Nepal
National AIDS Spending Assessment (NASA)
2021 - 2023



Government of Nepal
Ministry of Health and Food Safety
National Centre for AIDS and STD Control (NCASC)

December 2025

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This report provides the assessment of HIV and AIDS related expenditures occurred in Nepal for the period 20201-2023 estimated based on the expenditure boundaries, expenditure data, classification codes and estimation methodology. This document was produced with the technical and financial assistance of UNAIDS.

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Foreword From The Director

The National Centre for AIDS and STD Control is pleased to present the Nepal National AIDS Spending Assessment (NASA) 2024, assessing resources invested in Nepal's national HIV response during 2021–2023. The assessment provides important evidence on HIV financing, expenditure patterns, resource flows, and financing gaps to guide future planning and resource mobilization.

Nepal has conducted five HIV resource-tracking exercises, including four using the standardized NASA methodology. The findings demonstrate both significant progress in the HIV response and continued dependence on external financing. During 2021–2023, international financing accounted for approximately 75–85 percent of total HIV expenditure, with the Global Fund and United States Government together contributing around 60–68 percent of total HIV resources. Provincial and local government contributions remained limited, highlighting the need to strengthen domestic investment in HIV. Nepal has achieved substantial progress in reducing HIV transmission, with new infections declining by more than 80 percent, from over 3,000 in 2007 to around 500 in 2023. By 2023, approximately 93 percent of people living with HIV knew their status and 82 percent of the estimated 30,300 people living with HIV were receiving antiretroviral therapy. These achievements reflect the collective efforts of the Government of Nepal, communities, civil society, development partners, and health service providers. The continued reliance on external financing underscores the importance of strengthening domestic resource mobilization, improving budget allocation and execution, and increasing provincial and local investment to ensure the sustainability of HIV services. The Introduction of Social Health Insurance (SHI) for people living with HIV through government-reimbursed premium waivers is a positive step toward strengthening domestic financing and financial protection. NASA 2024, together with the National HIV Strategic Plan (NHSP) 2021–2026, also highlights gaps between projected resource requirements and actual expenditure, particularly for prevention. These findings provide an important basis for recalibrating future resource projections and improving allocative efficiency, value for money, and cost-effectiveness in the next phase of Nepal's HIV response.

I extend my sincere appreciation to all government institutions, provincial health authorities, NCASC staff, civil society organizations, and development partners for their valuable contributions. I particularly acknowledge WHO, UNAIDS, the United States Government, Epic Nepal/PHI 360, AIDS Healthcare Foundation Nepal, and Save the Children, with special appreciation to UNAIDS for its financial and technical support. I also sincerely thank Mr. Mahesh Sharma and Mr. Prabhu Raj Poudyal for their professional commitment and dedicated efforts in completing this assessment.

I trust that NASA 2024 will serve as a valuable evidence base for strengthening domestic investment, improving the sustainability and efficiency of HIV financing, and guiding Nepal's next phase of the national HIV response.

Dr: Sarbesh Sharma
Director

DIRECTOR

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASC	AIDS Spending Category
BCC	Behaviour change communication
BL	Bilateral Agencies
BP	Beneficiary Population
CCC	Community Care Centre
CHBC	Community Home Based Care
CLO	Community Led Organisations
CLORT	Community Led Organisation Resource tracking
DACC	District AIDS Coordination Committee
DIC	Drop-in Centre
EDP	External Development Partners
eVT	Elimination of Vertical Transmission
FAP	Financing Agent and Procurer
FE	Financing Entity
FHI	Family Health International
F/SW	Female/ Sex Worker
GAM	Global AIDS Monitoring
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoN	Government of Nepal
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioural Surveillance
INGO	International Non-Governmental Organization
IP	Implementing Partner
KP	Key population
LDC	Least Developed Country
LGBTI	Lesbian, gay, bisexual, transgender and intersexual
ML	Multilateral Agencies
MLM	Male Labour Migrants
MoHP	Ministry of Health and Population*
MSM	Men Who Have Sex with Men
n.e.c	Not elsewhere classified

***Note**: by the time this report was published, the name of Ministry of Health and population was changed to Ministry of Health and Food Safety. Therefore, throughout in this report **MoHP or Ministry of Health and Population** should be read as **Ministry of Health and Food Safety**.

NACP	National AIDS Control Programme
NAP	National Action Plan
NASA	National AIDS spending assessment
NCASC	National Centre for AIDS and STD Control
NGO	Non-Governmental Organization
NHSP	National HIV and AIDS Strategic Plan
NIB	National Health Insurance Board
OI	Opportunistic Infection
OST	Oral Substitution Therapy
OVC	Orphans and Vulnerable Children
PF	Production Factor
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PS	Provider of Services
PWID	People Who use Injecting Drug
RTS	Resource Tracking Software
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TG	Transgender, Trans
TI	Targeted Intervention
TWG	Technical Working Group
TOR	Term of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VL	Viral load
WHO	World Health Organization

Executive summary

Background and Purpose

The National HIV/AIDS Spending Assessment (NASA) 2021–2023 analyses financial flows supporting Nepal's HIV response using the internationally standardized NASA framework and methodology recommended by UNAIDS. The assessment follows the 2025 UNAIDS guidelines, whereby expenditures are systematically reconstructed across three dimensions—financing, provision, and consumption—and mapped through nine vectors, tracing resources from their sources to final beneficiaries. It captures how funds are mobilized, managed, allocated, and utilized across programme areas, beneficiary populations, and service delivery modalities.

In addition, this exercise extended the analysis to examine the contribution of Community-Led Organizations (CLOs) to the national HIV response, with particular attention to non-monetary and non-exchange transactions. These include in-kind contributions, volunteer labour, and other forms of community support that supplement financial resources but are not reflected in conventional expenditure tracking systems

The NASA findings support evidence-based decision-making to improve allocative efficiency, equity, and sustainability of HIV financing, in alignment with the National HIV Strategic Plan (NHSP) 2021-2026.

Overall Level and Trends of HIV/AIDS Spending

Total HIV/AIDS expenditure increased from approximately USD 16.7 million in 2021 to USD 20.9 million in 2023, amounting to USD 57.4 million over the three-year period. Despite this upward trend, actual spending met only about 52 percent of the total resource needs projected under the NHSP (2021-2026) for the year 2021–2023, indicating a persistent financing gap. Growth in spending was driven primarily by increases in care and treatment, HIV testing and counselling, and programme enablers, while prevention expenditure remained comparatively lower relative to planned needs.

Financing Entities

Nepal's HIV response during 2021–2023 remained highly dependent on international financing, which accounted for approximately 76–85 percent of total HIV/AIDS expenditure across the three years. The dominant financing entities were The Global Fund and US Government, which together financed around 60–68 percent of total HIV resources, directly financing service delivery through national and sub-national implementing partners. These funds were largely

channelled through mostly off-budget and off-treasury mechanisms, although aligned with national HIV strategies and approved by the Government of Nepal.

Government financing, decreased slightly in 2022, then increased in 2023, but not its 2021 level, accounting for a declining share of total HIV spending (from 24% in 2021 to 18% in 2023) and was concentrated mainly in care and treatment services, particularly antiretroviral therapy (ART), human resources, and facility-based service delivery. The public sector managed approximately 26–40 percent of total resources, primarily through federal-level allocations and delivered through public health facilities. Notably, the introduction and expansion of Social Health Insurance (SHI) for People Living with HIV (PLHIV)—including government reimbursement of waived insurance premiums—represents an important step toward strengthening domestic financing and reducing financial barriers to care. However, SHI currently covers mainly clinical services and does not substitute for broader needs of PLHIV.

Provincial and local government contributions to HIV financing from their own resources remained minimal and uneven, reflecting limited fiscal prioritization of HIV at sub-national levels[2]. This continued reliance on external funding poses significant risks to the sustainability of HIV programmes, particularly in the context of a changing global funding landscape. Strengthening domestic resource mobilization, improving budget execution, and increasing sub-national financing will be critical for sustaining HIV services over the medium to long term.

Allocation by Programme Areas (ASC)

HIV care and treatment consistently represented the largest share of spending, accounting for approximately 30–32 percent of total HIV/AIDS expenditure, reflecting the recurrent costs of ART and clinical management. HIV testing and counselling (HTC) with spending of 20-23% with steady growth over the three years, and prevention with spending of 20-22%. Together prevention and HTC accounted for roughly 40–43 percent of total HIV spending. The high HTC expenditure is largely driven by innovative and incentivised testing approaches to track the limited number of infections in widely scattered geographical areas. Comparison with NHSP projections indicates relative underinvestment in prevention, which received significantly less funding than envisaged in the NHSP 2021-2026.

Programme enablers and systems strengthening accounted for over 22 percent of total expenditure, driven largely by programme administration and management costs, as well as major laboratory infrastructure investments

[2] *Subnational governments receive four different types of grants from federal government to allow for flexible planning and executing budget as per their decision.* Understanding federal grants in fiscal federalism | The Farsight Nepal

financed by the Global Fund. These investments, while not directly attributable to specific beneficiaries, are essential for maintaining service delivery capacity.

Programme administration and management constituted the largest cost driver within programme enablers, accounting for over 70 percent of expenditure in this category, reflecting the complexity of reaching diverse key populations across a federalized system.

Beneficiary Populations and Equity

Spending by beneficiary population broadly reflected national HIV priorities. People Living with HIV (PLHIV) received nearly 30 percent of total expenditure (USD 17.6 million), primarily through care and treatment services. Key populations accounted for approximately 28–29 percent, consistent with the concentrated nature of Nepal's epidemic.

Vulnerable and accessible populations received around 11 percent, while the general population accounted for less than 6 percent. A substantial share of spending (21–27 percent annually) was classified as non-applicable i.e., expenditure such as programme management, system strengthening, advocacy, research and so on which cannot be attributed to any specific beneficiary group.

Women and children accounted for about 11–12% of total HIV spending during 2021–2023, of which the largest share was directed to sex workers and their clients (77-86%), reflecting higher HIV burden, followed by children living with HIV (6–9%). Spending on orphan and vulnerable children and the general female adult population (6% in 2021) declined over the period.

Provincial analysis reveals substantial variation in per PLHIV expenditure (Bagmati province USD 949 to USD 371 in Madhesh province) and per capita spending (Bagmati USD 1.34 to 0.34 USD in Karnali), suggesting uneven allocation of resources across provinces relative to HIV burden, population size, and service delivery needs. These disparities raise concerns about equity and call for more systematic, needs-based resource allocation mechanisms.

