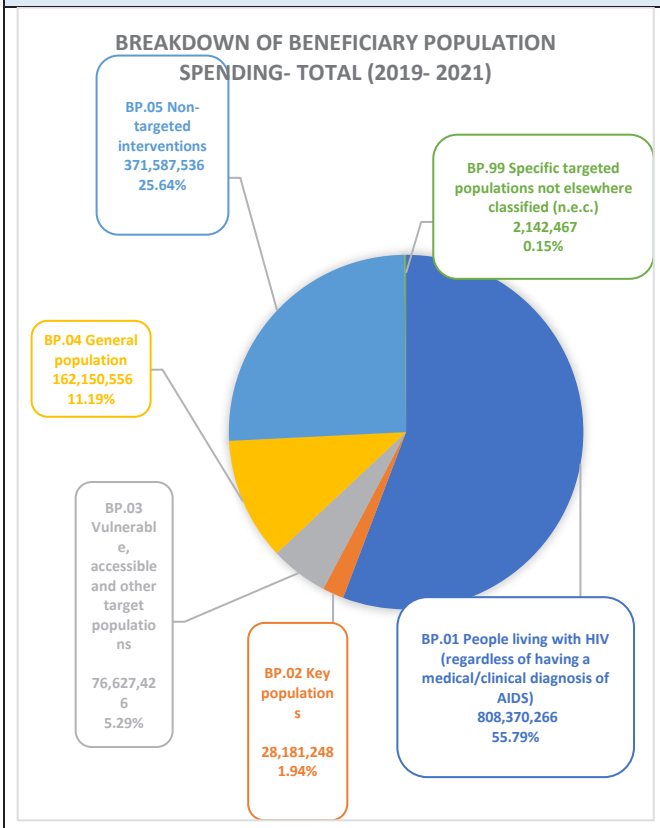


Figure 34.b: Year 2019

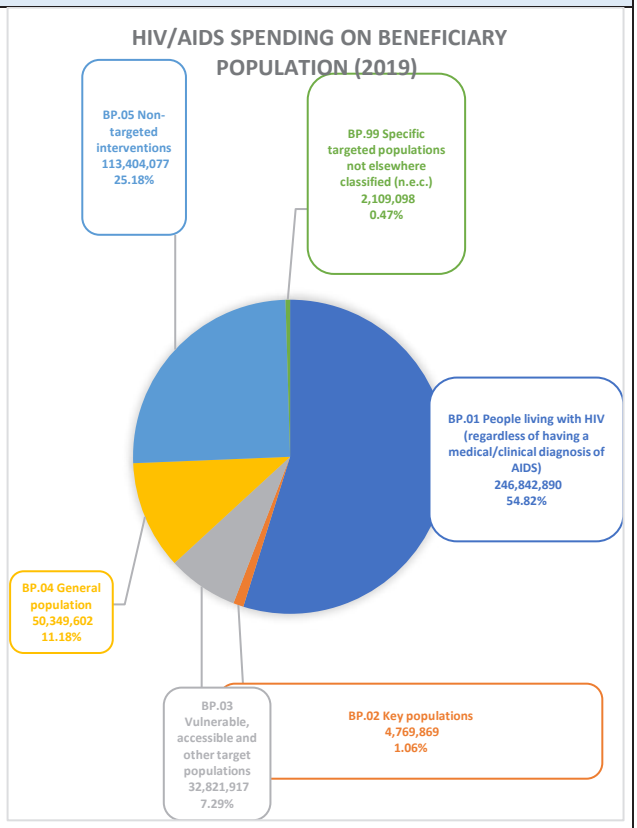


Figure 34.c: Year 2020

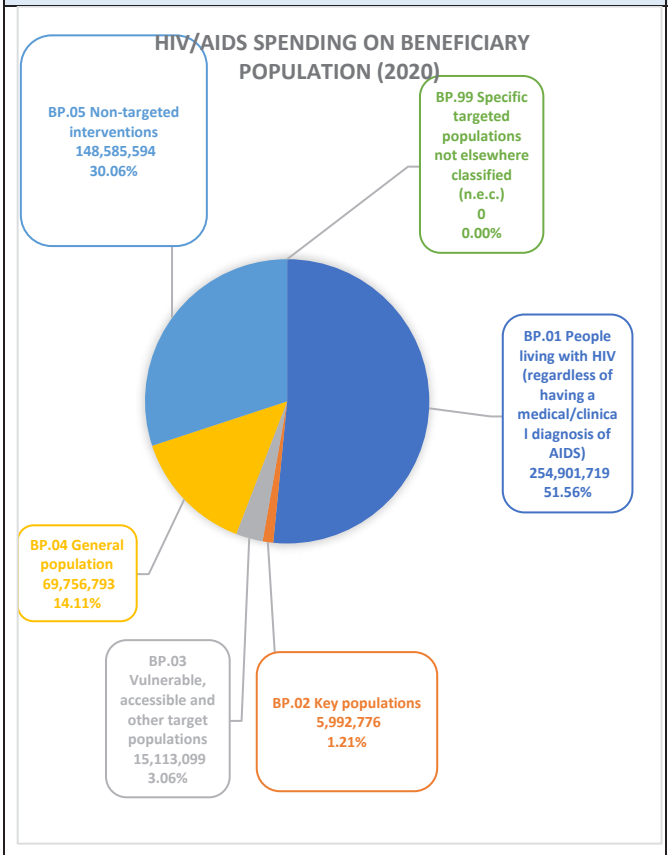
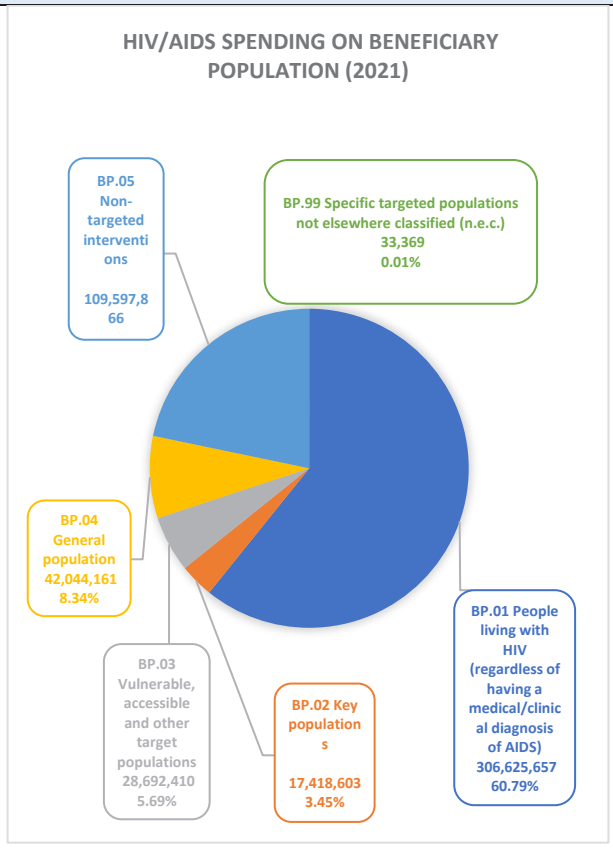


Figure 34.d: Year 2021



4. DIFFICULTIES ENCOUNTERED AND CHALLENGES

4.1 Difficulties

The following difficulties were encountered during the preparation of this report:

- certain implementation structures were confusing NASA with audit, leading to the protection of financial data and making it difficult to access the required data during the data collection phase;
- delay in the transmission of data by certain data providers; and
- mobility of certain data providers, who were not sufficiently available at the time of data collection;
- the new planning and reporting system for Government which did not allow for expenditures to be disaggregated to a level sufficient to analyse expenditure categories. This led to the use of estimate of expenditures for the years 2020 and 2021 based on the share of expenditure for the year 2019.

4.2 Challenges

For the future, several challenges remain:

- Capacity building of finance officers or accountants of various structures on data filling canvas and on the NASA methodology and classification;
- advocacy with the various structures for the timely supply of data;
- wide distribution of this report at national and international level;
- institutionalisation of NASA in Zambia and sustainability of the activity; and
- establishment of a team of national experts and the continuous strengthening of their capacities.

5. RECOMMENDATIONS

In order to help the national programme in decision-making, with a view to improving results for the coming years and in view of the results of this exercise to estimate resources and expenditure for the fight against HIV, AIDS and STIs and the difficulties inherent in the execution of the study, the following recommendations are made:

Health Accounts

i. As noted under challenges, it was not possible to derive Government HIV expenditure data by intervention. This is due to the current Government planning and budgeting system. For HIV expenditure, it may be necessary to provide the framework for resource tracking at intervention level by developing a National Operational Plan for the NASF, which will provide the basis for tracking resources at intervention level. This will also enhance resource allocation once there is visibility regarding where resources are spent.
ii. Use NASA data to determine the comprehensiveness and robustness of the national HIV and AIDS strategic plan and framework. Use NASA data for priority setting in HIV and AIDS planning processes.

Public Spending

i. Though there is increased Government spending on health and HIV national response, clearly demonstrating commitment towards increased resource allocation and the achievement of the Abuja target, more still needs to be done in order to reduce dependence on donor funding. An exit strategy for reducing donor funding and achieving sustainability needs to be developed.
ii. Direct actors and development partners towards the financing of the priority areas of intervention of the NASF 2020-2023.
iii. Intensify advocacy with technical and financial partners, the Government and the private sector so that they invest more in financing the national response by favouring the population-location approach.

NASA Processes

i. Recommendations for the NASA processes include the following:
ii. Institutionalise the NASA process in Zambia to ease data collection and reporting on HIV and AIDS spending;
iii. Allocate sufficient time to the planning phase of the data collection to facilitate analysis and understanding of how expenditure data is organised, stored and reported by different implementers and stakeholders, before designing and developing the data collection plan. This will reduce the proportion of expenditure that cannot be disaggregated for various reasons and reported in .98 and .99 codes;
iv. Regularly organise capacity building for data collection agents and managers of structures that support NAC in the provision of HIV expenditure data. These are particularly the structures involved in the response to HIV and AIDS, especially the priority actors the coordinators; monitoring-evaluation managers; and financial managers of structures at both national and district levels;
v. Expand the number and build the capacity of the national team on the mastery of the NASA RTT3 software (national and district);

vi. Raise awareness, and advocate to structures that hold the necessary data, so that they compile and transmit the data within the set time limits;
vii. Develop innovative ways of compelling the private sector to report HIV and AIDS spending, such as tying the issuance of annual licences to HIV and AIDS reporting as a matter of compliance; and
viii. Take the necessary steps to popularise NASA results.

6. CONCLUSION

The NASA 2019-2021 study was conducted through a participatory and inclusive process. There was involvement of the public sector, civil society, the private sector and financial partners. The Report highlights the overall level of funding for the national response, giving a detailed description of the destination and use of resources. In summary, this report presents the financing situation of the HIV and AIDS response in Zambia for the period 2019 to 2021.

In spite of the few limitations of the study, NASA provides important details concerning the financing of the national HIV and AIDS response. It is an information tool for monitoring and evaluating financial flows and advocacy. This tool makes it possible to carry out regular annual financial monitoring of the flow of resources and expenditure in the response to HIV and AIDS. NASA is an important tool in the preparation for NASF review and development of a grant application to be submitted to GFATM.

Despite the difficulties encountered in the process, the collection of financial data made it possible to successfully estimate the flow of resources and expenditure related to AIDS for the period 2019 to 2021.

There was remarkable effort in financing by the external partners (over **91%)** but efforts are still to be made by the external partners, the Government and the private sector because despite the efforts of each other, there is a gap between the funding needs of the National Strategic Framework (NSF 2020-2023) and the resources used in the response to HIV and AIDS. There is also a good allocation of resources towards people living with HIV. However, the situation remains worrying with regard to key populations whose resource allocations remains very low. This has also been observed globally in spending on prevention, which is below the UNAIDS standard.

The results from NASA will be a guide for better targeting of interventions and better allocation of resources at all levels. These results should help national authorities to make efficient use of the available resources, in the midst of scarcity and changing priorities at the international level.