Service Delivery Modalities

Prevention interventions were predominantly delivered through community- and home-based modalities, while care and treatment relied mainly on facility-based service delivery, complemented by community-based adherence and retention support.

NASA (2024) vs NHSP (2021-2026)

Findings from NASA 2024 and the NHSP 2021–2026 reveal a substantial gap between the projected resource requirements of the NHSP and actual expenditures for the national HIV response. This evidence provides an important basis for recalibrating resource projections in the forthcoming NHSP, ensuring that future planning is grounded in observed expenditure patterns and implementation realities.

Allocative and technical spending efficiency

While there is some misalignment between NASA expenditure and NHSP resource need projections, driven mainly by underspending on prevention efforts, which may imply limited allocative efficiency, some temporary technical efficiencies were observed in ART (Anti-Retroviral Therapy), with slight reduction in unit cost per ART client (USD 256 in 2021 to USD 234 in 2022), but increasing again to USD 266 in 2023, despite increasing numbers on treatment.

In OST (Opioid Substitution Therapy) the data pattern suggests moderate gains in technical efficiency; however, rising personnel and recurrent costs indicate growing cost pressures, which may affect the sustainability and future scale-up of OST services. Importantly, the OST drug costs per person appeared to have reduced over the period from USD 22 to USD 17, and if continue to reduce could lead to important cost savings

With minimal capital investment found in the total HIV spending (primarily from the Global Fund investments in laboratory infrastructure), the HIV programme relies heavily on recurrent inputs, hence further technical efficiency gains could be achieved through improved procurement efficiency and managing rising input costs (human resources, ARVs and OST drug costs), while scaling up the services to achieve further economies of scale.

Findings from the tracking of Community-Led Organizations (CLOs) resources.

Since the pilot CLO resource tracking in 2022 in Nepal, this updated assessment (in 2024) found a reduction in the number of active CLOs (five in total in contrast to 130 responses during CLOs piloting in 2022), as well as a narrowing of their programmatic activities since the earlier assessment. CLOs continue to rely almost entirely on major donors, with very limited success in mobilizing additional resources from local governments or alternative sources. Structural and regulatory barriers, particularly affecting female sex worker–led organizations, further constrain the community response.

CLOs' persistent weakness in mobilising the non-monitory resources impacts the long-term effectiveness of community-led HIV responses in Nepal. Addressing these gaps will require stronger institutional support, policy-level engagement, and deliberate strategies to integrate CLOs' contributions—both financial and non-financial into broader HIV financing and planning frameworks.

Support CLOs to diversify funding sources beyond the existing major financing entities by engaging alternative donors, INGOs, philanthropic foundations, corporate social responsibility (CSR) initiatives and most importantly with provincial and local government bodies. Promote open and fair social contracting mechanism to actively and regularly engage CLOs.

Key messages

The NASA 2021–2023 findings indicate that Nepal's HIV spending is broadly aligned with strategic priorities in terms of beneficiary focus and service delivery models. However, high dependence on international financing, insufficient federal and provincial contributions, underinvestment in prevention, and persistent financing gaps relative to NHSP (2021-2026) cost projections, particularly for prevention efforts pose significant risks to sustainability.

Strengthening government financing—particularly through predictable budget allocations, expanded SHI coverage, and greater sub-national engagement and contribution—will be essential to ensure a resilient and sustainable HIV response.

Introduction and background

1. Introduction and background

The National HIV/AIDS Spending Assessment (NASA) measures expenditure on the final consumption of goods and services related to the national HIV response. It tracks the flow of HIV-related expenditures from sources of funds through financing agents to service providers, classifying spending by financing schemes, AIDS service categories, factors of production, and beneficiary populations in accordance to the National HIV/AIDS Spending Assessment (NASA) framework developed by UNAIDS. The NASA resource-tracking process applies a comprehensive and standardized methodology that captures both health and non-health expenditures. This includes spending on areas such as prevention, treatment, and care, as well as cross-sectoral investments in social protection, education, labour, and other sectors contributing to the multisectoral response to HIV.

Additionally, the NASA guidelines also introduced Community Led Organisations – Resource Tracking (CLO-RT) framework as part of NASA exercise. This primarily intends to assess non-monetary and non-exchange transactions. These include in-kind contributions, volunteer labour, and other forms of support that do not involve direct financial payments.

The first NASA was conducted in Nepal in 2007, followed by a similar resource tracking exercise conducted in 2011, and two subsequent rounds of NASA in 2015 and 2018 — each covering a two-year period. The current assessment represents the fifth national effort to systematically assess AIDS-related spending in the country covering a three-year period from 2021 to 2023. This assessment is expected to enhance understanding of the trajectory of resource flows and their allocation toward the production of HIV-related goods and services. It provides critical strategic information to monitor progress, inform evidence-based decision-making, and guide stakeholders in more effective and equitable resource allocation. In addition, NASA evidence supports monitoring of key indicators for Global AIDS Monitoring (GAM) adopted by the United Nations and generates essential strategic information to strengthen the management and coordination of the national response to AIDS.

This report maps the flow of resources for the years 2021, 2022 and 2023 from their sources, their use and intended beneficiaries, presented systematically through tables and graphs. Effort is also made to draw the trends of such flow from previous exercises to the extent comparable data are available. This allows stakeholders to estimate financing gaps for HIV/AIDS overall, and for specific interventions across the HIV/AIDS prevention, care, and treatment spectrum.

1.1 Nepal's Socio-Economic Indicators

Nepal is classified as a least developed country (LDC) with relatively moderate economic growth coupled with socio- economic underdevelopment and low human development. Currently Nepal is categories under Lower Income Country (LIC) and in the process of graduating to Lower Middle-Income Country (LMIC) in 2026 following a five-year extension granted due to the COVID-19 pandemic. The World Bank estimated Nepal's Gross National Income (GNI) at USD 41.05 billion in 2023, which is decrease from 2022. The country has recorded an annual GDP growth of 2% in 2023, an increase compared to the negative growth rate of -2.4% in 2020(World Bank 2024). Similarly, Gross Domestic Product (GDP) per capita of 1,382.3 USD was observed for the year 2023 compared to 1154.2 USD in 2020 (World Bank 2024). The country has made some progress in Poverty reduction (SDG 1) and Health and well-being (SDG 3) including reductions in maternal and child mortality. (https://dashboards.sdgindex.org/profiles/nepal/).

The total population of Nepal, as of 2023, was 29. 6 million with an annual population growth rate of - 0.1 percent (World Bank,2024). In 2021, the absent population constituted 7.6 percent (2,190,592 persons) of the total population, compared to 6.5 percent (1,921,494 persons) in 2011 (NPHC2021, NPHC 2011, CBS). Life Expectancy at birth in 2023 was estimated at 70 years rebounding from a dip to 68 years in 2021 (World Bank,2024).

Nepal's GDP increased from USD 36.9 billion in 2021 to USD 41.18 billion in 2022, indicating economic recovery and growth. In 2023, GDP remained largely stable at USD 41.05 billion, suggesting a slowdown or plateau in economic expansion.

1.2 HIV situation and response in Nepal

HIV prevalence in the general population remains low at approximately 0.01%. However, prevalence among several key populations exceeds 5%, indicating a concentrated HIV epidemic among some key populations.

Recent Integrated Biological and Behavioural Surveillance (IBBS) surveys conducted by the National Centre for AIDS and STD Control (NCASC) show that HIV prevalence among transgender people (TG – both men and women) was highest in the Terai at 11.5% (IBBS 2018), followed by Kathmandu at 8.5% (IBBS 2017) and Pokhara at 4.5% (IBBS 2017).

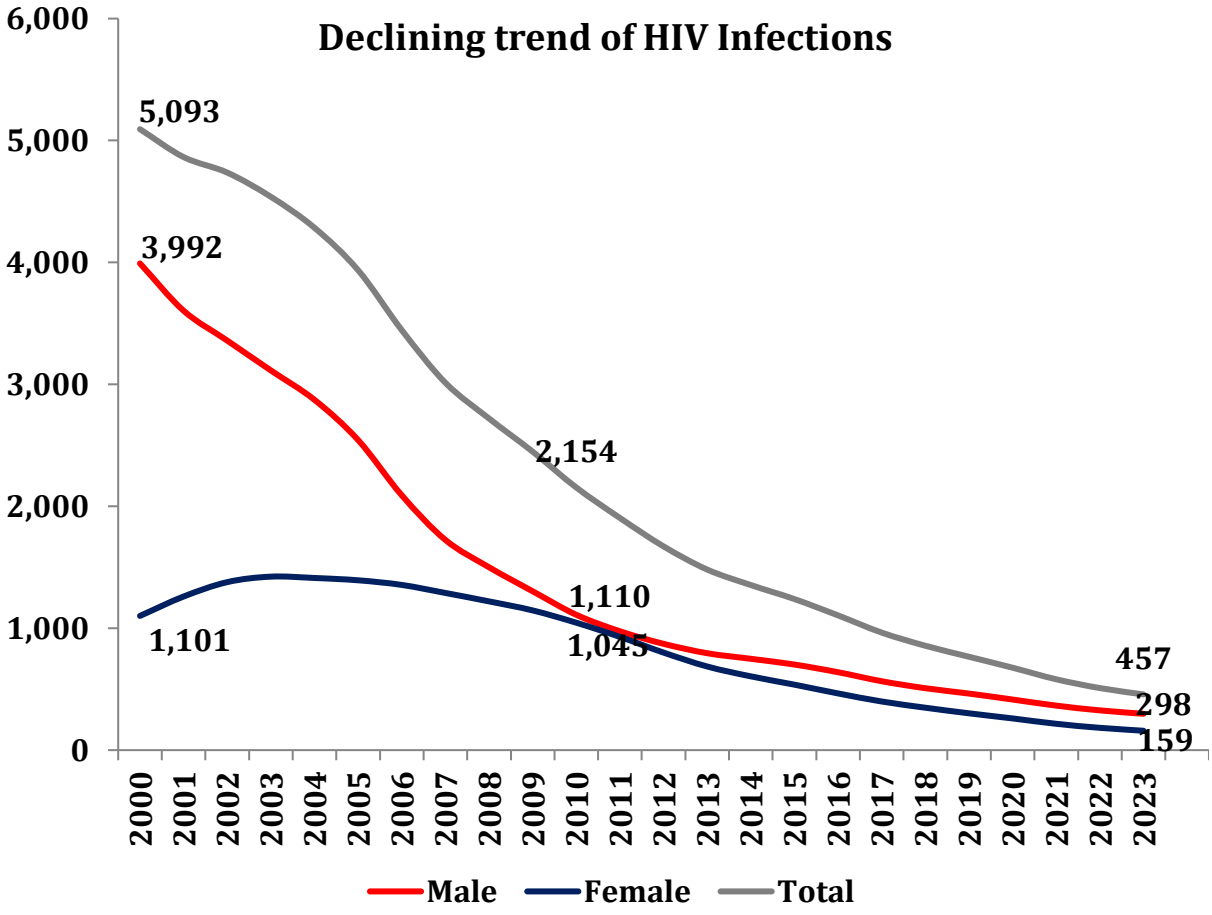
Similarly, among men who have sex with men (MSM), the highest HIV prevalence was recorded in the Terai at 6% (IBBS 2018), followed by Kathmandu at 5% (IBBS 2017) and Pokhara at 2.3% (IBBS 2017). Among people who inject drugs (PWID), HIV prevalence was highest in Kathmandu at 8.8% (IBBS 2018) and 4.9% in Pokhara

(IBBS 2017), while a nationwide survey conducted in 2020 reported a prevalence of 2.8%.

Among female sex workers (FSW), the highest HIV prevalence was observed in Kathmandu at 2.2% (IBBS 2017), followed by the Terai at 0.7% (IBBS 2018) and Pokhara at 0.3% (IBBS 2016). In contrast, the most recent survey among male labour migrants (MLM) reported a low HIV prevalence of 0.2% in 2024 (IBBS 2024).

As of 2023, there were an estimated 30,300 people living with HIV in Nepal, the majority (95%) of which are adults aged 15 and over. About half (51.5%) among adult (15-49) estimated adult population living with HIV were female. In the year 2023, a total of 457 new infections — including 35 among infants — was estimated compared to that of 2148 in 2010 (Figure 1). Similarly, the number of deaths declined from 1705 in 2010 to 261 in 2023 (Factsheet 2024, NCASC). In terms of the HIV testing and treatment cascade, 93% (28,841) of people living with HIV knew their status, 82% (24,793 adult and children) were on anti-retroviral treatment of which 73% (18,236) were virally suppressed. It is estimated that 71,538 people have been infected and 29,890 have died since the first case was reported in 1988 (Factsheet 2024, NCASC).

Figure 1: Declining Trend of New Infections in Nepal



Source: Factsheet 2024, NCASC

1.3 National Response to HIV

National Policy on HIV and STI (2011) established the overarching policy and governance frameworks for the country's HIV and STI response in Nepal. This is further reinforced by several complementary legal and policy instruments including National Drug Control Policy 2063 (2006 AD), National Drug Control Strategy, 2066 (2010 AD); National Blood Transfusion Policy; and National Policy on HIV/AIDS in the Workplace, 2064 BS (2007 AD). Together these frameworks guide and strengthen the national response to HIV in Nepal.

National HIV Strategic Plan (NHSP) 2021-2026 has been in operation in the country with the vision of "Ending the AIDS epidemic, as a public health threat in Nepal, by 2030". The Plan's mission is to provide inclusive, equitable and accessible services throughout the HIV care continuum. Anchored in the paradigm of 95-95-95, NHSP purses the following targets by 2021:

- Identify 95 % of the estimated PLHIV
- Treat 95 % of people diagnosed with HIV
- Attain viral load suppression for 95 % of PLHIV on ART
- Reduce 90% of new HIV infections (base line as 2010)
- Eliminate vertical transmission of HIV
- Achieve case rate of congenital syphilis of ≤50 per 100 000 live births.

The NHSP (2021-2026) has prioritized strategic allocation of resources for fast-tracking the HIV response over the period of five years. The anticipated resource required for the first fiscal year 2021/2022 amounts to USD 34.14 million, increasing every year to reach an investment of USD 43.54 million in the final fiscal year 2025/2026 adding up to the total of USD 199.12 million for the five years (Table 1).

Table 1: Anticipated resources required (in USD million) for the implementation of NHSP 2021-2026

Investment areas	2021/2022*	2022/2023	2023/2024	2024/2025	2025/2026
Prevention	12.86	15.02	15.83	16.41	16.74
Testing	6.51	7.74	8.24	8.66	8.92
Treatment	4.64	5.21	5.27	5.46	5.78
Care and support	2.96	3.24	3.30	3.36	3.45
Programmatic Enabler	1.22	0.93	1.22	0.93	1.22
Strategic Information	0.99	1.03	1.01	1.01	1.03
Addressing human rights barriers	0.50	0.52	0.55	0.68	0.72
Management Cost	4.45	5.05	5.31	5.47	5.68
Total USD (in million)	**34.14**	**38.74**	**40.73**	**41.97**	**43.54**
Source: NHSP (2021-2026)					**Note: Govt fiscal year is July-June*

According to the financial landscape of anticipated resources for 2021–2026, prepared in 2020 for the Funding Gap Analysis for the NHSP, the total funding expected to be available from the government and external development partners during this period was estimated at approximately USD 70.86 million. This estimate also incorporates the actual expenditures by AHF in fiscal years 2022/2023 and 2023/2024 (Table 2). However, findings from the NASA indicate that total expenditures for the HIV response amounted to USD 16.7 million in 2021, UDS 19.9 in 2022, and; USD 20.9 million in 2023, resulting in cumulative spending of USD 57.4 million over the three-year period. This level of expenditure is nearly one-fifth (19%) lower than the anticipated resource envelope projected in the Funding Gap Analysis.

Table 2: Financial landscape of anticipated resources (in USD million) for the period of 2021-2026

Source	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
GoN	5.09	5.35	5.61		
GFATM	6.30	8.60	9.13	3.56	
US Government	8.45	4.70	4.70	4.70	
AHF	0.85	0.85	0.85		
other (UN agencies)	0.3	0.1	0.19	0.13	
Total Current Committed	20.95	18.79	19.63	8.390	-
Projected investment need	34.14	38.74	40.73	41.97	43.54
Funding gap (in million USD)	13.19	19.95	21.09	33.58	43.54
Source: NHSP (2021-2026)					

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is by far the largest contributors to Nepal's HIV response. For HIV for the period of 2021-2024, the Global Fund allocated US$ USD 26,926,654 in Nepal for the targeted interventions notably: 1) People who Inject drugs, 2) Migrants, and 3) Prison Inmates. This amount is also complemented by an additional USD 1,100,000 in the matching fund to support the removal of human-rights barriers to accessing HIV services

The Government of Nepal also makes regular budget allocations for testing, treatment, Prevention from Mother to Child Transmission, TB-HIV, STI and strategic information. The government's investment on HIV is channelled through National AIDS and STI Control Centre via Ministry of Health and Population for its federal-level expenditure, as well as through conditional grants (grant restricted to spend on defined plan as per federal ministry's guidelines, in this case ringfenced to HIV only) to the provincial governments to support the HIV response at the subnational level. With federalization, under the Local Governance Operation Act 2018, provincial and local governments have the power to allocate their own resources to the HIV response. Several local governments have been reported to allocate budget for the cause of HIV especially for the support of key populations- though not of significant amount.

United States Government began supporting HIV-related programmes in 1993, including initiatives such as the IMPACT Project. Since then, the US Government has invested more than US$ 95 million in comprehensive HIV prevention, care, support, and treatment services in the country. Till the end of 2024, US Government supported HIV services—including prevention, care and treatment, gender-based violence (GBV) screening, and community outreach—for key populations, notably MSM, FSWs, PLHIV and transgender people, across multiple districts of Nepal.

The UN system, in particular, UNAIDS, WHO, UNICEF, UNFPA and UNODC, has been supporting the HIV response in Nepal in diverse areas notably; preparation of national strategy; size estimation of key affected populations; preparation of guidelines and directives; harm reduction; treatment and care; and expansion of services related to elimination of vertical transmission over the period of decades. Apart all these, UN system's role in providing technical assistance for resource mobilization is also noteworthy.

Apart from these actors, AIDS Health Care Foundation has been involved in the response to HIV in Nepal. Its main areas of involvement are in supporting the government delivery of service in two key programmatic areas: a) treatment care

and support of people living HIV, and; b) HIV testing among general population groups.

1.4 Public Health Financing in Nepal

The total federal budget increased slightly in 2022 compared to 2021, and while it declined in USD terms in 2023, it showed a small increase in Nepali Rupees (NPR), reflecting the effects of exchange rate depreciation rather than an actual contraction in budget allocation. This pattern suggests a degree of fiscal tightening or reprioritization of government expenditure despite a relatively stable GDP. (Table 3). All figures in nominal value.

Table 3: GDP, Federal Budget, and Health Sector Allocations (2021–2023)

Year	GDP (USD)	Federal Budget (USD)	Federal Health budget (USD)	NCASC Budget (USD)
2021	36.92 billion	13,939,254,752	1,197,598,245	4,781,851
2022	41.18 billion	14,267,218,054	980,304,840	4,451,553
2023	41.05 billion	13,259,821,195	778,105,281	3,950,738
	Source: World Bank	Source: Red Book	Source: Red Book	Source: Red Book

Allocations to the health sector show a consistent downward trend over the three-year period (in unadjusted value). The federal health sector budget declined from USD 1.20 billion in 2021 to USD 0.98 billion in 2022, and further to USD 0.78 billion in 2023, indicating a decreasing prioritization of health within the federal budget. The comparatively higher health sector allocation in 2021 reflects the exceptional priority accorded to the health sector in response to the COVID-19 pandemic.

The budget allocated to the National Centre for AIDS and STD Control (NCASC) also decreased steadily, in nominal terms, from USD 4.78 million in 2021 to USD 3.95 million in 2023, but increased as a share of the health budget (Table 4). This mirrors the overall reduction in health-sector funding and suggests increasing financial pressure on the national HIV and STI response.

Health Sector Budget as a share of GDP declined steadily from 3.24% in 2021 to 2.38% in 2022, and further to 1.90% in 2023, indicating a progressive reduction in national economic resources allocated to health (Table 4). The share of the federal budget allocated to the health sector also showed a clear downward trend, decreasing from 8.59% in 2021 to 6.87% in 2022, and to 5.87% in 2023, reflecting a declining prioritization of health within overall government spending following the COVID-19 response period. In contrast, the NCASC budget share within the health sector increased from 0.40% in 2021 to 0.45% in 2022, and further to 0.51% in 2023. This upward trend is generally attributable to the government's sustained

commitment to procuring antiretroviral drugs and HIV test kits, with procurement volumes increasing to support progress toward the 95–95–95 targets.