ANNEXES

Annex 1: NASA Classifications by vector

Table 1.a: Financing Entity (FE)

NASA Codes	Financing entity
FE.01.01.01	Central government
FE.01.01.02	State/provincial government
FE.01.01.03	Local/municipal government
FE.01.02	Social security institutions
FE.01.99	Other public n.e.c.
FE.02.01	Domestic corporations
FE.02.02	Households
FE.02.03	Domestic not-for-profit institutions (other than social insurance)
FE.02.99	Other Private financing n.e.c.
FE.03.01.01	Government of Australia
FE.03.01.02	Government of Austria
FE.03.01.03	Government of Belgium
FE.03.01.04	Government of Brazil
FE.03.01.05	Government of Canada
FE.03.01.06	Government of Denmark
FE.03.01.07	Government of Finland
FE.03.01.08	Government of France
FE.03.01.09	Government of Germany
FE.03.01.10	Government of Greece
FE.03.01.11	Government of India
FE.03.01.12	Government of Ireland
FE.03.01.13	Government of Italy
FE.03.01.14	Government of Japan
FE.03.01.15	Government of Korea
FE.03.01.16	Government of Luxembourg
FE.03.01.17	Government of Netherlands
FE.03.01.18	Government of New Zealand
FE.03.01.19	Government of Norway
FE.03.01.20	Government of People's Republic of China
FE.03.01.21	Government of Poland
FE.03.01.22	Government of Portugal
FE.03.01.23	Government of Russian Federation
FE.03.01.24	Government of South Africa

NASA Codes	Financing entity
FE.03.01.25	Government of Spain
FE.03.01.26	Government of Sweden
FE.03.01.27	Government of Switzerland
FE.03.01.28	Government of United Arab Emirates
FE.03.01.29	Government of United Kingdom
FE.03.01.30	Government of United States
FE.03.01.99	Other government(s) /other bilateral agencies n.e.c.
FE.03.02.01	Bureau of the Economic and Social Council (ECOSOC)
FE.03.02.02	European Commission
FE.03.02.03	Food and Agriculture Organization of the United Nations (FAO)
FE.03.02.04	International Labour Organization (ILO)
FE.03.02.05	International Organization for Migration (IOM)
FE.03.02.06	Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.)
FE.03.02.07	The Global Fund to Fight AIDS, Tuberculosis and Malaria
FE.03.02.08	UNAIDS Secretariat
FE.03.02.09	United Nations Children's Fund (UNICEF)
FE.03.02.10	United Nations Development Fund for Women (UNIFEM)
FE.03.02.11	United Nations Development Programme (UNDP)
FE.03.02.12	United Nations Educational, Scientific and Cultural Organization (UNESCO)
FE.03.02.13	United Nations High Commissioner for Refugees (UNHCR)
FE.03.02.14	United Nations Human Settlements Programme (UN-HABITAT)
FE.03.02.15	United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms
FE.03.02.16	United Nations Office on Drugs and Crime (UNODC)
FE.03.02.17	United Nations Population Fund (UNFPA)
FE.03.02.18	World Bank Group (WB)
FE.03.02.19	World Food Programme (WFP)
FE.03.02.20	World Health Organization (WHO)
FE.03.02.99	Other Multilateral organisations n.e.c.
FE.03.03.01	International HIV/AIDS Alliance
FE.03.03.02	ActionAid
FE.03.03.03	Aga Khan Foundation
FE.03.03.04	Association François-Xavier Bagnoud
FE.03.03.05	Bernard van Leer Foundation
FE.03.03.06	Bill and Melinda Gates Foundation
FE.03.03.07	Bristol-Myers Squibb Foundation
FE.03.03.08	Care International

NASA Codes	Financing entity
FE.03.03.09	Caritas Internationalis/Catholic Relief Services
FE.03.03.10	Deutsche Stiftung Weltbevölkerung
FE.03.03.11	Diana Princess of Wales Memorial Fund
FE.03.03.12	Elizabeth Glaser Paediatric AIDS Foundation
FE.03.03.13	European Foundation Centre
FE.03.03.14	Family Health International
FE.03.03.15	Foundation Mérieux
FE.03.03.16	Health Alliance International
FE.03.03.17	Helen K. and Arthur E. Johnson Foundation
FE.03.03.18	International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies
FE.03.03.19	King Baudouin Foundation
FE.03.03.20	Médecins sans Frontières
FE.03.03.21	Merck & Co., Inc
FE.03.03.22	Plan International
FE.03.03.23	PSI (Population Services International)
FE.03.03.24	SIDACTION (mainly Francophone countries)
FE.03.03.25	The Clinton Foundation
FE.03.03.26	The Ford Foundation
FE.03.03.27	The Henry J. Kaiser Family Foundation
FE.03.03.28	The Nuffield Trust
FE.03.03.29	The Open Society Institute/Soros Foundation
FE.03.03.30	The Rockefeller Foundation
FE.03.03.31	United Nations Foundation
FE.03.03.32	Wellcome Trust
FE.03.03.33	World Vision
FE.03.03.34	International Planned Parenthood Federation
FE.03.03.35	Order of Malta
FE.03.03.36	PATH
FE.03.03.37	Chemonics International
FE.03.03.38	Pact
FE.03.03.39	Management Sciences for Health
FE.03.03.40	FHI 360
FE.03.03.99	Other International not-for-profit organisations and foundations n.e.c.
FE.03.04	International for-profit organisations
FE.03.99	Other International n.e.c.
FE.99	Financial entity n.e.c.

Table 1.b: Revenue (REV)

NASA Codes	REVENUE (REV)
REV.01.01	Internal transfers and grants
REV.01.02	Transfers by government to social health insurance on behalf of specific groups
REV.01.03	Subsidies (Transfers from government domestic revenues to for-profit organisation financing schemes)
REV.01.04	Transfers from government domestic revenues to non-profit organisation financing schemes
REV.01.98	Transfers from government domestic revenue including reimbursable loans not disaggregated
REV.01.99	Transfers from government domestic revenue including reimbursable loans n.e.c.
REV.02	Transfers distributed by government from foreign origin
REV.03.01	Social insurance contributions from employees
REV.03.02	Social insurance contributions from employers
REV.03.03	Social insurance contributions from self-employed
REV.03.98	Social insurance contributions not disaggregated
REV.03.99	Social insurance contributions n.e.c.
REV.04.01	Compulsory prepayment from individuals/households
REV.04.02	Compulsory prepayment from employers
REV.04.98	Compulsory prepayment not disaggregated
REV.04.99	Compulsory prepayment n.e.c.
REV.05.01	Voluntary prepayment from individuals/households
REV.05.02	Voluntary prepayment from employers
REV.05.98	Voluntary prepayment not disaggregated
REV.05.99	Voluntary prepayment n.e.c.
REV.06.01	Other revenues from households n.e.c.
REV.06.02	Other revenues from corporations n.e.c.
REV.06.03	Other revenues from non-profit institutions n.e.c.
REV.06.98	Other domestic revenues not disaggregated
REV.06.99	Other domestic revenues n.e.c.
REV.07.01.01	Direct bilateral financial transfers
REV.07.01.02	Direct multilateral financial transfers
REV.07.01.98	Direct foreign financial transfers not disaggregated
REV.07.01.99	Direct foreign financial transfers n.e.c.
REV.07.02.01.01	Direct bilateral aid in goods
REV.07.02.01.02	Direct multilateral aid in goods
REV.07.02.01.03	Other direct foreign aid in goods
REV.07.02.02	Direct foreign aid in kind: services (including TA)
REV.07.02.98	Other direct foreign aid in kind not disaggregated
REV.07.02.99	Other direct foreign aid in kind n.e.c.
REV.07.98	Other direct foreign transfers not disaggregated

NASA Codes	REVENUE (REV)
REV.07.99	Other direct foreign transfers n.e.c.
REV.98	Revenues of health care financing schemes not disaggregated
REV.99	Other revenues of health care financing schemes n.e.c.

Table 1.c: Financing Schemes (SCH)

NASA Codes	FINANCING SCHEMES (SCH)
SCH.01.01.01	Central government schemes
SCH.01.01.02	State/regional/local government schemes
SCH.01.01.98	Government schemes not disaggregated
SCH.01.01.99	Government schemes n.e.c.
SCH.01.02.01.01	Private sector employee social health insurance schemes
SCH.01.02.01.02	Government employee social health insurance schemes
SCH.01.02.01.98	Social health insurance scheme not related to type of employment or not disaggregated
SCH.01.02.01.99	Social health insurance scheme n.e.c.
SCH.01.02.02	Compulsory private insurance schemes
SCH.01.02.98	Compulsory contributory health insurance schemes not disaggregated
SCH.01.02.99	Other compulsory contributory health insurance schemes n.e.c.
SCH.01.03	Compulsory Medical Saving Accounts (CMSA)
SCH.01.98	Government schemes not disaggregated
SCH.01.99	Other government schemes not elsewhere classified (n.e.c.)
SCH.02.01.01.01	Employer-based insurance (other than enterprises schemes)
SCH.02.01.01.02	Government-based voluntary insurance
SCH.02.01.01.98	Primary coverage schemes not disaggregated
SCH.02.01.01.99	Other primary coverage schemes n.e.c
SCH.02.01.02	Community-based insurance schemes and complementary/supplementary insurance schemes
SCH.02.01.03	Complementary/supplementary insurance (excluding Community-based insurance)
SCH.02.01.98	Voluntary insurance schemes not disaggregated
SCH.02.01.99	Other voluntary insurance schemes not elsewhere classified (n.e.c.)
SCH.02.02.01	Not-for-profit organisation schemes (excluding SCH.2.2.2)
SCH.02.02.02	Resident foreign agencies schemes
SCH.02.02.98	Not-for-profit organisation schemes not disaggregated
SCH.02.02.99	Not-for-profit organisation schemes n.e.c.
SCH.02.03.01	Enterprises (except health care providers) schemes
SCH.02.03.02	Health care providers schemes
SCH.02.03.98	For-profit enterprise schemes not disaggregated
SCH.02.03.99	For-profit enterprises not elsewhere classified (n.e.c.)
SCH.03.01	Out-of-pocket excluding cost-sharing

NASA Codes	FINANCING SCHEMES (SCH)
SCH.03.02.01	Cost sharing with government schemes and compulsory contributory health insurance schemes
SCH.03.02.02	Cost sharing with voluntary insurance schemes
SCH.03.98	Out-of-pocket not disaggregated
SCH.03.99	Out-of-pocket not elsewhere classified (n.e.c.)
SCH.04.01.01	Compulsory health insurance schemes (non-resident)
SCH.04.01.02	Other compulsory schemes (non-resident)
SCH.04.02.01	Voluntary health insurance schemes (non-resident)
SCH.04.02.02.01	Philanthropy/international NGOs schemes
SCH.04.02.02.02	Foreign development agencies schemes
SCH.04.02.02.03	Schemes of enclaves (e.g. international organisations or embassies)
SCH.04.98	Compulsory schemes (non-resident) not disaggregated
SCH.04.99	Compulsory schemes (non-resident) n.e.c.

Table 1.d: Financing Agent – Purchaser (FAP)

NASA Codes	Financing Agents - Purchaser
FAP.01.01.01.01	Ministry of Health (or equivalent sector entity)
FAP.01.01.01.02	Ministry of Education (or equivalent sector entity)
FAP.01.01.01.03	Ministry of Social Development (or equivalent sector entity)
FAP.01.01.01.04	Ministry of Defence (or equivalent sector entity)
FAP.01.01.01.05	Ministry of Finance (or equivalent sector entity)
FAP.01.01.01.06	Ministry of Labour (or equivalent sector entity)
FAP.01.01.01.07	Ministry of Justice (or equivalent sector entity)
FAP.01.01.01.08	Other ministries (or equivalent sector entities)
FAP.01.01.01.09	Prime Minister's or President's office
FAP.01.01.01.10	National AIDS Commission
FAP.01.01.01.99	Central or federal authorities' entities n.e.c.
FAP.01.01.02.01	Ministry of Health (or equivalent state sector entity)
FAP.01.01.02.02	Ministry of Education (or equivalent state sector entity)
FAP.01.01.02.03	Ministry of Social Development (or equivalent state sector entity)
FAP.01.01.02.04	Other ministries (or equivalent state sector entities)
FAP.01.01.02.05	Executive Office (or office of the head of the State/Province/Department)
FAP.01.01.02.06	State/Province/Department AIDS Commission
FAP.01.01.02.99	State/provincial/regional entities n.e.c.
FAP.01.01.03.01	Department of Health (or equivalent local sector entity)
FAP.01.01.03.02	Department of Education (or equivalent local sector entity)
FAP.01.01.03.03	Department of Social Development (or equivalent local sector entity)
FAP.01.01.03.04	Executive office (or office of the head of the local/municipal government)

NASA Codes	Financing Agents - Purchaser
FAP.01.01.03.05	Local/municipal government AIDS commission
FAP.01.01.03.99	Other local/municipal entities n.e.c.
FAP.01.02	Public social security
FAP.01.03	Government employee insurance programmes
FAP.01.04	Parastatal organizations
FAP.01.99	Other public financing agents n.e.c.
FAP.02.01	Private social security
FAP.02.02	Private employer insurance programmes
FAP.02.03	Private insurance enterprises (other than social insurance)
FAP.02.04	Private households' (out-of-pocket payments)
FAP.02.05	Not-for-profit institutions (other than social insurance)
FAP.02.06	Corporations other than providers of health services (non-parastatal)
FAP.02.99	Other private financing agents n.e.c.
FAP.03.01	Country offices of bilateral agencies managing external resources and fulfilling financing agent roles
FAP.03.02.01	Bureau of the Economic and Social Council (ECOSOC)
FAP.03.02.02	European Commission
FAP.03.02.03	Food and Agriculture Organization of the United Nations (FAO)
FAP.03.02.04	International Labour Organization (ILO)
FAP.03.02.05	International Organization for Migration (IOM)
FAP.03.02.06	Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.)
FAP.03.02.07	UNAIDS Secretariat
FAP.03.02.08	United Nations Children's Fund (UNICEF)
FAP.03.02.09	UN Women
FAP.03.02.10	United Nations Development Programme (UNDP)
FAP.03.02.11	United Nations Educational, Scientific and Cultural Organization (UNESCO)
FAP.03.02.12	United Nations High Commissioner for Refugees (UNHCR)
FAP.03.02.13	United Nations Human Settlements Programme (UN-HABITAT)
FAP.03.02.14	United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms
FAP.03.02.15	United Nations Office on Drugs and Crime (UNODC)
FAP.03.02.16	United Nations Population Fund (UNFPA)
FAP.03.02.17	World Bank Group
FAP.03.02.18	World Food Programme (WFP)
FAP.03.02.19	World Health Organization (WHO)
FAP.03.02.99	Other Multilateral entities n.e.c.
FAP.03.03.01	International HIV/AIDS Alliance
FAP.03.03.02	ActionAid

NASA Codes	Financing Agents - Purchaser
FAP.03.03.03	Aga Khan Foundation
FAP.03.03.04	Association François-Xavier Bagnoud
FAP.03.03.05	Bernard van Leer Foundation
FAP.03.03.06	Bill and Melinda Gates Foundation
FAP.03.03.07	Bristol-Myers Squibb Foundation
FAP.03.03.08	Care International
FAP.03.03.09	Caritas Internationalis/Catholic Relief Services
FAP.03.03.10	Deutsche Stiftung Weltbevölkerung
FAP.03.03.11	Diana Princess of Wales Memorial Fund
FAP.03.03.12	Elizabeth Glaser Paediatric AIDS Foundation
FAP.03.03.13	European Foundation Centre
FAP.03.03.14	Family Health International
FAP.03.03.15	Foundation Mérieux
FAP.03.03.16	American International Health Alliance
FAP.03.03.17	Helen K. and Arthur E. Johnson Foundation
FAP.03.03.18	International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies
FAP.03.03.19	King Baudouin Foundation
FAP.03.03.20	Médecins sans Frontières
FAP.03.03.21	Merck & Co., Inc
FAP.03.03.22	Plan International
FAP.03.03.23	PSI (Population Services International)
FAP.03.03.24	SIDACTION (mainly Francophone countries)
FAP.03.03.25	The Clinton Foundation
FAP.03.03.26	The Ford Foundation
FAP.03.03.27	The Henry J. Kaiser Family Foundation
FAP.03.03.28	The Nuffield Trust
FAP.03.03.29	The Open Society Institute/Soros Foundation
FAP.03.03.30	The Rockefeller Foundation
FAP.03.03.31	United Nations Foundation
FAP.03.03.32	Wellcome Trust
FAP.03.03.33	World Vision
FAP.03.03.34	International Planned Parenthood Federation
FAP.03.03.35	Order of Malta
FAP.03.03.36	PATH
FAP.03.03.37	Chemonics International
FAP.03.03.38	Pact
FAP.03.03.39	Management Sciences for Health

NASA Codes	Financing Agents - Purchaser
FAP.03.03.40	FHI 360
FAP.03.03.99	Other International not-for-profit organizations n.e.c.
FAP.03.04	Projects within Universities
FAP.03.05	International for-profit organisations
FAP.03.99	Other international financing agents n.e.c.
FAP.99	FAP n.e.c.