Table 4: Relative share of national health sector and NCASC budget

Year	Health Sector Budget as % of GDP	Health Sector as % of Federal Budget	NCASC Budget as % Health sector Budget
2021	3.24	8.59	0.40
2022	2.38	6.87	0.45
2023	1.90	5.87	0.51

According to the latest National Health Accounts FYs (2018/19 -2019/20), Total Health Expenditure (THE) was estimated at USD 1.6 billion and USD 1.9 billion, equivalent to 5.3% and 5.8% of GDP, and per capita total health expenditure was estimated at USD 54.7 and USD 63.6 in FYs 2018/19 and 2019/20, respectively. Similarly, General Government Health Expenditure (GGHE), including current and capital expenditure, amounted to USD 0.5 billion and USD 0.7 billion, which were 5.6% and 8.0% of General Government Expenditure (GGE) in the FYs 2018/19 and 2019/20, respectively.

National Health Accounts FYs (2018/19 -2019/20) further added that the share of General Government Health Expenditure (GGHE) in current health expenditure (CHE) increased from 26.5% in FY 2018/19 to 31.9% in FY 2019/20. At the federal level, the Ministry of Health and Population (MoHP) was the largest agency for managing government health expenditure, accounting for about 24.5% of GGHE, followed by provincial and local governments with about 0.6% and 9.1%, and other ministries and public bodies with 8.1% in FY 2018/19. Total external funding for health was estimated at 11.9% and 10.5% of CHE in the FYs 2018/19 and 2019/20, which includes direct foreign transfers and foreign transfers distributed for health through the government.

The level of Household out-of-pocket (OOP) spending on health – a proxy indicator for financial protection – is high in Nepal. National Health Accounts FYs (2018/19 - 2019/20) showed that the Household Out of Pocket (OOP) payments for health care were the largest source and payer for their health care, with a share of 57.9% and 54.2% of the current health expenditure in FYs 2018/19 and 2019/20, respectively - figures indicative of low levels of risk pooling and high potential for catastrophic health expenditures.

1.5 Previous HIV resource tracking findings

Nepal has, so far, conducted five rounds of resource tracking exercise and four of which is NASA. First round of NASA was conducted in 2007. Next resource tracking exercise was carried out in 2010 using a different methodology and classification

system of tracking the resources. Third round (2015), fourth (2018) and including this fifth round were based on NASA methodology (UNAIDS 2009).

NASA 2007

About US$ 33 million were committed by different partners for the two years period (2006-2008) or about 17 million for one year against US$ 64 million budget plan of National Action Plan (NAP 2006-2008). It is observed that US$ 17.5 million was actually spent indicating a consistent pattern of commitments and actual spending, though this spending is only 50% of total requirement according to NAP 2006-2008. An overwhelming proportion (85%) of resources were spent through NGOs providing HIV services to different categories of beneficiaries.

Resource Tracking Survey (RTS 2010)

A total of USD 20.5 million was spent in the year 2009 and USD 19.1 million was obligated for the fiscal year 2010. Global Fund constituted one of major sources of funding, which provided 31.3% of funding for HIV response for the fiscal year 2009; this was followed by DFID (30.9%) and US Government (26.8%). Effort was made to analyse the spending data by district and regions (five regions).

NASA 2015

Overall, US$ 16,357,125 and US$ 18,815,087 were spent for the year 2013 and 2014 respectively from 26 financing sources that fall within the five broader categories of financing sources (Government of Nepal, bilateral sources, multilateral sources, international organisations and private sources including OOPE). Government of Nepal financed HIV programme utilising two mechanisms, national revenue sources and the pool fund mechanism of donors and government.

NASA 2018

Total spending on the HIV response was estimated at USD 18.8 million in 2016 and USD 20.0 million in 2017. In this round of NASA, funding was invested from 14 distinct financing sources, including two bilateral partners, six multilateral organizations, four international non-governmental organizations, and two domestic sources—namely, the Government of Nepal and public/private out-of-pocket expenditures.

The rationale for an HIV spending assessment

2. The rationale for an HIV spending assessment

NASA is a very powerful tool and is designed to generate useful evidence to assist the policy makers and implementors in the planning and financing of HIV responses ranging from HIV prevention to care and treatment with emphasis on key populations programming, community-led responses, and programmes to address structural barriers. The findings from NASA have been effectively used to measure the potential financial gap particularly tracking the actual expenditure as per NSP priorities and mobilize additional resources for the HIV response. It will provide crucial insights on the extent of harmonization and alignment of the resource allocation with programmatic priorities.

In addition, civil society organizations (CSOs), particularly community-led organizations (CLOs), play a critical role in organizing key populations and delivering a wide range of HIV prevention, care, treatment, and support services to infected and affected communities. In this context, it is important to assess the extent of effort undertaken by key populations and CLOs in mobilizing additional resources—particularly non-monetary and non-transactional contributions—such as volunteer time, in-kind goods, rent-free office space, and other community-based support mechanisms that supplement formal financial investments in the HIV response. This is particularly important when future HIV funding is threatened by competing global priorities and the economic downturn while expectations to achieve more remain high, and hence the NASA data will inform sustainability planning. Development of expenditures per unit from the primary data generated through NASA will support HIV economic studies on efficiency assessment.

This exercise is particularly important at this point of time as the country is almost mid-way through the implementation of NHSP (2021 -2026). As such, NASA finding would be an indicator of progress in spending term at this midpoint of the National HIV Plan 2021 -2026. Moreover, the findings and recommendation are expected to be useful to the federal, and subnational governments for prioritizing key areas for allocating resources for HIV. The NASA (2024) findings will contribute the government – federal and sub national and other partners to refine the investment needs in different HIV interventions. This has advantage to help refine the budgeting during the country's Global Fund grant preparation and negotiation period. It will also contribute to refining the funding landscape and priority, providing strategic intelligence on funding, identifying funding gaps, and documenting country co-financing commitments. Additionally, it will also assist in refining costing/budgeting of planned HIV interventions in the funding request (NASA 2024 ToR). Apart from generating good quality spending evidence the NASA findings will shed light on overall financial governance in the national response to HIV.

Aim and objectives of NASA in Nepal

3. Aim and objectives of NASA in Nepal

The purpose of NASA in Nepal is to draw a detailed and systematic analysis of HIV spending, covering all relevant sectors and stakeholders. The data should answer specific policy questions and meet stakeholders' needs for evidence-based allocative decisions.

The primary objective of NASA 2024 was to collect and analyse HIV expenditure data of Nepal for the period of 2021 to 2023 (three years) by applying the most up-to-date NASA methodology.

The specific objectives of this NASA exercise were;

- Track the flows of resources for HIV from funding source to its ultimate users, the beneficiary populations using NASA vectors
- Review and further analyze NASA's findings in conjunction with NHSP 2021-2026 costing and other external data as practical (i.e., National Health Accounts)
- Enhance local capacity in HIV financing monitoring using NASA methodology towards institutionalization
- Engage communities in national NASA process and integrate CLO resource tracking particularly non-monetary and non-exchange transactions in national NASA exercise. These include in-kind contributions, volunteer labour, and other forms of support that do not involve direct financial payments.
- Expand the NASA assessment in Nepal by undertaking specific analyses on expenditures per unit, and exploring analyses on SHI and UHC financing schemes, and detailed commodity spending analyses.
- To the extent data permitting, explore to what level social contracting mechanism to implement HIV related services have been utilised using domestic resources.

Methodology and scope

4. Methodology and scope

4.1 NASA Concept

NASA approach is a comprehensive and systematic methodology developed by UNAIDS to determine the flow of resources from source to agent and to providers who provides goods and services to specific population group. It describes the allocation of funds, from their origin to the end point beneficiary groups who benefit from specific interventions, good and services (a schematic diagram is presented below). The most important aspect of NASA is that it is designed to track both health and non-health expenditure related to HIV/AIDS as well as track the expenditure by intended beneficiaries

4.2 Approach

The NASA is grounded in standardized methods, definitions, and accounting rules drawn from internationally recognized systems such as National Accounts and the System of Health Accounts (SHA). While NASA is aligned with the core principles and framework of the SHA, it extends beyond traditional health expenditures. It encompasses a broader range of spending to capture the multisectoral response to HIV and AIDS.

NASA records all expenditures related to HIV and AIDS, including social mitigation efforts, legal services, educational and life-skills activities, psychosocial support, care for Orphans and Vulnerable Children (OVC), and initiatives aimed at fostering a supportive and enabling environment.

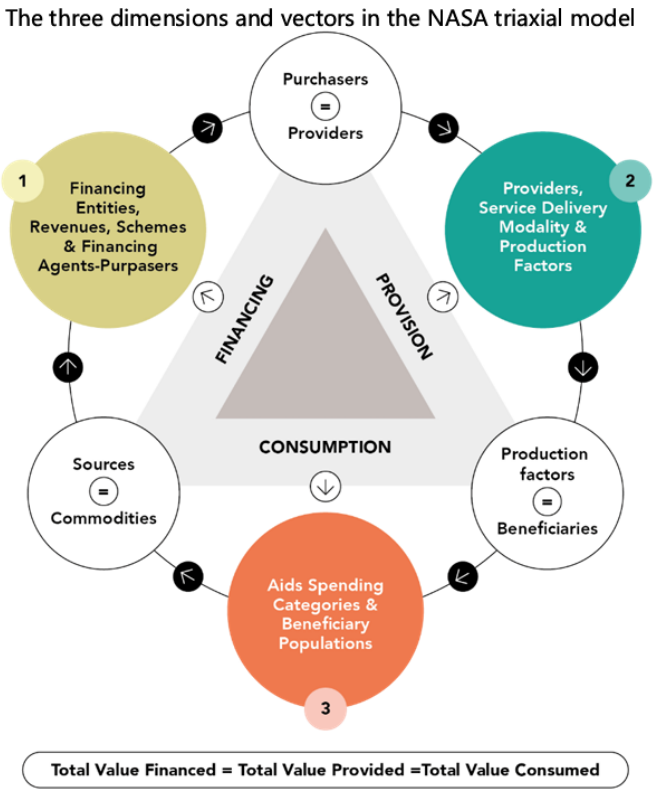
As standard methodology and guidelines 2025 (UNAIDS) NASA, expenditure is reconstructed under three dimensions and nine vectors as follow[3]. Besides, community led resource tracking method (CLRT) was incorporated into the current NASA to collect non transactional resources from community led organizations (CLOs).

4.3 Scope of NASA 2024

The scope of the current NASA is to cover all three dimensions (financing, provision, consumption) and nine vectors. covering expenditure of three years – 2021, 2022 and 2023 from all sources encompassing all major financial flow towards HIV and AIDS response. Figure 3 depicts the reconstruction of transaction to make the resource flow complete.

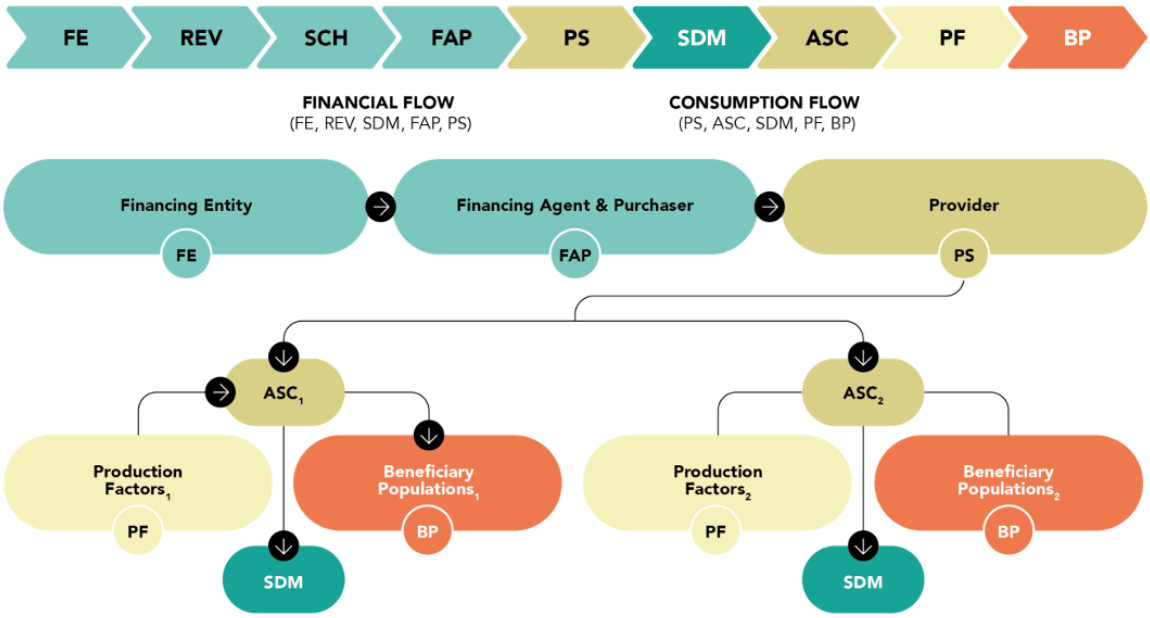
[3] Publications | UNAIDS

Figure 2: Dimensions and vectors of NASA



Source: *UNAIDS, 2025. Guidelines for Conducting the National HIV/AIDS Spending Assessment (NASA) Publications | UNAIDS*

Figure 3: NASA Variables covered – flow diagram[4].



Source*: UNAIDS, 2025. Guidelines for Conducting the National HIV/AIDS Spending Assessment (NASA). Publications | UNAIDS)*

[4] Publications | UNAIDS

- Incorporate the community led resource tracking method (CLRT) into the current NASA and collect non-monetary resources from community led organizations (CLOs)
- Asses if the past shortcoming during resource tracking has been addressed, in particular following:
  - Previous NASA had recommended to expand the data collection to Provincial level as well as conduct other specific analysis such as allocative efficiency, technical efficiency and commodity analysis. Current NASA has included some of those recommendations as well as examined to what extent the previous NASA recommendations have been enacted during analysis and report writing.
  - Some other policy related recommendation has also been reviewed and examined to what extent those recommendations have been implemented.

4.4 NASA classifications

The NASA classification system provides a structured framework for categorizing and analysing financial transactions within the HIV response. This system enables detailed examination of how resources are mobilized, managed and spent across various dimensions, ensuring consistency and comparability of data. The classification system is organized into nine core vectors, each capturing specific elements of the financial flow, including funding sources, financing schemes, service providers, production factors and target populations. By using these standardized categories, the NASA classification system allows for a comprehensive understanding of the allocation, management, and utilization of HIV related resources (UNAIDS 2025).

4.5 Data collection and processing

- Under the leadership of NCASC, the preparatory work began with the preparation of concept note and detail road map of NASA exercise.
- NCASC formally sent information and request letter to relevant ministries, institutions, external development partners (EDPs), NGOs and other stakeholders to support the NASA process and provide spending data to NASA team in a specified format.
- While face to face data collection allowed for better understanding of spending nature and the challenges in clearly disaggregating spending data into different categories, most organisation preferred to share the data electronically.
- The collected data were entered into the Data Consolidation Tool (DCT), an Excel-based tool that follows the nine NASA categories. The DCT helps convert raw data into the NASA format and organizes, cleans, and checks the

information so that any missing or inconsistent entries can be found and corrected.

- To avoid double-counting, the team compared each transaction with information from different sources. All verified data were entered into the DCT, and the completed files were later imported into the NASA Resource Tracking Tool (RTT).
- The RTT consolidates all datasets and automatically flags any coding or data errors, which are then reviewed and corrected. Using the NASA framework, the RTT supports the entry, validation, mapping, and classification of spending data. It also plays a key role in generating financing flow diagrams, as well as producing tables, charts, and graphs that summarize the results. In addition, the RTT creates a complete Excel dataset, which allows for most of the analysis and production of tables, figures and charts.

4.6 Assessment of community led responses (CLO)

The NASA framework tracks the resources of CLOs using standard methodology recommended by UNAIDS. This assessment focuses on measuring non-financial resource flows, including in-kind donations, volunteer labour, and other non-monetary transactions. A 2022 UNAIDS pilot project demonstrated that identifying, quantifying, and valuing these resources requires significant effort.

The NASA Nepal 2024 assessment followed the methodological steps outlined below:

4.6.1 CLO Mapping and Screening

Initial Mapping and verification: NASA Nepal utilized the CLO mapping and screening previously conducted in 2022 during the UNAIDS global pilot (in which Nepal also participated). Key Populations (KPs) networks were consulted to verify and update the mapping done earlier. These networks reported a reduction in the number of affiliated CLOs and changes to their program activities.

A self-identification form, created by UNAIDS for the CLR resource tracking pilots, was distributed to the identified CLOs via their respective networks. The CLOs were requested to complete and return the form to the NASA team through these networks.

4.6.2 Data Collection

Due to a very poor response rate from the initial self-identification form distribution, the NASA team adjusted the data collection strategy. The NASA team decided to conduct Focus Group Discussions (FGDs) instead with potential CLOs during the planned provincial and district data collection visits, as the application of standard data collection tool was impractical given the low response.

Respective KP-led organizations were engaged to facilitate the invitation process and the subsequent FGDs.

The specific outcomes of the CLO FGDs are reported in the Annex.

4.6.3 Data collection approach

The assessment employed both top-down and bottom-up data collection approaches. The top-down approach focused on tracking sources of funds, primarily using donor expenditure reports. To support this process, key stakeholders from various organizations were invited to participate in a four-day training on HIV/AIDS spending assessment. The training covered NASA principles, methodologies, tools, and international best practices. It also served as an opportunity to collect HIV spending data directly from participants using a customized NASA data collection template. The major donor however, provided soft copy detail financial report later to NASA team for further processing.

In parallel, a bottom-up approach was used to capture expenditure data from service providers (GF SRs and Implementing Partners - IPs) as well as from provincial government and health institutions. The NASA consultants along with team from NCASC visited all seven provinces and collected data from different institutions. Collected expenditure records as primary data sources were entered the information into the NASA data collection tool.

Additionally, the NASA team identified CLOs across different provinces and made efforts to gather both their financial and non-financial expenditure data as a supplementary component of the assessment.

Secondary data sources like annual reports, progress report, PUDR (PR report), National Health Accounts and other sources were used to triangulate the data and for other references.

4.6.4 Data collection form

Generic data collection form developed by UNAIDS was adapted to suit country situation. Both electronic and hard copies were made available to all those organisations who were identified for the NASA data collection. The data collection form was predesigned in an Excel sheet aiming to collecting information regarding name of financing source/s, name of the project, activities and their descriptions, who are the intended beneficiaries of each of activity, whether or not any fund is transferred to other agency, total expenditure and production factor (inputs) for each of the activities. Instruction on how to fill form and a sample of completed form were part of data collection form.

4.6.5 Estimations

The estimation of the Government of Nepal's indirect contributions—such as human resource (HR) costs for HIV services and the value of space and utilities (e.g., electricity, internet, water, and cleaning)—was carried out using following comprehensive methods and available data.

Human Resource Costs at ART Sites:

HR cost estimates for ART sites were primarily based on data provided by the AIDS Healthcare Foundation (AHF) through their routine time-and-motion surveys. This methodology tracks the time each ART client—both new and continuing—spends receiving services across different departments in government ART facilities.

Table 5: HR (cost) contribution calculation at ART facility

Human Resource (cost) contribution calculation at ART facility			2021: USD @	118.1969	
ART facility department/unit	Mean time spent/client (Minutes)*	Staff cadre providing services in each unit	Average of (monthly) basic salary (USD)	Salary per minute of health workers in respective unit	Amount spent per client (USD)
Registration	2	Reg clerk	338.09	0.02	0.06
Triage	2	ANM, AHW, Sr AHW	331.84	0.02	0.04
Clinician Consultation	18	MO, Sr MO	427.61	0.03	0.53
Counselor Consultation	8	SN, HA, Sr AHW	331.84	0.02	0.18
Laboratory	30	LT, LA	331.84	0.02	0.68
Pharmacy	6	Asst pharmacist	331.84	0.02	0.15
Back to Registration/Triage	2	ANM, AHW, Sr AHW	331.84	0.02	0.04
	Total HR cost per client visiting ART clinic (average)				1.68

Note: USD rate varies for each year. Normally, one staff is assigned in each unit - but level/position may vary or staff are put in rotation in ART facilities. Therefore a monthly average of salay of cadre by unit is calculated. Government laboratory perform wide range of tests and function with full set of lab professionals. Lab Technician and Lab Assistant are assumed to be the minimum level of cadre required to perform most of HIV related lab functions

*Data from time and motion survey by AHF

The time and motion data are compiled to ascertain the average time spent by a client in each department while receiving services. In support of NASA team, AHF conducted this survey in six major ART sites (300 ART clients were surveyed), each serving more than 500 clients.