Table 1.e: Providers of Services (PS)

NASA Codes	Providers of Services (PS)
PS.01.01.01	Hospitals (public)
PS.01.01.02	Ambulatory care (public)
PS.01.01.03	Mental health and substance abuse facilities (public)
PS.01.01.04	Laboratory and imaging facilities (public)
PS.01.01.05	Blood banks (public)
PS.01.01.06	Ambulance services (public)
PS.01.01.07	Pharmacies and providers of medical goods (public)
PS.01.01.08	Traditional or non-allopathic care providers (public)
PS.01.01.09.01	Primary education (public)
PS.01.01.09.02	Secondary education (public)
PS.01.01.09.03	Higher education (public)
PS.01.01.09.98	Public schools and training centres not disaggregated
PS.01.01.09.99	Public schools and training centres n.e.c.
PS.01.01.10	Foster homes/shelters (public)
PS.01.01.11	Orphanages (public)
PS.01.01.12	Research institutions (public)
PS.01.01.13.01	National AIDS Coordinating Authority (NACs)
PS.01.01.13.02	Departments inside the Ministry of Health or equivalent
PS.01.01.13.03	Departments inside the Ministry of Education or equivalent
PS.01.01.13.04	Departments inside the Ministry of Social Development or equivalent
PS.01.01.13.05	Departments inside the Ministry of Defence or equivalent
PS.01.01.13.06	Departments inside the Ministry of Finance or equivalent
PS.01.01.13.07	Departments inside the Ministry of Labour or equivalent
PS.01.01.13.08	Departments inside the Ministry of Justice or equivalent
PS.01.01.13.98	Government entities not disaggregated
PS.01.01.13.99	Government entities n.e.c.
PS.01.01.98	Governmental organisations not disaggregated
PS.01.01.99	Governmental organisations n.e.c.

NASA Codes	Providers of Services (PS)
PS.01.02.01	Hospitals (parastatal)
PS.01.02.02	Ambulatory care (parastatal)
PS.01.02.03	Mental health and substance abuse facilities (parastatal)
PS.01.02.04	Laboratory and imaging facilities (parastatal)
PS.01.02.05	Blood banks (parastatal)
PS.01.02.06	Ambulance services (parastatal)
PS.01.02.07	Pharmacies and providers of medical goods (parastatal)
PS.01.02.08	Traditional or non-allopathic care providers (parastatal)
PS.01.02.09.01	Primary education (parastatal)
PS.01.02.09.02	Secondary education (parastatal)
PS.01.02.09.03	Higher education (parastatal)
PS.01.02.09.98	Parastatal schools and training facilities not disaggregated
PS.01.02.09.99	Parastatal schools and training facilities n.e.c.
PS.01.02.10	Foster homes/shelters (parastatal)
PS.01.02.11	Parastatal orphanages
PS.01.02.12	Parastatal research institutions
PS.01.02.98	Parastatal organisations not disaggregated
PS.01.02.99	Parastatal organisations n.e.c.
PS.01.98	Public sector providers not disaggregated
PS.01.99	Public sector providers n.e.c.
PS.02.01.01.01	Hospitals (private non-profit non-faith based)
PS.02.01.01.02	Ambulatory care (private non-profit non-faith based)
PS.02.01.01.03	Mental health and substance abuse facilities (private non-profit non-faith based)
PS.02.01.01.04	Laboratory and imaging facilities (private non-profit non-faith based)
PS.02.01.01.05	Blood banks (private non-profit non-faith based)
PS.02.01.01.06	Ambulance services (private non-profit non-faith based)
PS.02.01.01.07	Pharmacies and providers of medical goods (private non-profit non-faith based)
PS.02.01.01.08	Traditional or non-allopathic care providers (private non-profit non-faith based)
PS.02.01.01.09.01	Primary education (private non-profit non-faith based)
PS.02.01.01.09.02	Secondary education (private non-profit non-faith based)
PS.02.01.01.09.03	Higher education (private non-profit non-faith based)
PS.02.01.01.09.98	Private non-profit non-faith based non-profit schools and training centres not disaggregated
PS.02.01.01.09.99	Private non-profit non-faith based non-profit schools and training centres n.e.c.
PS.02.01.01.10	Foster homes/shelters (private non-profit non-faith based)
PS.02.01.01.11	Orphanages (private non-profit non-faith based)
PS.02.01.01.12	Research institutions (private non-profit non-faith based)
PS.02.01.01.13	Self-help and informal community-based organizations (private non-profit non-faith based)

NASA Codes	Providers of Services (PS)
PS.02.01.01.14	Civil society organisations (private non-profit non-faith based)
PS.02.01.01.98	Other private non-profit non-faith-based providers not disaggregated
PS.02.01.01.99	Other private non-profit non-faith-based providers n.e.c.
PS.02.01.02.01	Hospitals (private non-profit faith based)
PS.02.01.02.02	Ambulatory care (private non-profit faith based)
PS.02.01.02.03	Mental health and substance abuse facilities (private non-profit faith based)
PS.02.01.02.04	Laboratory and imaging facilities (private non-profit faith based)
PS.02.01.02.05	Blood banks (private non-profit faith based)
PS.02.01.02.06	Ambulance services (private non-profit faith based)
PS.02.01.02.07	Pharmacies and providers of medical goods (private non-profit faith based)
PS.02.01.02.08	Traditional or non-allopathic care providers (private non-profit faith based)
PS.02.01.02.09.01	Primary education (private non-profit faith based)
PS.02.01.02.09.02	Secondary education (private non-profit faith based)
PS.02.01.02.09.03	Higher education (private non-profit faith based)
PS.02.01.02.09.98	Private non-profit faith-based schools and training centres not disaggregated
PS.02.01.02.09.99	Private non-profit faith-based schools and training centres n.e.c.
PS.02.01.02.10	Foster homes/shelters (private non-profit faith based)
PS.02.01.02.11	Orphanages (private non-profit faith-based)
PS.02.01.02.12	Self-help and informal community-based organisations (private non-profit faith-based)
PS.02.01.02.13	Civil society organisations (private non-profit faith based)
PS.02.01.02.98	Other non-profit faith-based private sector providers not disaggregated
PS.02.01.02.99	Other non-profit faith-based private sector providers n.e.c.
PS.02.01.98	Other non-profit private sector providers not disaggregated
PS.02.01.99	Other non-profit private sector providers n.e.c.
PS.02.02.01	Hospitals (profit-making private)
PS.02.02.02	Ambulatory care (profit-making private)
PS.02.02.03	Mental health and substance abuse facilities (profit-making private)
PS.02.02.04	Laboratory and imaging facilities (profit-making private)
PS.02.02.05	Blood banks (profit-making private)
PS.02.02.06	Ambulance services (profit-making private)
PS.02.02.07	Pharmacies and providers of medical goods (profit-making private)
PS.02.02.08	Traditional or non-allopathic care providers (profit-making private)
PS.02.02.09.01	Primary education (profit-making private)
PS.02.02.09.02	Secondary education (profit-making private)
PS.02.02.09.03	Higher education (profit-making private)
PS.02.02.09.98	Profit-making private schools and training centres not disaggregated
PS.02.02.09.99	Profit-making private schools and training centres n.e.c.

NASA Codes	Providers of Services (PS)
PS.02.02.10	Foster homes/shelters (profit-making private)
PS.02.02.11	Orphanages (profit-making private)
PS.02.02.12	Research institutions (profit-making private)
PS.02.02.13	Consultancy firms (profit-making private)
PS.02.02.98	Profit-making private sector providers not disaggregated
PS.02.02.99	Profit-making private sector providers n.e.c.
PS.02.98	Private sector providers not disaggregated
PS.02.99	Private sector providers n.e.c.
PS.03.01	Bilateral agencies
PS.03.02	Multilateral agencies
PS.03.03	International NGOs and foundations
PS.03.98	Bilateral, multilateral entities, international NGOs and foundations – in country offices not disaggregated
PS.03.99	Bilateral, multilateral entities, international NGOs and foundations – in country offices n.e.c.
PS.04	Rest-of-the world providers (activities undertaken outside the country)
PS.98	Providers not disaggregated
PS.99	Providers n.e.c.

Table 1.f: Service Delivery Modalities (SDM)

NASA Codes	Types of Service Delivery Modalities
SDM.01.01	Facility-based: Outpatient
SDM.01.02	Facility-based: Inpatient
SDM.01.03	Directly observed treatment (DOT)
SDM.01.98	Facility-based not disaggregated
SDM.01.99	Other facility-based n.e.c.
SDM.02.01	Community-based: centre
SDM.02.02	Community-based: pick up points (CPUP)
SDM.02.03	Community-based: automated distribution unit/dispensing machine
SDM.02.04	Community-based: mobile unit
SDM.02.05	Community-based: outreach
SDM.02.06	Community-based: home-based (including door-to-door)
SDM.02.07	HIV self-testing
SDM.02.98	Home and community based not disaggregated
SDM.02.99	Home and community based n.e.c.
SDM.03	Non applicable (ASC which does not have a specific SDM)
SDM.98	Modalities not disaggregated
SDM.99	Modalities n.e.c.

Table 1.g: Production Factors (PF)

NASA Codes	Production Factors
PF.01.02.02	Office utilities costs (electricity, water, heating, etc.)
PF.01.02.03	Travel expenditure
PF.01.02.04	Administrative and programme management costs
PF.01.02.98	Other current costs not disaggregated
PF.01.02.99	Other current costs n.e.c.
PF.01.03.01.01	Antiretroviral drugs
PF.01.03.01.02	Anti-tuberculosis drugs
PF.01.03.01.03	OST drugs
PF.01.03.01.04	STI drugs
PF.01.03.01.05	Hepatitis vaccines
PF.01.03.01.06	Hepatitis treatment drugs
PF.01.03.01.07	OI other than TB drugs
PF.01.03.01.98	Pharmaceuticals not disaggregated
PF.01.03.01.99	Pharmaceuticals n.e.c.
PF.01.03.02.01	Syringes and needles
PF.01.03.02.02	Condoms
PF.01.03.02.03	Lubricants
PF.01.03.02.98	Medical supplies not disaggregated
PF.01.03.02.99	Medical supplies n.e.c.
PF.01.03.03.01	HIV tests screening/diagnostics
PF.01.03.03.02	VL tests
PF.01.03.03.03	CD4 tests
PF.01.03.03.04	Diagnostic tests for STI (including rapid testing)
PF.01.03.03.05	Diagnostic tests for TB (including rapid testing)
PF.01.03.03.06	Diagnostic tests for hepatitis (including rapid testing)
PF.01.03.03.98	Reagents and materials not disaggregated
PF.01.03.03.99	Reagents and materials n.e.c.
PF.01.03.04.01	Food and nutrients
PF.01.03.04.02	Promotion and information materials
PF.01.03.04.98	Non-medical supplies not disaggregated
PF.01.03.04.99	Non-medical supplies n.e.c.
PF.01.03.05	Office Supplies
PF.01.03.98	Medical products and supplies not disaggregated
PF.01.03.99	Medical products and supplies n.e.c.
PF.01.04	Contracted external services
PF.01.05	Transportation related to beneficiaries

NASA Codes	Production Factors
PF.01.06	Housing/accommodation services for beneficiaries
PF.01.07	Financial support for beneficiaries
PF.01.08	Training- Training related per diems/transport/other costs
PF.01.09	Logistics of events, including catering services
PF.01.10.01	Financial intermediary services
PF.01.10.02	Indirect cost rate
PF.01.10.98	Indirect costs not disaggregated
PF.01.10.99	Indirect costs n.e.c
PF.01.98	Current direct and indirect expenditures not disaggregated
PF.01.99	Current direct and indirect expenditures n.e.c.
PF.02.01.01	Laboratory and other infrastructure upgrading
PF.02.01.02	Construction and renovation
PF.02.01.98	Building not disaggregated
PF.02.01.99	Building n.e.c.
PF.02.02	Vehicles
PF.02.03.01	Information technology (hardware and software)
PF.02.03.02	Laboratory and other medical equipment
PF.02.03.03	Non-medical equipment and furniture
PF.02.03.98	Other capital investment not disaggregated
PF.02.03.99	Other capital investment n.e.c.
PF.02.98	Capital expenditure not disaggregated
PF.02.99	Capital expenditure n.e.c.
PF.98	Production factors not disaggregated

Table 1.h: AIDS Spending Categories (ASC)

NASA Codes	Aids Spending Category (ASC)
ASC.01.01.01.01	Condom promotion and distribution as part of dedicated programmes for AGYW - only if earmarked HIV funds are spent
ASC.01.01.01.02	Youth-friendly SRH services for AGYW - only if earmarked HIV funds are spent
ASC.01.01.01.03	Behaviour change communication (BCC) as part of programmes for AGYW and their male partners - only if earmarked HIV funds are spent
ASC.01.01.01.04	Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent
ASC.01.01.01.98	Programmatic activities for AGYW not disaggregated by type
ASC.01.01.01.99	Other activities for AGYW n.e.c.
ASC.01.01.02.01.01	Condom and lubricant programmes as part of programmes for sex workers
ASC.01.01.02.01.02	STI/SRH services for sex workers (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.01.03	Peer education for sex workers - only if earmarked HIV funds are spent

NASA Codes	Aids Spending Category (ASC)
ASC.01.01.02.01.04	Community empowerment including prevention of violence against sex workers and legal support - only if earmarked HIV funds are spent
ASC.01.01.02.01.98	Programmatic activities for sex workers and their clients not disaggregated by type
ASC.01.01.02.01.99	Other programmatic activities for sex workers and their clients, n.e.c.
ASC.01.01.02.02.01	Condom and lubricant programmes for MSM
ASC.01.01.02.02.02	STI/SRH services for MSM (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.02.03	Behaviour change communication (BCC) as part of programmes for MSM
ASC.01.01.02.02.04	Empowerment including prevention of violence against MSM and legal support
ASC.01.01.02.02.98	Programmatic activities for MSM not disaggregated by type
ASC.01.01.02.02.99	Other programmatic activities for MSM n.e.c.
ASC.01.01.02.03.01	Condom and lubricant programmes for transgenders
ASC.01.01.02.03.02	STI/SRH services for TG (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.03.03	Behaviour change communication (BCC) as part of programmes for TG
ASC.01.01.02.03.04	Community empowerment and prevention of stigma and discrimination among TG
ASC.01.01.02.03.98	Programmatic activities for TG not disaggregated by type
ASC.01.01.02.03.99	Other programmatic activities for TG n.e.c.
ASC.01.01.02.04.01	Condom and lubricant programme as part of programmes for PWID
ASC.01.01.02.04.02	STI/SRH services for PWID (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.04.03	Behaviour change communication (BCC) as part of programmes for PWID
ASC.01.01.02.04.04	Community empowerment and prevention of stigma and discrimination among PWID
ASC.01.01.02.04.05	Sterile syringe and needle exchange as part of programmes for PWID
ASC.01.01.02.04.06.01	Provision of drug substitution treatment for PWID
ASC.01.01.02.04.06.02	Social and psychological support for PWID on Opioid substitution therapy
ASC.01.01.02.04.06.98	Drug substitution treatment and social support not disaggregated
ASC.01.01.02.04.06.99	Drug substitution treatment and social support not elsewhere classified (n.e.c.)
ASC.01.01.02.04.07	Diagnosis and treatment of mental health disorders for PWID - only if earmarked HIV funds are spent
ASC.01.01.02.04.08	Overdose prevention for PWID (includes nolaxon) - only if earmarked HIV funds are spent
ASC.01.01.02.04.98	Other programmatic activities for PWID not disaggregated by type
ASC.01.01.02.04.99	Other programmatic activities for PWID, n.e.c.
ASC.01.01.02.05.01	Condom and lubricant programmes for inmates (prisoners)
ASC.01.01.02.05.02	STI/SRH services for inmates (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.05.03	Interpersonal communication on HIV prevention as part of programmes for inmates (prisoners)
ASC.01.01.02.05.04	Community empowerment and prevention of stigma and discrimination among inmates (prisoners)
ASC.01.01.02.05.98	Programmatic activities for inmates not disaggregated by type
ASC.01.01.02.05.99	Other programmatic activities for inmates n.e.c.
ASC.01.01.02.98	Services for key populations not disaggregated (exclusively for the five populations here described)
ASC.01.01.02.99	Services for key populations not elsewhere classified (n.e.c.) (exclusively for the five populations here described)

NASA Codes	Aids Spending Category (ASC)
ASC.01.01.03.01	Provision of free condoms for HIV prevention (excluding for KPs and AGYW)
ASC.01.01.03.02	Social marketing of condoms for HIV prevention (excluding for KPs and AGYW)
ASC.01.01.03.03	Condom demand generation (excluding for KPs and AGYW)
ASC.01.01.03.04	Sale of condoms (purchased by individuals)
ASC.01.01.03.98	Condom activities (for HIV prevention) not disaggregated
ASC.01.01.03.99	Condom activities (for HIV prevention) n.e.c (excluding for KPs and AGYW)
ASC.01.01.04.01	Voluntary medical male circumcision (VMMC) programmes
ASC.01.01.04.02	Demand generation for VMMC programmes
ASC.01.01.04.98	VMMC activities (for HIV prevention) not disaggregated
ASC.01.01.04.99	Other programmatic activities on VMMC (for HIV prevention) n.e.c.
ASC.01.01.05.01	PrEP as part of programmes for AGYW
ASC.01.01.05.02	PrEP as part of programmes for sex workers and their clients
ASC.01.01.05.03	PrEP as part of programmes for gay men and other men who have sex with men (MSM)
ASC.01.01.05.04	PrEP as part of programmes for Transgenders (TG)
ASC.01.01.05.05	PrEP as part of programmes for PWIDs
ASC.01.01.05.06	PrEP as part of programmes for sero-discordant couples
ASC.01.01.05.07	PrEP as part of programmes for inmates of correctional facilities or pre-trial detention centres (prisoners)
ASC.01.01.05.98	PrEP not disaggregated by key population
ASC.01.01.05.99	PrEP not elsewhere classified n.e.c.
ASC.01.02.01.01	Safe infant feeding practices (including substitution of breastmilk)
ASC.01.02.01.02	Delivery practices as part of PMTCT programmes
ASC.01.02.01.03	Reproductive health and family planning services as part of PMTCT programmes
ASC.01.02.01.98	PMTCT not disaggregated by activity
ASC.01.02.01.99	PMTCT activities n.e.c.
ASC.01.02.02	Social and behavioural change communication (SBCC) for populations other than key populations
ASC.01.02.03	Community mobilisation for populations other than key populations
ASC.01.02.04.01	Condom and lubricant promotion and provision as part of programmes for vulnerable and accessible populations
ASC.01.02.04.02	STI prevention and treatment as part of programmes for vulnerable and accessible populations
ASC.01.02.04.03	Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations
ASC.01.02.04.98	Programmatic activities for vulnerable and accessible population not disaggregated by type
ASC.01.02.04.99	Other programmatic activities for vulnerable and accessible populations n.e.c
ASC.01.02.05.01	Prevention activities implemented in school
ASC.01.02.05.02	Prevention activities implemented out-of-school
ASC.01.02.05.98	Prevention activities for children and youth not disaggregated by type
ASC.01.02.05.99	Prevention activities for children and youth n.e.c
ASC.01.02.06.01	BCC for PLHIV and SDC

NASA Codes	Aids Spending Category (ASC)
ASC.01.02.06.02	Condoms and lubricants programmes for PLHIV and SDC
ASC.01.02.06.03	STI prevention and treatment as part of programmes for PLHIV and their partners
ASC.01.02.06.98	Programmatic activities for PLHIV and SDC not disaggregated by type
ASC.01.02.06.99	Other programmatic activities for PLHIV and SDC not elsewhere classified n.e.c.
ASC.01.02.07	Prevention and wellness programmes in the workplace
ASC.01.02.08	Microbicides
ASC.01.02.09	Post-exposure prophylaxis
ASC.01.02.10	STI prevention and treatment programmes for populations other than key populations - only if funded from earmarked HIV budgets
ASC.01.02.98	Prevention activities not disaggregated
ASC.01.02.99	Other prevention activities n.e.c.
ASC.02.01	HIV testing and counselling for sex workers
ASC.02.02	HIV testing and counselling for MSM
ASC.02.03	HIV testing and counselling for TG
ASC.02.04	HIV testing and counselling for PWID
ASC.02.05	HIV testing and counselling for inmates of correctional and pre-trial facilities
ASC.02.06	HIV testing and counselling for pregnant women (part of PMTCT programme)
ASC.02.07	Early infant diagnosis (EID) of HIV
ASC.02.08	HIV testing and counselling for vulnerable and accessible populations
ASC.02.09	Voluntary HIV testing and counselling for general population
ASC.02.10	Provider initiated testing and counselling (PITC)
ASC.02.11	HIV screening in blood banks
ASC.02.12	Mandatory HIV testing (not VCT) (including premarital, job applications, visas etc.)
ASC.02.98	HIV testing and counselling activities not disaggregated
ASC.02.99	Other HIV counselling and testing activities n.e.c.
ASC.03.01.01.01	First-line ART – adults
ASC.03.01.01.02	Second-line ART – adults
ASC.03.01.01.03	Third-line or salvage ART – adults
ASC.03.01.01.98	Adult antiretroviral therapy not disaggregated by line of treatment
ASC.03.01.02.01	First-line ART – paediatric
ASC.03.01.02.02	Second-line ART – paediatric
ASC.03.01.02.03	Third-line or salvage ART – paediatric
ASC.03.01.02.98	Paediatric antiretroviral therapy not disaggregated by line of treatment
ASC.03.01.03	ART for PMTCT (for pregnant women not previously on treatment)
ASC.03.01.98	Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT
ASC.03.01.99	Antiretroviral therapy n.e.
ASC.03.02	Adherence and retention on ART - support (including nutrition and transport) and monitoring
ASC.03.03	Specific ART-related laboratory monitoring

NASA Codes	Aids Spending Category (ASC)
ASC.03.04.01.01	TB prevention
ASC.03.04.01.02	TB screening, case detection and diagnosis
ASC.03.04.01.03.01	TB (drug-sensitive) treatment (including DOTS)
ASC.03.04.01.03.02	TB (drug-resistant) treatment
ASC.03.04.01.03.98	TB treatment not disaggregated by type of TB
ASC.03.04.01.03.99	TB treatment n.e.c
ASC.03.04.01.04	TB adherence and retention support
ASC.03.04.01.05	Nutritional support associated with TB treatment
ASC.03.04.01.06	TB psychosocial support
ASC.03.04.01.98	TB activities not disaggregated by type
ASC.03.04.01.99	Other TB activities n.e.c
ASC.03.04.02.01	Hepatitis prevention (including HBV vaccination)
ASC.03.04.02.02	Hepatitis screening and diagnosis
ASC.03.04.02.03	Hepatitis treatment
ASC.03.04.02.98	Hepatitis activities not disaggregated by type
ASC.03.04.02.99	Hepatitis activities n.e.c
ASC.03.04.03	Other OI prophylaxis (excluding TB and Hepatitis)
ASC.03.04.04	Other OI treatment (excluding TB and Hepatitis)
ASC.03.04.98	Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)
ASC.03.04.99	Other OI prophylaxis and treatment n.e.c (excluding TB and hepatitis)
ASC.03.05	Psychological treatment and support service
ASC.03.06	Palliative care
ASC.03.07	Traditional medicine and informal care and treatment services
ASC.03.98	Care and treatment services not disaggregated
ASC.03.99	Care and treatment services n.e.c.
ASC.04.01.01	OVC Basic needs (health, education, housing)
ASC.04.01.02	OVC Institutional and Community support
ASC.04.01.03	OVC Social Services (including financial benefits)
ASC.04.01.98	OVC Services not disaggregated by activity
ASC.04.01.99	OVC services n.e.c.
ASC.04.02.01	Social protection through monetary or in-kind benefits
ASC.04.02.02	Social protection through provision of social services
ASC.04.02.03	HIV-specific income generation projects
ASC.04.02.98	Social protection services and social services not disaggregated by type
ASC.04.02.99	Social protection services and social services n.e.c.
ASC.04.98	Social protection activities not disaggregated
ASC.04.99	Social protection activities n.e.c

NASA Codes	Aids Spending Category (ASC)
ASC.05.01	Advocacy
ASC.05.02.01	Stigma and discrimination reduction
ASC.05.02.02	HIV-related legal services
ASC.05.02.03	Monitoring and reforming laws, regulations and policies relating to HIV
ASC.05.02.04	Sensitisation of law-makers and law enforcement agents
ASC.05.02.05	Reducing discrimination and violence against women in the context of HIV
ASC.05.02.06	Capacity building in human rights
ASC.05.02.98	Human rights programmes not disaggregated by type
ASC.05.02.99	Human rights programmes n.e.c.
ASC.05.98	Social enablers not disaggregated by type
ASC.05.99	Social enablers n.e.c.
ASC.06.01	Strategic planning, coordination and policy development
ASC.06.02.01	Representation of PLHIV in key processes
ASC.06.02.02	Representation of youth in key processes
ASC.06.02.03	Representation of women in key processes
ASC.06.02.04	Representation of key populations in key processes
ASC.06.02.98	Building meaningful engagement activities not disaggregated by target group
ASC.06.02.99	Building meaningful engagement activities n.e.c.
ASC.06.03	Programme administration and management costs (above service-delivery level)
ASC.06.04.01	Monitoring and evaluation
ASC.06.04.02	Operations and implementation science research
ASC.06.04.03	Serological-surveillance (sero-surveillance)
ASC.06.04.04	Management information systems
ASC.06.04.05	HIV drug-resistance surveillance
ASC.06.04.06	Financial tracking and monitoring (National AIDS Spending Assessments -NASA)
ASC.06.04.98	Strategic information not disaggregated by type
ASC.06.04.99	Strategic information n.e.c.
ASC.06.05.01	Procurement and supply chain
ASC.06.05.02	Laboratory system strengthening
ASC.06.05.03	Institutional & organisational development (health, social, educational etc)
ASC.06.05.04	Financial and accounting systems strengthening
ASC.06.05.98	Public system strengthening not disaggregated
ASC.06.05.99	Public system strengthening n.e.c.
ASC.06.06.01	Civil society institutional and NGO development
ASC.06.06.02	Community worker education, training and support
ASC.06.06.03	Resource mobilisation for community-based organisations
ASC.06.06.04	Recruitment and retention of volunteers