The average salary of Government health workers (per cadre in each department) was calculated using the standard government salary structure. HR contribution per client was then derived by multiplying the time spent by the respective health worker per client by the corresponding salary rate. The average HR cost per client calculated from these sites was applied uniformly to all ART sites nationwide based on the number of patients with HIV seen by each facility in each year.

Cost of Space and Utilities provided by Government Facilities:

As part of the time-and-motion assessment, AHF also estimated the total floor area (in square feet) occupied by ART service areas of different ART sites and estimated the local market rental value of comparable spaces. During provincial visits, the NASA team similarly collected information on space usage, rental values, and approximate utility costs for ART sites. These data were consolidated to determine the average space per ART site and the average rental value per square

foot. These averages were then applied to all ART sites to estimate the government's in-kind contribution of space and utilities for ART/Pre-Exposure Prophylaxis (PrEP) service delivery.

4.6.6 Quality assurance and Data validation

Quality control was maintained throughout the process. Consultants supported the NASA team during data collection, processing, and entry. The team checked that spending was correctly classified, compared it with the guidelines, and fixed any errors. They also reviewed how data was mapped from different sources to make sure it followed the rules and was accurate. Classifications were checked against recognized standards, and changes were suggested when needed.

Transaction records from the field were reviewed to ensure they were complete and accurate, inconsistencies were identified and corrected. Standard coding in the Resource Tracking Tool (RTT) was followed, and the system's control board highlighted any issues that required fixing. Preliminary findings were shared with key stakeholders for review, and UNAIDS (Global Centre), provided an external expert to check the data tools, RTT file, analysis, and report. In addition, the UNAIDS Global Centre and UNAIDS Regional Support Teams (RST – Bangkok), UNAIDS country team and other stakeholders reviewed the document and provided comments and suggestions to improve the quality of the report. All comments were addressed to meet global standards.

The RTT system also produced Excel datasets that were used to analyse the information and create tables, charts, and diagrams.

4.7 Overview of data and quality of sources

The table below (Table 6) highlights the type of organisations and number of organisations approached for NASA data. Altogether 85 organisations across various types were approached and 71 (84%) responses were received. Almost all were FAP except few NGOs and Networks who were provider (PS) as well[5].

In addition, 28 CSOs affiliated with key populations were met across all seven provinces to collect information on non-monetary tractions incurred during the assessment period.

For organizations such as CSOs, government agencies, hospitals, ambulatory care facilities, and laboratory and imaging facilities that were recorded as service providers in NASA 2024, the financial data for those organizations were reported by their respective financing agent and procurer (FAP)

[5] Note: As UNAIDS cosponsors, all UN agencies based in Nepal were approached as some agencies at times support HIV related activities (non UBRAF, event based, or linked to their larger programme) though in a small scale or just an event.

Table 6: Data source

Organizations by type	Organisationas approached for Data	%	Data obtained	Response Rate %
Provincial Health Authority	28	33	28	100
National Health entities (including Health Insurance, SHA team at MoHP)	3	4	2	67
National Networit of KP, NGOs/CSOs	12	14	8	67
Community led organisations (CLOs) - Non-monitary, qualitative data	24	28	24	100
UN Organizations	11	13	4	36
CCM	1	1	1	100
Implementing Agencies (INGO), donors (GF, US Gov, AHF)	3	4	3	100
NGOs	3	4	1	33
Total	**85**	**100**	**71**	**84**

4.8 Assumptions and clarifications

Following key assumptions were applied.

Social Health Insurance (SHI) for PLHIV: The Government of Nepal provides Social Health Insurance (SHI) coverage to People Living with HIV (PLHIV) and their family by waiving the standard family premium of NPR 3,500. Although the premium is waived for PLHIV, the government reimburses this amount to the National Health Insurance Board (NIB). Under SHI, PLHIV are entitled to treatment services at public health facilities and designated private providers, with payments made directly by NIB to the facilities upon claim submission. Each insured individual is covered up to a defined reimbursement ceiling.

For the NASA analysis, NIB supplied payment records for services provided to PLHIV and their family members, disaggregated by district and province. Because specific household-level information by type of treatment (i.e., diagnostic, treatment, prescriptions) for insured PLHIV was unavailable, NASA assumed that all reported payments represented expenditures for treating Other Opportunistic Infections (OI)—specifically category ASC.03.04.05—excluding tuberculosis, hepatitis, and cervical cancer. Some expenditure like ART, Viral Load test and HTC are not part of SHI insurance package as it is directly provided by the government to all individuals irrespective of the insurance status.

When estimating the premium amount waived for PLHIV but reimbursed to NIB by the government, assumption of a standard family size of four was applied to reflect the smaller family size of PLHIV. Thus, for every insured PLHIV household, NPR 3,500 was considered reimbursed for a family unit of four members.

Laboratory system strengthening As part of health system strengthening efforts, the Global Fund supported the construction of two laboratories in Lumbini and Koshi Provinces. Although the grant for this activity was initially approved under GC5, actual disbursements began in 2021 under GC7, which falls within the current NASA assessment period, and continued through 2024.

As construction payments were made over multiple years, expenditures were spread across the assessment period. Due to the change in Principal Recipient from Save the Children and the subsequent closure of the financial management system, detailed payment data were unavailable. Consequently, budget figures were used as a proxy for actual expenditures.

Although the budget for this activity was recorded under the TB program, the laboratories are not TB-specific. Instead, they represent broader health and laboratory system–strengthening investments that support multiple disease programs, including HIV. The total construction budget was USD 1.1 million per laboratory, amounting to USD 2.2 million for both facilities. Since the full cost cannot be attributed solely to HIV, the Global Fund's standard disease-split methodology was applied, with 50 percent of the total cost allocated to HIV. Actual amount (not the devalued annualised amount) was used for NASA purpose.

Average exchange rate used for 2021, 2022 and 2023 was 118.196, 125.731 and 132.076 respectively for one US Dollar based on based on official (Nepal Rastra Bank) average rate for the year. All Nepali figures irrespective of spending month, were converted to US dollar using this exchange rate.

All Global Fund and US Government recipients' data were assumed to be captured in the data provided by Global Fund PRs and EpiC Nepal/FHI 360 country office therefore any spending data obtained from sub-recipient/IP providers was used to triangulate the data but was excluded in the data entry due to double counting. However, if the SR/IP data reported different financing source other than GF and US Government, such data were considered for NASA analysis.

Considering the data received from major sources and from almost all the FAP (who also provided data of almost all Providers under their purview) it is assumed that the NASA 2024 captures data from over 90% of HIV/AIDS spending organisations in the country for this round of NASA.

Where expenditures were not detailed according to production factor or beneficiary population, a proportionate distribution method was utilized. Most data received did have ASC and BP defined where further check was required, and a considerable level of confusion and differences existed in assigning the

Production Factor. This was resolved either by asking more detail data or by discussion with organisation/person who provided the data.

Since Country Coordinating Mechanism (CCM) is responsible for all three diseases, the expenditure of CCM was distributed according to the disease split proportion provided by the GF for TB, Malaria and HIV. GF funding to CCM is managed by Care International, therefore Care International is considered as FAP (FAP.03.03.08 Care International)

Limitations

- Out of pocket expenses (OOPE). Because no reliable secondary data sources were available to estimate HIV-related OOPE, the NASA team consulted with the SHA team at the Ministry of Health to explore the possibility of obtaining relevant data or suitable proxies. Despite several attempts, HIV-specific OOPE data or disaggregated estimates were not available from SHA. As a result, the NASA team decided to exclude OOPE from this round of the assessment.

- Private spending, primarily out-of-pocket expenditure related to blood safety services—where individuals pay blood banks for blood—was recorded only for four years in previous round of NASA. Due to the absence of reliable and consistent data, private spending was not included in the current assessment. Consequently, trends in private expenditure should be interpreted with caution.

- In several instances, expenditures were reported under the "not disaggregated" sub-category. Efforts were made to follow up with reporting organizations to obtain further breakdowns; however, additional disaggregation was often not available. Consequently, these expenditures were coded as "not disaggregated" in accordance with NASA methodology. This points to gaps in programmatic detail within reporting systems and highlights the need to strengthen routine data recording and disaggregation practices.

- Global Fund Covid 19 Response Mechanism (C 19 RM) response. GF C19 RM provided additional fund through the existing PR (Save the Children) and MoHP, and also reprogrammed some of the existing GC 6 grant for Covid response. PR channelled the fund through existing SRs for covid response where beneficiaries were the respective KPs along with other general population. In consultation with UNAIDS and country team, spending on Covid response was excluded in NASA.

- Spending for individual or programme paid outside the country was also out of scope of current NASA. For example, training cost paid and organised

outside the country which might have beneficial results to KPs and HIV programme in the country.

4.9 Challenges

Number of challenges were encountered during the exercise, some of the critical challenges were as follows.

Many organisations felt providing financial data with reasonable level of details to suit that NASA classification as an additional task and a burden, therefore there were significant delays in submitting the data from few organisations.

Some Agents (particularly multilaterals and bilateral) often did not provide detail and adequate breakdown of expenditure as well as tend to distribute or mask some expenses (i.e., benefit related to wages, remuneration, international trainings/visits) under different ASC/PF heading/category. Disaggregation and classification of such data was a challenge that required number of discussions with the organisation to resolve this.

Moreover, provider's interpretations and NASA coding varied enormously even for the similar nature of expenditure, therefore maintaining consistency in coding was a great challenge. Details of functions (ASC category) and PF category varied enormously even for the similar activities. For example, when a short-term consultant was hired for specific task, some organisation assigned 'consulting service' as PF category whereas other assigned 'wages' as PF for consultant. NASA consultant had to make extra effort in applying standard NASA classification across the programme.

There were significant variations in accounting systems (software used), fiscal years and the classification of spending among national institutions and donor supported projects, which created challenges for data synthesis and comparability. For example, the Government fiscal year is from 16 July to 15 July, whereas donors have different fiscal years. Also, that the spending made for 'capacity building support' to NGO was termed as institutional building by some organisation while other termed it as training. Considering the nature of intervention which most often was training, the NASA consultant applied the appropriate code.

In some instances, there was limited institutional memory and adequate documentation of past expenditure and financial information, this resulted in a serious delay in obtaining adequate financial and other information for NASA purpose.