NASA Codes	Aids Spending Category (ASC)
ASC.06.06.98	Community system strengthening not disaggregated
ASC.06.06.99	Community system strengthening n.e.c.
ASC.06.07.01	Capacity building for health workers, excluding those at community level
ASC.06.07.02	Recruitment, retention and scale-up of health workers, excluding for community health workers (to be included under ASC.06.06)
ASC.06.07.98	Health and community workforce intervention(s) not disaggregated
ASC.06.07.99	Other health and community workforce intervention(s) n.e.c.
ASC.06.98	Programme enablers and systems strengthening not disaggregated
ASC.06.99	Programme enablers and systems strengthening not disaggregated
ASC.07.01	Formative education to build-up an HIV workforce and other trainings not related to any specific activity (e.g. pre-service) using HIV earmarked resources
ASC.07.02.01	Reducing violence against women and young girls
ASC.07.02.02	Reducing sexual diversity violence
ASC.07.02.98	Formative education to build-up an HIV workforce and other trainings not related to any specific activity not disaggregated
ASC.07.02.99	Formative education to build-up an HIV workforce and other trainings not related to any specific activity not elsewhere classified (n.e.c.)
ASC.07.03	Promote HIV-sensitive, cross-sectoral development
ASC.07.98	Development synergies not disaggregated
ASC.07.99	Development synergies n.e.c.
ASC.08.01	Biomedical research
ASC.08.02	Clinical research
ASC.08.03	Epidemiological research
ASC.08.04	Socio-behavioural research
ASC.08.05	Economic research
ASC.08.06	Vaccine-related research
ASC.08.98	HIV and AIDS-related research activities not disaggregated by type
ASC.08.99	HIV and AIDS-related research activities n.e.c.

Table 1.i: Beneficiary Population (BP)

NASA Codes	Beneficiary Population (BP)
BP.01.01.01	Adult and young men (aged 15 and over) living with HIV
BP.01.01.02	Adult and young women (aged 15 over) living with HIV
BP.01.01.03	Pregnant and breastfeeding women (and not on ART)
BP.01.01.98	Adult and young people (aged 15 over) living with HIV not broken down by gender
BP.01.02.01	Boys (aged under 15) living with HIV
BP.01.02.02	Girls (aged under 15) living with HIV
BP.01.02.98	Children (aged under 15) living with HIV not broken down by gender
BP.01.98	People living with HIV not broken down by age or gender

NASA Codes	Beneficiary Population (BP)
BP.02.01.01	Adults (>18years) who Inject drug users (PWID) and their sexual partners
BP.02.01.02	Children (<18years) who inject drugs
BP.02.02.01	Female sex workers and their clients
BP.02.02.02	Transgender sex workers
BP.02.02.03	Male sex workers (and their clients)
BP.02.02.98	Sex workers, not broken down by gender, and their clients
BP.02.03	Gay men and other men who have sex with men (MSM)
BP.02.04	Transgender
BP.02.05	Inmates of correctional facilities (prisoners) and other institutionalised persons
BP.02.98	"Key populations" not broken down by type
BP.03.01	Orphans and vulnerable children (OVC)
BP.03.02	Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns
BP.03.03	Adolescent girls and young women in countries with high HIV prevalence
BP.03.04	Refugees (externally displaced)
BP.03.05	Internally displaced populations (because of an emergency)
BP.03.06	Migrants/mobile populations
BP.03.07	Indigenous groups
BP.03.08	Truck drivers/transport workers and commercial drivers
BP.03.09	Children and youth living in the street
BP.03.10	Children and youth gang members
BP.03.11	Children and youth out of school
BP.03.12	Institutionalised children and youth
BP.03.13	Partners of people living with HIV (including sero-discordant couples)
BP.03.14	Recipients of blood or blood products
BP.03.15	People attending STI clinics
BP.03.16	Elementary school students
BP.03.17	Junior high/high school students
BP.03.18	University students
BP.03.19	Health care workers
BP.03.20	Sailors
BP.03.21	Military
BP.03.22	Police and other uniformed services (other than the military)
BP.03.23	Ex-combatants and other armed non-uniformed groups
BP.03.24	Employees (e.g. for workplace interventions)
BP.03.98	Vulnerable, accessible and other target populations not broken down by type
BP.03.99	Other vulnerable, accessible and other target populations n.e.c.
BP.04.01.01	Male adult population

NASA Codes	Beneficiary Population (BP)
BP.04.01.02	Female adult population
BP.04.01.98	General adult population (aged older than 24) not broken down by gender
BP.04.02.01	Boys
BP.04.02.02	Girls
BP.04.02.98	Children (aged under 15) not broken down by gender
BP.04.03.01	Young men
BP.04.03.02	Young females (excluding the AGYW programmes in high HIV prevalence countries)
BP.04.03.98	Youth (aged 15 to 24) not broken down by gender
BP.04.98	General population not broken down by age or gender.
BP.05	Non-targeted interventions
BP.99	Specific targeted populations not elsewhere classified (n.e.c.)

Annex 2: NASF estimates of costs (2019-2021)

Annex 2.a: Estimated resources required for the NASF interventions (US$ million, 2016 prices)

NASF Intervention	2017	2018	2019	2020	2021	% over period
Maternal syphilis (diagnosis treatment t)	0.60	0.62	0.65	0.67	0.69	0.1%
Paediatric syphilis (diagnosis & treatment)	0.01	0.01	0.01	0.01	0.02	0.003%
Youth focused interventions	6.64	6.98	7.34	7.70	7.90	1.6%
Interventions for sex workers	0.48	0.50	0.51	0.53	0.55	0.1%
Cash transfers	3.33	4.39	5.92	6.52	7.78	1.2%
Interventions for MSM	0.02	0.03	0.03	0.03	0.03	0.01%
Community mobilisation	4.91	5.73	6.60	7.53	7.80	1.4%
Condom provision	32.06	35.51	39.47	43.38	47.63	0.0%
STI diagnosis & treatment	6.87	7.75	8.68	9.67	10.71	8.6%
HIV testing services (HTS)	19.29	20.94	22.69	24.54	26.47	1.9%
VMMC	24.03	25.10	26.22	27.39	28.90	4.9%
PrEP	1.62	1.72	1.83	1.95	2.07	0.4%
PMTCT	2.98	2.99	2.92	2.82	2.73	0.6%
Mass media	7.31	8.48	9.74	11.07	12.48	2.1%
Blood safety	0.13	0.13	0.14	0.14	0.15	0.03%
ARV therapy	230.79	258.50	262.96	270.25	272.97	56.3%
Enabling environment	2.71	3.02	3.15	3.29	3.41	0.7%
Programme management	8.81	9.80	10.22	10.70	11.08	2.2%
Research	2.37	2.64	2.75	2.88	2.98	0.6%
Monitoring and evaluation (8%)	27.11	30.16	31.46	32.93	34.09	6.8%
Strategic communication	7.79	8.67	9.04	9.47	9.80	1.9%
Logistics	4.07	4.52	4.72	4.94	5.11	1.0%
Laboratory (equip/strengthening)	6.78	7.54	7.86	8.23	8.52	1.7%
Total (US$ millions)	400.70	445.75	464.91	486.66	503.86	100.0%

Source: *National HIV/AIDS strategic framework 2017-2021*

Annex 2.b: Detailed RNASF resource need (US$ million, 2020-2023)

RNASF interventions (US$ millions)	2020	2021	2022	2023	% 2021-2023
HIV Testing					
Testing: Provider initiated	18.24	15.04	11.96	9.03	2%
Testing: Assisted partner notification	0.84	2.72	4.03	4.68	1%
Testing: Self-test	-	0.56	0.96	1.18	0%
Testing: Early infant diagnosis	0.92	1.09	1.25	1.41	0%
Treatment					
Adult ARVs: first line	86.10	83.49	85.07	86.53	14%
Adult ARVs: second line	14.30	14.80	15.30	15.80	2%

Adult ARVs: third line	13.10	13.55	14.01	14.47	2%
Adult ARVs: HR costs	10.20	10.56	10.37	10.16	2%
Adult ARVs: labs	10.81	11.18	11.56	11.94	2%
Paediatric ART	15.70	15.94	15.43	14.73	3%
VL testing	24.99	25.83	26.63	27.40	4%
ART support activities (adherence, DSDs, CLM etc)	42.14	43.61	45.09	46.55	7%
Additional ART service delivery costs	61.56	63.70	65.86	68.00	11%
PMTCT	2.27	2.54	2.51	2.47	0%
PEP	0.02	0.03	0.05	0.07	0%
Cervical Cancer	6.58	6.78	7.09	7.32	1%
TB preventive therapy	2.54	2.93	2.93	2.93	0%
General population 25+					
Condom promotion	7.27	8.58	10.15	11.83	2%
SBCC, comm-mobilisation, demand creation	6.43	6.61	6.88	7.16	1%
PrEP (only AGYW, SW, MSM, PLW)	-	19.79	23.49	23.51	4%
STI treatment and prevention	4.54	4.71	4.89	5.09	1%
Key and vulnerable populations					
FSW services	11.07	11.52	13.64	15.80	2%
MSM services	1.02	2.71	3.15	3.78	1%
PWID services	-	1.15	1.32	1.49	0%
Vulnerable populations (package not defined)	5.16	5.16	5.16	5.16	1%
Programmes for AGYW					
Family planning	0.11	0.27	0.38	0.49	0%
Parenting/care giver programmes	1.15	2.55	3.37	4.25	1%
Educational subsidy	3.07	18.39	24.32	30.67	4%
Economic empowerment	1.64	12.42	18.04	24.05	3%
Comprehensive sexuality education	1.77	1.93	2.09	2.27	0%
Community norms change	0.77	1.10	1.45	1.82	0%
PrEP for adolescents	3.75	4.69	5.41	5.41	1%
Programmes for ABYM					
VMMC	22.27	34.08	35.06	30.25	5%
Condoms for ABYM	0.82	0.85	0.88	0.91	0%
CSE for ABYM	2.82	3.04	3.28	3.53	1%
Mitigation and support					
OVC	22.15	22.15	22.15	22.15	4%
Critical enablers					
CE: CSS	4.00	4.04	4.24	4.45	1%

CE: Research, surveillance, M&E, HMIS	16.85	16.85	16.85	16.85	3%
CE: HSS PSM	16.85	16.85	16.85	16.85	3%
CE: HSS Lab strengthening	16.85	16.85	16.85	16.85	3%
CE: HSS HR capacity building	4.00	4.04	4.24	4.45	1%
CE: Policies, laws & human rights, stigma & discrimination reduction	2.00	2.02	2.12	2.23	0%
CE: Gender equality, empowerment, GBV interventions, access to SHRS	4.00	4.04	4.24	4.45	1%
CE: Planning, Coord, PM, QA, leadership & governance	38.93	43.81	46.59	48.29	8%
Total RNASF cost estimates (US$m)	**$ 509.61**	**$ 584.57**	**$ 617.21**	**$ 638.73**	**100%**

Source: *National HIV/AIDS strategic framework 2020-2023*

Annex 3: Data Collection Tool

National Aids Council of Zambia

National Aids Spending Assessment (NASA) 2029-2021					
Data Collection Tool					
Location/Region		**Year of the expenditure estimate**		**Currency**	
Financing entity (FE)					
Name of financing entity					
Financing Agent/Purchaser (FAP)					
Name of the Financing Agent/Purchaser					
Provider of Services (PS)					
Name of the Provider of Services (PS)					

	NASA Classification Code	**Comments**	**Amount spent (selected currency)**	**No of beneficiaries reached**
AIDS SPENDING CATEGORY (ASC) 1				Do not populate
Service Delivery Model (SDM)				Do not populate
Beneficiary population (BP)				
Production Factor (PF) 1				Do not populate
Production Factor (PF) 2				Do not populate
Production Factor (PF) 3				Do not populate

Production Factor (PF) 4				Do not populate
Production Factor (PF) 5				Do not populate
Production Factor (PF) 6				Do not populate
Production Factor (PF) 7				Do not populate
Production Factor (PF) 8				Do not populate
Production Factor (PF) 9				Do not populate
Production Factor (PF) 10				Do not populate
Production Factor (PF) 11				Do not populate
Production Factor (PF) 12				Do not populate
Total Spent PF				

AIDS SPENDING CATEGORY (ASC) 2				Do not populate
Service Delivery Model (SDM)				Do not populate
Beneficiary population (BP)				

Production Factor (PF) 1				Do not populate
Production Factor (PF) 2				Do not populate
Production Factor (PF) 3				Do not populate
Production Factor (PF) 4				Do not populate
Production Factor (PF) 5				Do not populate
Production Factor (PF) 6				Do not populate
Production Factor (PF) 7				Do not populate
Production Factor (PF) 8				Do not populate

Production Factor (PF) 9				Do not populate
Production Factor (PF) 10				Do not populate
Production Factor (PF) 11				Do not populate
Production Factor (PF) 12				Do not populate
Total Spent PF				
The total of "beneficiary population" must be equal to the total "Production Factor".				
Data provider focal point name		**Tel:**	**Email:**	
Data Collector name		**Tel:**	**Email:**	

The information on the "Data collection tool" sheet must be provided for each service provider and for each intervention.