Findings

5. Findings

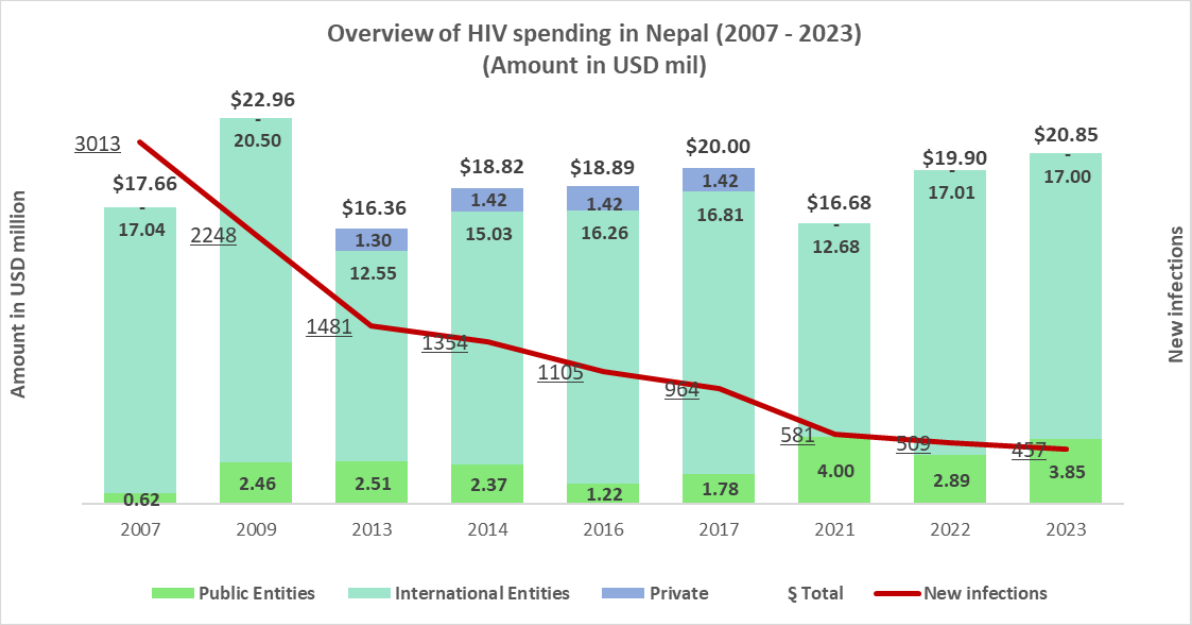
5.1 Overview of HIV/AIDS spending in Nepal 2007 – 2023

Over the 16-year period from 2007 to 2023, annual HIV expenditures—ranging approximately between USD 16 million and USD 22 million in recent years—coincided with a sustained and substantial decline in new HIV infections. During this period, the annual number of newly reported infections decreased by more than 80 percent, from over 3,000 cases in 2007 to approximately 500 cases in 2023.

Although establishing a direct causal relationship between HIV expenditure levels and trends in new HIV infections is beyond the scope of NASA, a juxtaposition of financial and epidemiological data suggests sustained investment has correlated with a significant decline in the HIV epidemic. (Figure 4).

This epidemiological progress has occurred alongside a significant expansion of HIV service coverage. By 2023, approximately 93 percent of people living with HIV (PLHIV) were aware of their HIV status, and 82 percent of an estimated 30,300 PLHIV were receiving antiretroviral therapy (ART). While multiple structural, behavioural, and programmatic factors contributed to these outcomes, the sustained level of investment in HIV prevention, testing, and treatment services likely played a critical role in supporting service scale-up and reducing HIV incidence over time.

Figure 4: Overview of HIV Spending in Nepal (2007-2023)



(Source: NASA, except 2009 - where Resource tracking method was applied)

International partners consistently accounted for the largest share of HIV spending throughout the period, underscoring Nepal's continued reliance on external funding for its HIV response. Public (government) expenditure remained comparatively low but showed some increase over time.

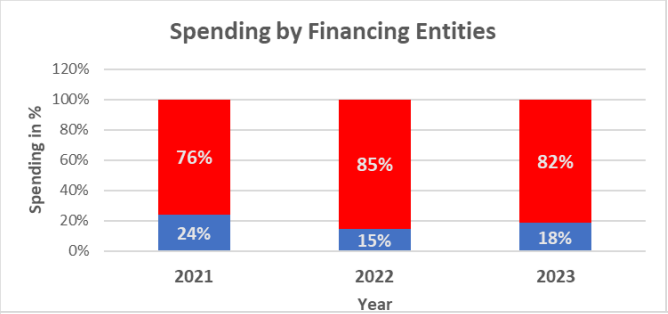
Overall, the spending pattern reflects a relatively stable yet highly donor-dependent HIV financing landscape in Nepal over the period, with limited diversification of funding sources and only modest growth in public-sector contributions. The observed increase in domestic financing is largely driven by government allocations for antiretroviral (ARV) procurement, as well as the inclusion of Social Health Insurance (SHI) and adjustment of government contributions, particularly human resources at ART facilities.

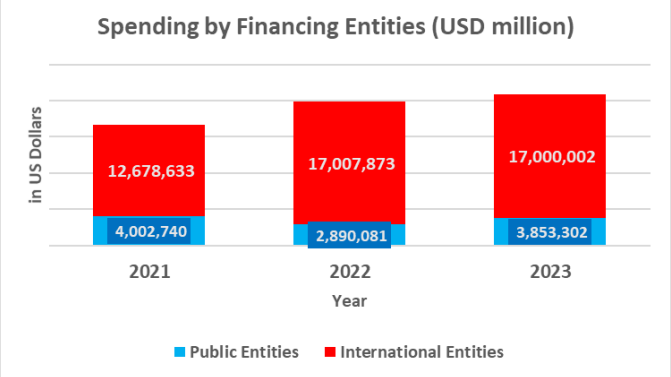
5.2 Total expenditure by Financing entities

5.2.1 Spending by financing entities

Figure (Figure 5) illustrates HIV/AIDS spending in Nepal by financing entities and shows that international sources continue to fund the majority of the HIV response. Total HIV/AIDS expenditure increased from USD 16.68 million in 2021 to USD 19.90 million in 2022 and USD 20.85 million in 2023. Despite this overall growth, the composition of financing has remained largely unchanged, with international partners consistently accounting for the largest share of spending (82% in 2023, slightly reduced from 85% in 2022).

Figure 5: HIV/AIDS Spending by Financing Entities





Government contributions fluctuated between 15 and 25 percent of total HIV/AIDS spending during this period, indicating limited progress toward increased domestic financing.

The introduction of the Social Health Insurance (SHI) program for PLHIV in 2019 marks an important step toward strengthening government involvement, particularly in treatment financing.

However, the figure underscores Nepal's continued reliance on external funding and highlights the need for sustained efforts to expand domestic investment to improve the long-term sustainability of the HIV response

5.2.2 Spending by financing entity by name

Analysis of HIV/AIDS spending by financing entity shows that the Global Fund remained the largest contributor to Nepal's HIV response across all three years, followed by the United States Government. Government funding showed fluctuations over the period, accounting for 24 percent of total spending in 2021, declining to 15 percent in 2022, and rising again to 18 percent in 2023. A positive development is the emergence of provincial government contributions, indicating gradual decentralization of HIV financing responsibilities (Table 7).

Table 7: Financing entities (Amount in USD)

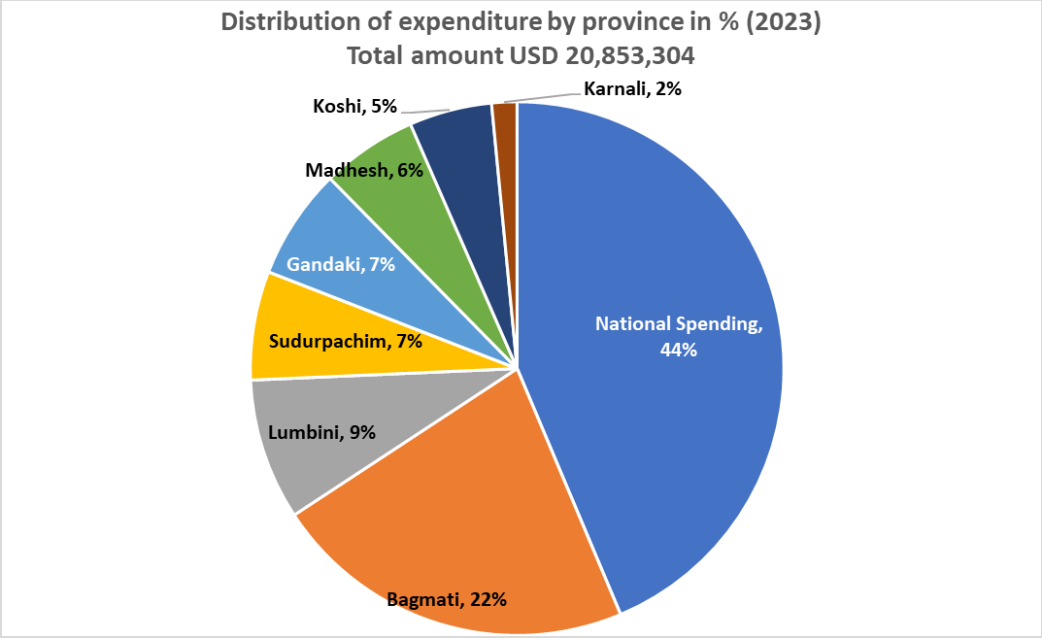
Financing Entity	2021	2022	2023	2021 (%)	2022 (%)	2023 (%)
Central Gov	3,988,839	2,859,350	3,838,996	23.9	14.4	18.4
Provincial Gov	13,901	30,731	14,306	0.1	0.2	0.1
US Gov	5,223,074	6,802,190	7,378,513	31.3	34.2	35.4
Global Fund	6,268,520	9,044,122	8,378,567	37.6	45.5	40.2
UN agencies	394,476	293,684	380,443	2.4	1.5	1.8
INGOs	792,563	867,877	862,479	4.8	4.4	4.1
Grand Total (USD)	**16,681,373**	**19,897,954**	**20,853,304**	**100.00**	**100.00**	**100.00**

5.3 Geographical distribution

5.3.1 Spending by Provinces

Geographically, HIV spending varies across provinces, reflecting differences in population size, HIV burden, and service delivery needs. The pattern is similar in 2021 and 2022 (Figure 6). While Bagmati Province accounts for a higher share of spending, and Karnali Province consistently records lower expenditure, spending levels across the remaining provinces are relatively comparable. It is also important to note that a portion of national-level expenditure—such as procurement of commodities and centrally managed programs—benefits provinces directly. These regional variations highlight the need for programmatic explanations and context-specific planning to ensure equitable and needs-based allocation of HIV resources across provinces.