There will be as many sheets as there are interventions per service provider. We therefore invite you to duplicate this "data collection tool" sheet as many times as needed.

Appendix 4: PEPFAR – NASA Crosswalk

PEPFAR Program	PEPFAR Sub-program	PEPFAR Beneficiary	PEPFAR Sub-beneficiary	CONCAT	NASA ACS	NASA SDM	NASA BP
ASP	HMIS, surveillance, & research	Females	Adult women	ASP HMIS, surveillance, & research Females Adult women	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Females	Young women & adolescent females	ASP HMIS, surveillance, & research Females Young women & adolescent females	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	Men having sex with men	ASP HMIS, surveillance, & research Key Pops Men having sex with men	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	Not disaggregated	ASP HMIS, surveillance, & research Key Pops Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	People in prisons	ASP HMIS, surveillance, & research Key Pops People in prisons	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	Sex workers	ASP HMIS, surveillance, & research Key Pops Sex workers	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	Transgender	ASP HMIS, surveillance, & research Key Pops Transgender	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Males	Not disaggregated	ASP HMIS, surveillance, & research Males Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Non-Targeted Pop	Adults	ASP HMIS, surveillance, & research Non-Targeted Pop Adults	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Non-Targeted Pop	Not disaggregated	ASP HMIS, surveillance, & research Non-Targeted Pop Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Non-Targeted Pop	Young people & adolescents	ASP HMIS, surveillance, & research Non-Targeted Pop Young people & adolescents	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions

ASP	HMIS, surveillance, & research	OVC	Not disaggregated	ASP HMIS, surveillance, & research OVC Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	OVC	Orphans & vulnerable children	ASP HMIS, surveillance, & research OVC Orphans & vulnerable children	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Pregnant & Breastfeeding Women	Not disaggregated	ASP HMIS, surveillance, & research Pregnant & Breastfeeding Women Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Not Specified	Not Specified	ASP HMIS, surveillance, & research Not Specified Not Specified	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	OVC	Orphans & vulnerable children	ASP Human resources for health OVC Orphans & vulnerable children	ASC.06.07.98 Health and community workforce intervention(s) not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	Non-Targeted Pop	Not disaggregated	ASP Human resources for health Non-Targeted Pop Not disaggregated	ASC.06.07.98 Health and community workforce intervention(s) not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	Priority Pops	Military & other uniformed services	ASP Human resources for health Priority Pops Military & other uniformed services	ASC.06.07.98 Health and community workforce intervention(s) not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Institutional prevention	Non-Targeted Pop	Adults	ASP Institutional prevention Non-Targeted Pop Adults	ASC.01.02.99 Other prevention activities n.e.c.	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
ASP	Laboratory systems strengthening	Non-Targeted Pop	Children	ASP Laboratory systems strengthening Non-Targeted Pop Children	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laboratory systems strengthening	Non-Targeted Pop	Not disaggregated	ASP Laboratory systems strengthening Non-Targeted Pop Not disaggregated	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laboratory systems strengthening	Not Specified	Not Specified	ASP Laboratory systems strengthening Not Specified Not Specified	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions

ASP	Not Specified	Not Specified	Not Specified	ASP Not Specified Not Specified Not Specified	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laws, regulations & policy environment	Non-Targeted Pop	Not disaggregated	ASP Laws, regulations & policy environment Non-Targeted Pop Not disaggregated	ASC.05.02.03 Monitoring and reforming laws, regulations and policies relating to HIV	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Not Disaggregated	Non-Targeted Pop	Not disaggregated	ASP Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Not Disaggregated	Non-Targeted Pop	Young people & adolescents	ASP Not Disaggregated Non-Targeted Pop Young people & adolescents	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	Non-Targeted Pop	Adults	ASP Human resources for health Non-Targeted Pop Adults	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	Females	Young women & adolescent females	ASP Human resources for health Females Young women & adolescent females	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Females	Young women & adolescent females	ASP Policy, planning, coordination & management Females Young women & adolescent females	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Key Pops	Not disaggregated	ASP Policy, planning, coordination & management Key Pops Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Males	Not disaggregated	ASP Policy, planning, coordination & management Males Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Non-Targeted Pop	Adults	ASP Policy, planning, coordination & management Non-Targeted Pop Adults	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Non-Targeted Pop	Children	ASP Policy, planning, coordination & management Non-Targeted Pop Children	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Non-Targeted Pop	Children	ASP Policy, planning, coordination & management of disease control programs Non-Targeted Pop Children	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions

ASP	Policy, planning, coordination & management	Non-Targeted Pop	Not disaggregated	ASP Policy, planning, coordination & management Non-Targeted Pop Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Key Pops	Not disaggregated	ASP Policy, planning, coordination & management of disease control programs Key Pops Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Non-Targeted Pop	Not disaggregated	ASP Policy, planning, coordination & management of disease control programs Non-Targeted Pop Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Pregnant & Breastfeeding Women	Not disaggregated	ASP Policy, planning, coordination & management of disease control programs Pregnant & Breastfeeding Women Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	OVC	Orphans & vulnerable children	ASP Policy, planning, coordination & management of disease control programs OVC Orphans & vulnerable children	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Females	Adult women	ASP Policy, planning, coordination & management of disease control programs Females Adult women	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Non-Targeted Pop	Adults	ASP Policy, planning, coordination & management of disease control programs Non-Targeted Pop Adults	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Females	Young women & adolescent females	ASP Policy, planning, coordination & management of disease control programs Females Young women & adolescent females	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of	Males	Not disaggregated	ASP Policy, planning, coordination & management of disease control programs Males Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions

	disease control programs						
ASP	Procurement & supply chain management	Key Pops	Not disaggregated	ASP Procurement & supply chain management Key Pops Not disaggregated	ASC.06.05.01 Procurement and supply chain	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Procurement & supply chain management	Non-Targeted Pop	Not disaggregated	ASP Procurement & supply chain management Non-Targeted Pop Not disaggregated	ASC.06.05.01 Procurement and supply chain	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Public financial management strengthening	Non-Targeted Pop	Not disaggregated	ASP Public financial management strengthening Non-Targeted Pop Not disaggregated	ASC.06.05.04 Financial and accounting systems strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
C&T	HIV Clinical Services	Key Pops	Men having sex with men	C&T HIV Clinical Services Key Pops Men having sex with men	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Key Pops	Not disaggregated	C&T HIV Clinical Services Key Pops Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Non-Targeted Pop	Children	C&T HIV Clinical Services Non-Targeted Pop Children	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender
C&T	HIV Clinical Services	Non-Targeted Pop	Not disaggregated	C&T HIV Clinical Services Non-Targeted Pop Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Pregnant & Breastfeeding Women	Not disaggregated	C&T HIV Clinical Services Pregnant & Breastfeeding Women Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Non-Targeted Pop	Young people & adolescents	C&T HIV Clinical Services Non-Targeted Pop Young people & adolescents	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.98 Adult and young people (aged 15 over) living with HIV not broken down by gender
C&T	HIV Clinical Services	Females	Adult women	C&T HIV Clinical Services Females Adult women	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.02 Adult and young women (aged 15 over) living with HIV
C&T	HIV Clinical Services	Females	Not disaggregated	C&T HIV Clinical Services Females Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.02 Adult and young women (aged 15 over) living with HIV

C&T	HIV Clinical Services	Non-Targeted Pop	Adults	C&T HIV Clinical Services Non-Targeted Pop Adults	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.98 Adult and young people (aged 15 over) living with HIV not broken down by gender
C&T	HIV Clinical Services	Females	Young women & adolescent females	C&T HIV Clinical Services Females Young women & adolescent females	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.02 Adult and young women (aged 15 over) living with HIV
C&T	HIV Clinical Services	Males	Not disaggregated	C&T HIV Clinical Services Males Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.01 Adult and young men (aged 15 and over) living with HIV
C&T	HIV Clinical Services	Males	Adult men	C&T HIV Clinical Services Males Adult men	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.01 Adult and young men (aged 15 and over) living with HIV
C&T	HIV Clinical Services	Key Pops	Sex workers	C&T HIV Clinical Services Key Pops Sex workers	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Drugs	Non-Targeted Pop	Children	C&T HIV Drugs Non-Targeted Pop Children	ASC.03.01.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	SDM.01.01 Facility-based: Outpatient	BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender
C&T	HIV Drugs	Not Specified	Not Specified	C&T HIV Drugs Not Specified Not Specified	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Drugs	Non-Targeted Pop	Adults	C&T HIV Drugs Non-Targeted Pop Adults	ASC.03.01.01.98 Adult antiretroviral therapy not disaggregated by line of treatment	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Drugs	Non-Targeted Pop	Not disaggregated	C&T HIV Drugs Non-Targeted Pop Not disaggregated	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Laboratory Services	Key Pops	People who inject drugs	C&T HIV Laboratory Services Key Pops People who inject drugs	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Laboratory Services	Non-Targeted Pop	Children	C&T HIV Laboratory Services Non-Targeted Pop Children	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.02.98 Children (aged under 15) living

							with HIV not broken down by gender
C&T	HIV Laboratory Services	Non-Targeted Pop	Not disaggregated	C&T HIV Laboratory Services Non-Targeted Pop Not disaggregated	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Key Pops	Men having sex with men	C&T Not Disaggregated Key Pops Men having sex with men	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Key Pops	Not disaggregated	C&T Not Disaggregated Key Pops Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Key Pops	People in prisons	C&T Not Disaggregated Key Pops People in prisons	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Key Pops	Sex workers	C&T Not Disaggregated Key Pops Sex workers	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Males	Not disaggregated	C&T Not Disaggregated Males Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Non-Targeted Pop	Adults	C&T Not Disaggregated Non-Targeted Pop Adults	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Non-Targeted Pop	Not disaggregated	C&T Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Pregnant & Breastfeeding Women	Not disaggregated	C&T Not Disaggregated Pregnant & Breastfeeding Women Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns
C&T	Not Specified	Non-Targeted Pop	Children	C&T Not Specified Non-Targeted Pop Children	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender

C&T	Not Specified	Not Specified	Not Specified	C&T Not Specified Not Specified Not Specified	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
HTS	Not Specified	Not Specified	Not Specified	HTS Not Specified Not Specified Not Specified	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.01.98 People living with HIV not broken down by age or gender
HTS	Not Specified	Pregnant & Breastfeeding Women	Not Specified	HTS Not Specified Pregnant & Breastfeeding Women Not Specified	ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	SDM.01.01 Facility-based: Outpatient	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns
HTS	Community-based testing	Females	Young women & adolescent females	HTS Community-based testing Females Young women & adolescent females	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
HTS	Community-based testing	Key Pops	People in prisons	HTS Community-based testing Key Pops People in prisons	ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities	SDM.02.98 Home and community based not disaggregated	BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons
HTS	Community-based testing	Key Pops	People who inject drugs	HTS Community-based testing Key Pops People who inject drugs	ASC.02.04 HIV testing and counselling for PWID	SDM.02.98 Home and community based not disaggregated	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners
HTS	Community-based testing	Males	Adult men	HTS Community-based testing Males Adult men	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.01.01 Male adult population
HTS	Community-based testing	Males	Young men & adolescent males	HTS Community-based testing Males Young men & adolescent males	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.03.01 Young men
HTS	Community-based testing	Non-Targeted Pop	Children	HTS Community-based testing Non-Targeted Pop Children	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.02.98 Children (aged under 15) not broken down by gender
HTS	Community-based testing	Non-Targeted Pop	Not disaggregated	HTS Community-based testing Non-Targeted Pop Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.

HTS	Community-based testing	Non-Targeted Pop	Young people & adolescents	HTS Community-based testing Non-Targeted Pop Young people & adolescents	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.
HTS	Community-based testing	Priority Pops	Not disaggregated	HTS Community-based testing Priority Pops Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.
HTS	Facility-based testing	Key Pops	People in prisons	HTS Facility-based testing Key Pops People in prisons	ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities	SDM.01.01 Facility-based: Outpatient	BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons
HTS	Facility-based testing	Non-Targeted Pop	Not disaggregated	HTS Facility-based testing Non-Targeted Pop Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.98 General population not broken down by age or gender.
HTS	Facility-based testing	Pregnant & Breastfeeding Women	Not disaggregated	HTS Facility-based testing Pregnant & Breastfeeding Women Not disaggregated	ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	SDM.01.01 Facility-based: Outpatient	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns
HTS	Facility-based testing	Key Pops	Not disaggregated	HTS Facility-based testing Key Pops Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.02.98 "Key populations" not broken down by type
HTS	Not Disaggregated	Females	Not disaggregated	HTS Not Disaggregated Females Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.02 Female adult population
HTS	Not Disaggregated	Key Pops	Men having sex with men	HTS Not Disaggregated Key Pops Men having sex with men	ASC.02.02 HIV testing and counselling for MSM	SDM.98 Modalities not disaggregated	BP.02.03 Gay men and other men who have sex with men (MSM)
HTS	Not Disaggregated	Key Pops	Not disaggregated	HTS Not Disaggregated Key Pops Not disaggregated	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.98 Modalities not disaggregated	BP.02.98 "Key populations" not broken down by type
HTS	Not Disaggregated	Key Pops	People who inject drugs	HTS Not Disaggregated Key Pops People who inject drugs	ASC.02.04 HIV testing and counselling for PWID	SDM.98 Modalities not disaggregated	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners

HTS	Not Disaggregated	Key Pops	Sex workers	HTS Not Disaggregated Key Pops Sex workers	ASC.02.01 HIV testing and counselling for sex workers	SDM.98 Modalities not disaggregated	BP.02.02.98 Sex workers, not broken down by gender, and their clients
HTS	Not Disaggregated	Males	Not disaggregated	HTS Not Disaggregated Males Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.01 Male adult population
HTS	Not Disaggregated	Non-Targeted Pop	Adults	HTS Not Disaggregated Non-Targeted Pop Adults	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.98 General adult population (aged older than 24) not broken down by gender
HTS	Not Disaggregated	Non-Targeted Pop	Not disaggregated	HTS Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
HTS	Not Disaggregated	Non-Targeted Pop	Young people & adolescents	HTS Not Disaggregated Non-Targeted Pop Young people & adolescents	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender
HTS	Not Disaggregated	Pregnant & Breastfeeding Women	Not disaggregated	HTS Not Disaggregated Pregnant & Breastfeeding Women Not disaggregated	ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	SDM.01.01 Facility-based: Outpatient	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns
PM	IM Closeout costs	Non-Targeted Pop	Not disaggregated	PM IM Closeout costs Non-Targeted Pop Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	IM Program Management	Females	Young women & adolescent females	PM IM Programme Management Females Young women & adolescent females	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	IM Programme Management	Key Pops	Not disaggregated	PM IM Programme Management Key Pops Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions

PM	IM Programme Management	Non-Targeted Pop	Not disaggregated	PM IM Programme Management Non-Targeted Pop Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	IM Programme Management	OVC	Not disaggregated	PM IM Programme Management OVC Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	IM Programme Management	Priority Pops	Not disaggregated	PM IM Programme Management Priority Pops Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	Programme Management	Non-Targeted Pop	Not disaggregated	PM Programme Management Non-Targeted Pop Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	USG Programme Management	Non-Targeted Pop	Not disaggregated	PM USG Programme Management Non-Targeted Pop Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PREV	Comm. mobilisation, behaviour & norms change	Females	Young women & adolescent females	PREV Comm. mobilisation, behaviour & norms change Females Young women & adolescent females	ASC.01.01.01.03 Behaviour change communication (BCC) as part of programmes for AGYW and their male partners - only if earmarked HIV funds are spent	SDM.02.99 Home and community based n.e.c.	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
PREV	Comm. mobilisation, behaviour & norms change	Key Pops	Men having sex with men	PREV Comm. mobilisation, behaviour & norms change Key Pops Men having sex with men	ASC.01.01.02.02.03 Behaviour change communication (BCC) as part of programmes for MSM	SDM.02.99 Home and community based n.e.c.	BP.02.03 Gay men and other men who have sex with men (MSM)
PREV	Comm. mobilisation, behaviour & norms change	Key Pops	Not disaggregated	PREV Comm. mobilisation, behaviour & norms change Key Pops Not disaggregated	ASC.01.01.02.98 Services for key populations not disaggregated (exclusively for the five populations here described)	SDM.02.99 Home and community based n.e.c.	BP.02.98 "Key populations" not broken down by type
PREV	Comm. mobilisation, behaviour & norms change	Key Pops	People in prisons	PREV Comm. mobilisation, behaviour & norms change Key Pops People in prisons	ASC.01.01.02.05.03 Interpersonal communication on HIV prevention as part of programmes for inmates (prisoners)	SDM.02.99 Home and community based n.e.c.	BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons
PREV	Comm. mobilisation, behaviour & norms change	Key Pops	People who inject drugs	PREV Comm. mobilisation, behaviour & norms change Key Pops People who inject drugs	ASC.01.01.02.04.03 Behaviour change communication (BCC) as part of programmes for PWID	SDM.02.99 Home and community based n.e.c.	BP.02.01.01 Adults (>18years) who Inject

							drug users (PWID) and their sexual partners
PREV	Comm. mobilisation, behaviour & norms change	Key Pops	Sex workers	PREV Comm. mobilisation, behaviour & norms change Key Pops Sex workers	ASC.01.01.02.01.04 Community empowerment including prevention of violence against sex workers and legal support - only if earmarked HIV funds are spent	SDM.02.99 Home and community based n.e.c.	BP.02.02.98 Sex workers, not broken down by gender, and their clients
PREV	Comm. mobilisation, behaviour & norms change	Non-Targeted Pop	Not disaggregated	PREV Comm. mobilisation, behaviour & norms change Non-Targeted Pop Not disaggregated	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.99 Home and community based n.e.c.	BP.04.98 General population not broken down by age or gender.
PREV	Comm. mobilisation, behaviour & norms change	Non-Targeted Pop	Young people & adolescents	PREV Comm. mobilisation, behaviour & norms change Non-Targeted Pop Young people & adolescents	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.99 Home and community based n.e.c.	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender
PREV	Comm. mobilisation, behaviour & norms change	OVC	Not disaggregated	PREV Comm. mobilisation, behaviour & norms change OVC Not disaggregated	ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	SDM.02.99 Home and community based n.e.c.	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Comm. mobilisation, behaviour & norms change	OVC	Orphans & vulnerable children	PREV Comm. mobilisation, behaviour & norms change OVC Orphans & vulnerable children	ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	SDM.02.99 Home and community based n.e.c.	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Comm. mobilisation, behaviour & norms change	Non-Targeted Pop	Adults	PREV Comm. mobilisation, behaviour & norms change Non-Targeted Pop Adults	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.99 Home and community based n.e.c.	BP.04.01.98 General adult population (aged older than 24) not broken down by gender
PREV	Condom & Lubricant Programming	Pregnant & Breastfeeding Women	Not disaggregated	PREV Condom & Lubricant Programming Pregnant & Breastfeeding Women Not disaggregated	ASC.01.02.01.03 Reproductive health and family planning services as part of PMTCT programmes	SDM.01.01 Facility-based: Outpatient	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns
PREV	Condom & Lubricant Programming	Non-Targeted Pop	Adults	PREV Condom & Lubricant Programming Non-Targeted Pop Adults	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.98 General adult population (aged older than 24) not

							broken down by gender
PREV	Condom & Lubricant Programming	Females	Not disaggregated	PREV Condom & Lubricant Programming Females Not disaggregated	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.02 Female adult population
PREV	Condom & Lubricant Programming	Males	Not disaggregated	PREV Condom & Lubricant Programming Males Not disaggregated	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.01 Male adult population
PREV	Condom & Lubricant Programming	Non-Targeted Pop	Not disaggregated	PREV Condom & Lubricant Programming Non-Targeted Pop Not disaggregated	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
PREV	Not Disaggregated	OVC	Orphans & vulnerable children	PREV Not Disaggregated OVC Orphans & vulnerable children	ASC.04.01.98 OVC Services not disaggregated by activity	SDM.98 Modalities not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Not Specified	Not Specified	Not Specified	PREV Not Specified Not Specified Not Specified	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
PREV	Medication assisted treatment	Key Pops	People who inject drugs	PREV Medication assisted treatment Key Pops People who inject drugs	ASC.01.01.02.04.06.01 Provision of drug substitution treatment for PWID	SDM.01.01 Facility-based: Outpatient	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners
PREV	Not Disaggregated	Females	Young women & adolescent females	PREV Not Disaggregated Females Young women & adolescent females	ASC.01.01.01.98 Programmatic activities for AGYW not disaggregated by type	SDM.98 Modalities not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
PREV	Not Disaggregated	Key Pops	Men having sex with men	PREV Not Disaggregated Key Pops Men having sex with men	ASC.01.01.02.02.98 Programmatic activities for MSM not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.03 Gay men and other men who have sex with men (MSM)
PREV	Not Disaggregated	Key Pops	Not disaggregated	PREV Not Disaggregated Key Pops Not disaggregated	ASC.01.01.02.98 Services for key populations not disaggregated (exclusively for the five populations here described)	SDM.98 Modalities not disaggregated	BP.02.98 "Key populations" not broken down by type
PREV	Not Disaggregated	Key Pops	People in prisons	PREV Not Disaggregated Key Pops People in prisons	ASC.01.01.02.05.98 Programmatic activities for inmates not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons

PREV	Not Disaggregated	Key Pops	People who inject drugs	PREV Not Disaggregated Key Pops People who inject drugs	ASC.01.01.02.04.98 Other programmatic activities for PWID not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners
PREV	Not Disaggregated	Key Pops	Sex workers	PREV Not Disaggregated Key Pops Sex workers	ASC.01.01.02.01.98 Programmatic activities for sex workers and their clients not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.02.98 Sex workers, not broken down by gender, and their clients
PREV	Not Disaggregated	Non-Targeted Pop	Adults	PREV Not Disaggregated Non-Targeted Pop Adults	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
PREV	Not Disaggregated	Females	Adult women	PREV Not Disaggregated Females Adult women	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.02 Female adult population
PREV	Not Disaggregated	Non-Targeted Pop	Not disaggregated	PREV Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
PREV	Not Disaggregated	Non-Targeted Pop	Young people & adolescents	PREV Not Disaggregated Non-Targeted Pop Young people & adolescents	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
PREV	Not Disaggregated	OVC	Not disaggregated	PREV Not Disaggregated OVC Not disaggregated	ASC.04.01.98 OVC Services not disaggregated by activity	SDM.98 Modalities not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Not Disaggregated	Priority Pops	Not disaggregated	PREV Not Disaggregated Priority Pops Not disaggregated	ASC.01.01.02.98 Services for key populations not disaggregated (exclusively for the five populations here described)	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	PrEP	Females	Young women & adolescent females	PREV PrEP Females Young women & adolescent females	ASC.01.01.05.01 PrEP as part of programmes for AGYW	SDM.98 Modalities not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
PREV	PrEP	Key Pops	Not disaggregated	PREV PrEP Key Pops Not disaggregated	ASC.01.01.05.98 PrEP not disaggregated by key population	SDM.98 Modalities not disaggregated	BP.02.98 “Key populations” not broken down by type
PREV	PrEP	Key Pops	Sex workers	PREV PrEP Key Pops Sex workers	ASC.01.01.05.02 PrEP as part of programmes for sex workers and their clients	SDM.98 Modalities not disaggregated	BP.02.02.98 Sex workers, not broken down by gender, and their clients

PREV	PrEP	Non-Targeted Pop	Not disaggregated	PREV PrEP Non-Targeted Pop Not disaggregated	ASC.01.01.05.98 PrEP not disaggregated by key population	SDM.98 Modalities not disaggregated	BP.02.98 "Key populations" not broken down by type
PREV	PrEP	Priority Pops	Not disaggregated	PREV PrEP Priority Pops Not disaggregated	ASC.01.01.05.98 PrEP not disaggregated by key population	SDM.98 Modalities not disaggregated	BP.02.98 "Key populations" not broken down by type
PREV	Primary prevention of HIV and sexual violence	Females	Young women & adolescent females	PREV Primary prevention of HIV and sexual violence Females Young women & adolescent females	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	Priority Pops	Not disaggregated	PREV Primary prevention of HIV and sexual violence Priority Pops Not disaggregated	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	OVC	Not disaggregated	PREV Primary prevention of HIV and sexual violence OVC Not disaggregated	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	Males	Boys	PREV Primary prevention of HIV and sexual violence Males Boys	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	Key Pops	Not disaggregated	PREV Primary prevention of HIV and sexual violence Key Pops Not disaggregated	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	VMMC	Non-Targeted Pop	Not disaggregated	PREV VMMC Non-Targeted Pop Not disaggregated	ASC.05.02.05 Reducing discrimination and violence against women in the context of HIV	SDM.98 Modalities not disaggregated	BP.04.01.01 Male adult population
PREV	VMMC	Key Pops	Not disaggregated	PREV VMMC Key Pops Not disaggregated	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
PREV	VMMC	Males	Adult men	PREV VMMC Males Adult men	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
PREV	VMMC	Males	Not disaggregated	PREV VMMC Males Not disaggregated	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population

PREV	VMMC	Males	Not Specified	PREV VMMC Males Not Specified	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
PREV	VMMC	Males	Young men & adolescent males	PREV VMMC Males Young men & adolescent males	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
PREV	VMMC	Priority Pops	Military & other uniformed services	PREV VMMC Priority Pops Military & other uniformed services	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.03.21 Military
SE	Case Management	OVC	Orphans & vulnerable children	SE Case Management OVC Orphans & vulnerable children	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Case Management	OVC	Not disaggregated	SE Case Management OVC Not disaggregated	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Economic strengthening	OVC	Orphans & vulnerable children	SE Economic strengthening OVC Orphans & vulnerable children	ASC.04.01.03 OVC Social Services (including financial benefits)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Economic strengthening	Females	Young women & adolescent females	SE Economic strengthening Females Young women & adolescent females	ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Economic strengthening	Non-Targeted Pop	Young people & adolescents	SE Economic strengthening Non-Targeted Pop Young people & adolescents	ASC.04.02.03 HIV-specific income generation projects	SDM.02.98 Home and community based not disaggregated	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender
SE	Economic strengthening	OVC	Not disaggregated	SE Economic strengthening OVC Not disaggregated	ASC.04.01.03 OVC Social Services (including financial benefits)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Economic strengthening	Females	Girls	SE Economic strengthening Females Girls	ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Education assistance	Females	Girls	SE Education assistance Females Girls	ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women

					part of programmes for AGYW - only if earmarked HIV funds are spent		in countries with high HIV prevalence
SE	Education assistance	Females	Young women & adolescent females	SE Education assistance Females Young women & adolescent females	ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Education assistance	OVC	Orphans & vulnerable children	SE Education assistance OVC Orphans & vulnerable children	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Education assistance	OVC	Not disaggregated	SE Education assistance OVC Not disaggregated	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Legal, human rights & protection	Non-Targeted Pop	Not disaggregated	SE Legal, human rights & protection Non-Targeted Pop Not disaggregated	ASC.05.02.03 Monitoring and reforming laws, regulations and policies relating to HIV	SDM.02.98 Home and community based not disaggregated	BP.04.01.98 General adult population (aged older than 24) not broken down by gender
SE	Legal, human rights & protection	Females	Young women & adolescent females	SE Legal, human rights & protection Females Young women & adolescent females	ASC.01.01.01.99 Other activities for AGYW n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Legal, human rights & protection	OVC	Not disaggregated	SE Legal, human rights & protection OVC Not disaggregated	ASC.04.01.99 OVC services n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Legal, human rights & protection	OVC	Orphans & vulnerable children	SE Legal, human rights & protection OVC Orphans & vulnerable children	ASC.04.01.99 OVC services n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Legal, human rights & protection	OVC	Care givers	SE Legal, human rights & protection OVC Care givers	ASC.04.01.99 OVC services n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Not Disaggregated	Non-Targeted Pop	Not disaggregated	SE Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.04.01.98 General adult population (aged older than 24) not broken down by gender

SE	Not Disaggregated	Females	Girls	SE Not Disaggregated Females Girls	ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Not Disaggregated	OVC	Not disaggregated	SE Not Disaggregated OVC Not disaggregated	ASC.04.01.98 OVC Services not disaggregated by activity	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Not Disaggregated	OVC	Orphans & vulnerable children	SE Not Disaggregated OVC Orphans & vulnerable children	ASC.04.01.98 OVC Services not disaggregated by activity	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Psychosocial support	Non-Targeted Pop	Adults	SE Psychosocial support Non-Targeted Pop Adults	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.01.98 People living with HIV not broken down by age or gender
SE	Psychosocial support	Non-Targeted Pop	Not disaggregated	SE Psychosocial support Non-Targeted Pop Not disaggregated	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.01.98 People living with HIV not broken down by age or gender
SE	Psychosocial support	Non-Targeted Pop	Young people & adolescents	SE Psychosocial support Non-Targeted Pop Young people & adolescents	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.01.98 People living with HIV not broken down by age or gender
SE	Psychosocial support	OVC	Not disaggregated	SE Psychosocial support OVC Not disaggregated	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Psychosocial support	OVC	Orphans & vulnerable children	SE Psychosocial support OVC Orphans & vulnerable children	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Not Disaggregated	Females	Young women & adolescent females	SE Not Disaggregated Females Young women & adolescent females	ASC.01.01.01.99 Other activities for AGYW n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Not Specified	Not Specified	Not Specified	SE Not Specified Not Specified Not Specified	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
SE	Not Specified	OVC	Not Specified	SE Not Specified OVC Not Specified	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)

Applied Pipeline	Applied Pipeline	Applied Pipeline	Applied Pipeline	Applied Pipeline Applied Pipeline Applied Pipeline Applied Pipeline	ASC.99	SDM.99	BP.99
ASP	HMIS, surveillance, & research	Females	Not disaggregated	ASP HMIS, surveillance, & research Females Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Priority Pops	Military & other uniformed services	ASP HMIS, surveillance, & research Priority Pops Military & other uniformed services	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laboratory systems strengthening	Key Pops	Not disaggregated	ASP Laboratory systems strengthening Key Pops Not disaggregated	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laboratory systems strengthening	Priority Pops	Military & other uniformed services	ASP Laboratory systems strengthening Priority Pops Military & other uniformed services	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Not Disaggregated	Priority Pops	Military & other uniformed services	ASP Not Disaggregated Priority Pops Military & other uniformed services	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.02.98 "Key populations" not broken down by type
ASP	Policy, planning, coordination & management of disease control Programmes	Priority Pops	Military & other uniformed services	ASP Policy, planning, coordination & management of disease control Programmes Priority Pops Military & other uniformed services	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Procurement & supply chain management	Priority Pops	Military & other uniformed services	ASP Procurement & supply chain management Priority Pops Military & other uniformed services	ASC.06.05.01 Procurement and supply chain	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Public financial management strengthening	Non-Targeted Pop	Adults	ASP Public financial management strengthening Non-Targeted Pop Adults	ASC.06.05.04 Financial and accounting systems strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
C&T	HIV Clinical Services	Females	Girls	C&T HIV Clinical Services Females Girls	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.02.02 Girls (aged under 15) living with HIV
C&T	HIV Clinical Services	Key Pops	People in prisons	C&T HIV Clinical Services Key Pops People in prisons	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Priority Pops	Military & other uniformed services	C&T HIV Clinical Services Priority Pops Military & other uniformed services	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender

C&T	HIV Drugs	Key Pops	Not disaggregated	C&T HIV Drugs Key Pops Not disaggregated	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Laboratory Services	Females	Not disaggregated	C&T HIV Laboratory Services Females Not disaggregated	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Laboratory Services	Priority Pops	Military & other uniformed services	C&T HIV Laboratory Services Priority Pops Military & other uniformed services	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Females	Young women & adolescent females	C&T Not Disaggregated Females Young women & adolescent females	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.02 Adult and young women (aged 15 over) living with HIV
C&T	Not Disaggregated	Priority Pops	Military & other uniformed services	C&T Not Disaggregated Priority Pops Military & other uniformed services	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
HTS	Community-based testing	Females	Adult women	HTS Community-based testing Females Adult women	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population
HTS	Community-based testing	Key Pops	Transgender	HTS Community-based testing Key Pops Transgender	ASC.02.03 HIV testing and counselling for TG	SDM.02.98 Home and community based not disaggregated	BP.02.04 Transgender
HTS	Community-based testing	Key Pops	Not disaggregated	HTS Community-based testing Key Pops Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.02.98 "Key populations" not broken down by type
HTS	Community-based testing	Key Pops	Men having sex with men	HTS Community-based testing Key Pops Men having sex with men	ASC.02.02 HIV testing and counselling for MSM	SDM.02.98 Home and community based not disaggregated	BP.02.03 Gay men and other men who have sex with men (MSM)
HTS	Community-based testing	Key Pops	Sex workers	HTS Community-based testing Key Pops Sex workers	ASC.02.01 HIV testing and counselling for sex workers	SDM.02.98 Home and community based not disaggregated	BP.02.02.98 Sex workers, not broken down by gender, and their clients
HTS	Community-based testing	Males	Not disaggregated	HTS Community-based testing Males Not disaggregated	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.02.98 Home and community based not disaggregated	BP.04.01.01 Male adult population
HTS	Community-based testing	OVC	Not disaggregated	HTS Community-based testing OVC Not disaggregated	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)

HTS	Community-based testing	OVC	Orphans & vulnerable children	HTS Community-based testing OVC Orphans & vulnerable children	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
HTS	Community-based testing	Priority Pops	Mobile Pops	HTS Community-based testing Priority Pops Mobile Pops	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.02.98 Home and community based not disaggregated	BP.03.06 Migrants/mobile populations
HTS	Community-based testing	Priority Pops	Military & other uniformed services	HTS Community-based testing Priority Pops Military & other uniformed services	ASC.02.99 Other HIV counselling and testing activities n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.21 Military
HTS	Facility-based testing	Females	Not disaggregated	HTS Facility-based testing Females Not disaggregated	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.01.02 Female adult population
HTS	Facility-based testing	Females	Adult women	HTS Facility-based testing Females Adult women	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.01.02 Female adult population
HTS	Facility-based testing	Females	Young women & adolescent females	HTS Facility-based testing Females Young women & adolescent females	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.01.01 Facility-based: Outpatient	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
HTS	Facility-based testing	Males	Young men & adolescent males	HTS Facility-based testing Males Young men & adolescent males	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
HTS	Facility-based testing	Males	Adult men	HTS Facility-based testing Males Adult men	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
HTS	Facility-based testing	Non-Targeted Pop	Children	HTS Facility-based testing Non-Targeted Pop Children	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.01.01 Facility-based: Outpatient	BP.04.02.98 Children (aged under 15) not broken down by gender
HTS	Facility-based testing	Non-Targeted Pop	Adults	HTS Facility-based testing Non-Targeted Pop Adults	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.98 General population not broken down by age or gender.
HTS	Facility-based testing	OVC	Not disaggregated	HTS Facility-based testing OVC Not disaggregated	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.01.01 Facility-based: Outpatient	BP.03.01 Orphans and vulnerable children (OVC)
HTS	Facility-based testing	Priority Pops	Military & other uniformed services	HTS Facility-based testing Priority Pops Military & other uniformed services	ASC.02.99 Other HIV counselling and testing activities n.e.c.	SDM.01.01 Facility-based: Outpatient	BP.03.21 Military

PREV	Comm. mobilisation, behaviour & norms change	Females	Adult women	PREV Comm. mobilisation, behaviour & norms change Females Adult women	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population
PREV	Comm. mobilisation, behaviour & norms change	Females	Not disaggregated	PREV Comm. mobilisation, behaviour & norms change Females Not disaggregated	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population
PREV	Comm. mobilisation, behaviour & norms change	Key Pops	Transgender	PREV Comm. mobilisation, behaviour & norms change Key Pops Transgender	ASC.01.01.02.03.03 Behaviour change communication (BCC) as part of programmes for TG	SDM.02.98 Home and community based not disaggregated	BP.02.04 Transgender
PREV	Comm. mobilisation, behaviour & norms change	Males	Young men & adolescent males	PREV Comm. mobilisation, behaviour & norms change Males Young men & adolescent males	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.04.01.01 Male adult population
PREV	Comm. mobilisation, behaviour & norms change	Males	Adult men	PREV Comm. mobilisation, behaviour & norms change Males Adult men	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.04.01.01 Male adult population
PREV	Comm. mobilisation, behaviour & norms change	OVC	Care givers	PREV Comm. mobilisation, behaviour & norms change OVC Care givers	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
PREV	Comm. mobilisation, behaviour & norms change	OVC	Orphans & vulnerable children	PREV Comm. mobilisation, behaviour & norms change OVC Orphans & vulnerable children	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Comm. mobilisation, behaviour & norms change	Priority Pops	Military & other uniformed services	PREV Comm. mobilisation, behaviour & norms change Priority Pops Military & other uniformed services	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.03.21 Military
PREV	Comm. mobilisation, behaviour & norms change	Priority Pops	Mobile Pops	PREV Comm. mobilisation, behaviour & norms change Priority Pops Mobile Pops	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.03.06 Migrants/mobile populations
PREV	Comm. mobilisation, behaviour & norms change	Priority Pops	Not disaggregated	PREV Comm. mobilisation, behaviour & norms change Priority Pops Not disaggregated	ASC.01.02.03 Community mobilisation for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Condom & Lubricant Programming	Females	Young women & adolescent females	PREV Condom & Lubricant Programming Females Young women & adolescent females	ASC.01.01.01.01 Condom promotion and distribution as part of dedicated programmes for AGYW - only if earmarked HIV funds are spent	SDM.98 Modalities not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
PREV	Not disaggregated	Males	Not disaggregated	PREV Not disaggregated Males Not disaggregated	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.99 Specific targeted populations not

							elsewhere classified (n.e.c.)
PREV	Not disaggregated	Non-Targeted Pop	Children	PREV Not disaggregated Non-Targeted Pop Children	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.02.98 Children (aged under 15) not broken down by gender
PREV	Not disaggregated	Pregnant & Breastfeeding Women	Not disaggregated	PREV Not disaggregated Pregnant & Breastfeeding Women Not disaggregated	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns
PREV	PrEP	Non-Targeted Pop	Young people & adolescents	PREV PrEP Non-Targeted Pop Young people & adolescents	ASC.01.01.05.99 PrEP not elsewhere classified n.e.c.	SDM.98 Modalities not disaggregated	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender
PREV	PrEP	Pregnant & Breastfeeding Women	Not disaggregated	PREV PrEP Pregnant & Breastfeeding Women Not disaggregated	ASC.01.01.05.99 PrEP not elsewhere classified n.e.c.	SDM.98 Modalities not disaggregated	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns
PREV	PrEP	Priority Pops	Military & other uniformed services	PREV PrEP Priority Pops Military & other uniformed services	ASC.01.01.05.99 PrEP not elsewhere classified n.e.c.	SDM.98 Modalities not disaggregated	BP.03.21 Military
PREV	Primary prevention of HIV and sexual violence	Non-Targeted Pop	Not disaggregated	PREV Primary prevention of HIV and sexual violence Non-Targeted Pop Not disaggregated	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	Priority Pops	Military & other uniformed services	PREV Primary prevention of HIV and sexual violence Priority Pops Military & other uniformed services	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.21 Military
PREV	VMMC	Males	Boys	PREV VMMC Males Boys	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.02.01 Boys
SE	Case Management	Females	Young women & adolescent females	SE Case Management Females Young women & adolescent females	ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW -	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence

					only if earmarked HIV funds are spent		
SE	Case Management	OVC	Care givers	SE Case Management OVC Care givers	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
SE	Case Management	Priority Pops	Military & other uniformed services	SE Case Management Priority Pops Military & other uniformed services	ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent	SDM.02.98 Home and community based not disaggregated	BP.03.21 Military
SE	Economic strengthening	Females	Adult women	SE Economic strengthening Females Adult women	ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population
SE	Economic strengthening	Males	Young men & adolescent males	SE Economic strengthening Males Young men & adolescent males	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
SE	Economic strengthening	Males	Adult men	SE Economic strengthening Males Adult men	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
SE	Legal, human rights & protection	Non-Targeted Pop	Adults	SE Legal, human rights & protection Non-Targeted Pop Adults	ASC.05.02.98 Human rights programmes not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.
SE	Not disaggregated	Non-Targeted Pop	Adults	SE Not disaggregated Non-Targeted Pop Adults	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.
SE	Not disaggregated	OVC	Care givers	SE Not disaggregated OVC Care givers	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)

SE	Not disaggregated	Priority Pops	Not disaggregated	SE Not disaggregated Priority Pops Not disaggregated	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
SE	Psychosocial support	Females	Adult women	SE Psychosocial support Females Adult women	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population
SE	Psychosocial support	Females	Young women & adolescent females	SE Psychosocial support Females Young women & adolescent females	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Psychosocial support	OVC	Care givers	SE Psychosocial support OVC Care givers	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)

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