Figure 6: HIV Expenditure by province



5.3.2 Per Capita and Per PLHIV spending by provinces

Expressing provincial HIV expenditure per PLHIV and per capita provides a useful perspective on the relative intensity of investment in relation to the number of PLHIV and overall population size. However, these indicators should be interpreted with caution, as the distribution of key and vulnerable populations varies significantly across provinces, influencing comparability. Besides, capital investment (laboratory construction in Koshi and Lumbini provinces) and distribution of national spending across the provinces likely to have affected the calculation. Per capita expenditure and expenditure per person living with HIV (PLHIV) vary substantially across provinces (Table 8). These variations reflect differences in population size, estimated number of PLHIV, levels of vulnerability, and varying risks of HIV transmission.

Table 8: Per capita and per PLHIV expenditure by Province (in USD) 2023

Province	Total Expenditure (2023)	Expenditure per Capita	Per PLHIV
Bagmati	6,890,394	1.13	800
Lumbini	3,506,171	0.68	540
Sudurpaschim	2,706,623	1.00	539
Gandaki	2,427,308	0.98	628
Madhesh	2,751,844	0.45	474
Koshi	2,006,755	0.40	554
Karnali	564,210	0.33	611
Total	**20,853,304**	**0.72**	**607.3**

Note: National spending has been distributed proportionally across the provinces by number of PLHIV of the respective provinces

5.4 Fund transfer mechanism (Revenue of financing scheme)

The REV category represents the distribution of funds through specific contribution mechanisms, including in cash and in-kind (UNAIDS 2025). In other words, describe the main flows from which financing schemes obtain the resources

Table 9: Revenue of financing scheme (%)

Revenue (in %)	2021	2022	2023
Internal transfers and grants	22	12	16
Transfers by govt on behalf of specific groups (incl social health insurance	2	2	2
Distributed by govt from foreign origin		0.36	
Direct bilateral financial transfers	31	34	35
Direct multilateral financial transfers	40	47	42
INGOs transfers	5	4	4
Grand Total (Amount in USD)	16,681,373	19,897,954	20,853,304

In Nepal, direct bilateral and multilateral transfers account for more than 70 percent of total HIV financing (Table 9), representing the funding from the Global Fund and the USG, while internal transfers and grants from government constitute 16 to 22 percent of total HIV financing. This indicates that most international HIV funding bypasses regular government financial systems, even though programs are aligned with the national HIV strategy and receive formal approval. Such funding is commonly classified by the Ministry of Finance as off-budget and off-treasury, although some flows may be partially or fully on-budget. While NASA does not distinguish between these treasury modalities, funding recorded under category "distributed by government from foreign origin" most closely represents resources that flow through on-budget, on-treasury mechanisms.

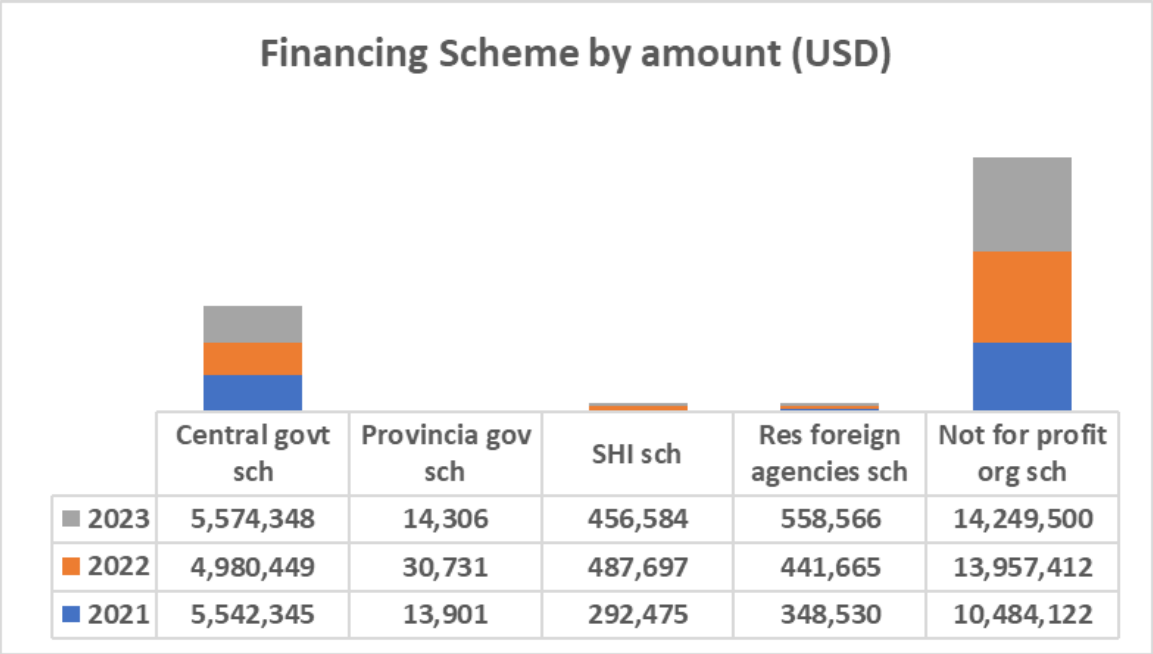
5.5 Financing scheme (SCH) for HIV programme in Nepal

Financing schemes are structural arrangements through which HIV services and goods are paid for and obtained by the beneficiary. This reflects the structure of financing arrangements and coverage entitlements (UNAIDS 2025).

The figure (Figure 7) shows the most HIV services were provided through 'not for profit organisation scheme and central government scheme. Programmatically this represents the services provided by NGOs/CSOs and Government (such as ART). Social Health Insurance (SHI) scheme, though a new initiative for PLHIV, is an important policy shift in HIV response in Nepal. Spending under this scheme is low

largely due to fewer number of insured PLHIV and limited geographical coverage of these initiatives.

Figure 7: Financing scheme by amount (USD)



	Central govt sch	Provincia gov sch	SHI sch	Res foreign agencies sch	Not for profit org sch
2023	5,574,348	14,306	456,584	558,566	14,249,500
2022	4,980,449	30,731	487,697	441,665	13,957,412
2021	5,542,345	13,901	292,475	348,530	10,484,122

5.6 Financing agent and purchaser (FAP)

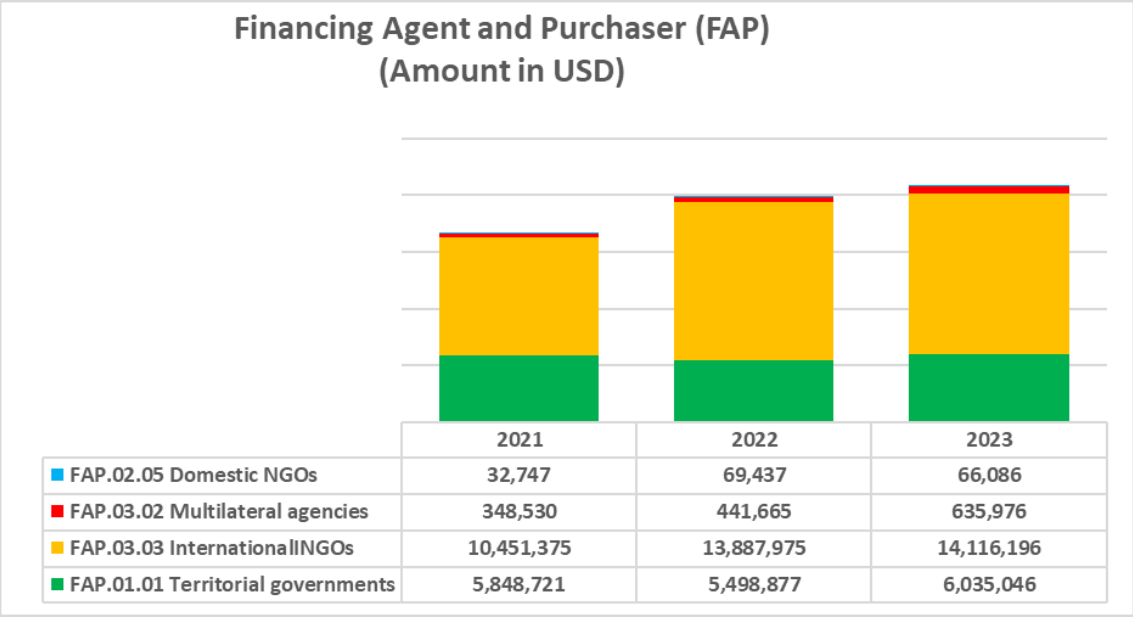
The FAP identifies the institutions or organizations responsible for managing and allocating funds for HIV programmes. They receive funds from Financing entities (FE) and decide on the allocation to service providers - PS (such as hospitals, CSOs, to finance a programme or as a payment to buy goods and services, such as care and treatment, prevention, etc. (UNAIDS 2025).

In Nepal, HIV spending data indicate that international purchasing organizations—particularly international not-for-profit organizations (primarily as principal recipients) —manage the largest share of HIV resources, accounting for approximately 60 to 68 percent of total funds. These organizations channel funds for HIV goods and services through various service providers (PS). In the same way, public-sector financing agents managed around 26 to 40 percent of HIV resources received from different financing entities (
Table 10, Figure 8)

Table 10: Financing Agent and Procurer (FAP) spending by year (in USD)

FAP	2021	(%)	2022	(%)	2023	(%)
FAP.01 Public sector						
FAP.01.01 Territorial governments	5,848,721	39.1%	5,498,877	26.73%	6,035,046	32.82%
FAP.02 Domestic Private sector						
FAP.02.05 Domestic Not-for-profit organizations (other than social insurance)	32,747	0.7%	69,437	2.90%	66,086	2.60%
FAP.03 International purchasing organizations						
FAP.03.02 Multilateral agencies managing external resources	348,530	0.3%	441,665	1.56%	635,976	2.79%
FAP.03.03 International not-for-profit organizations and foundations	10,451,375	59.9%	13,887,975	68.81%	14,116,196	61.79%
Grand Total (USD)	**16,681,373**	**100%**	**19,897,954**	**100%**	**20,853,304**	**100%**

Figure 8: Spending by type FAP (USD)



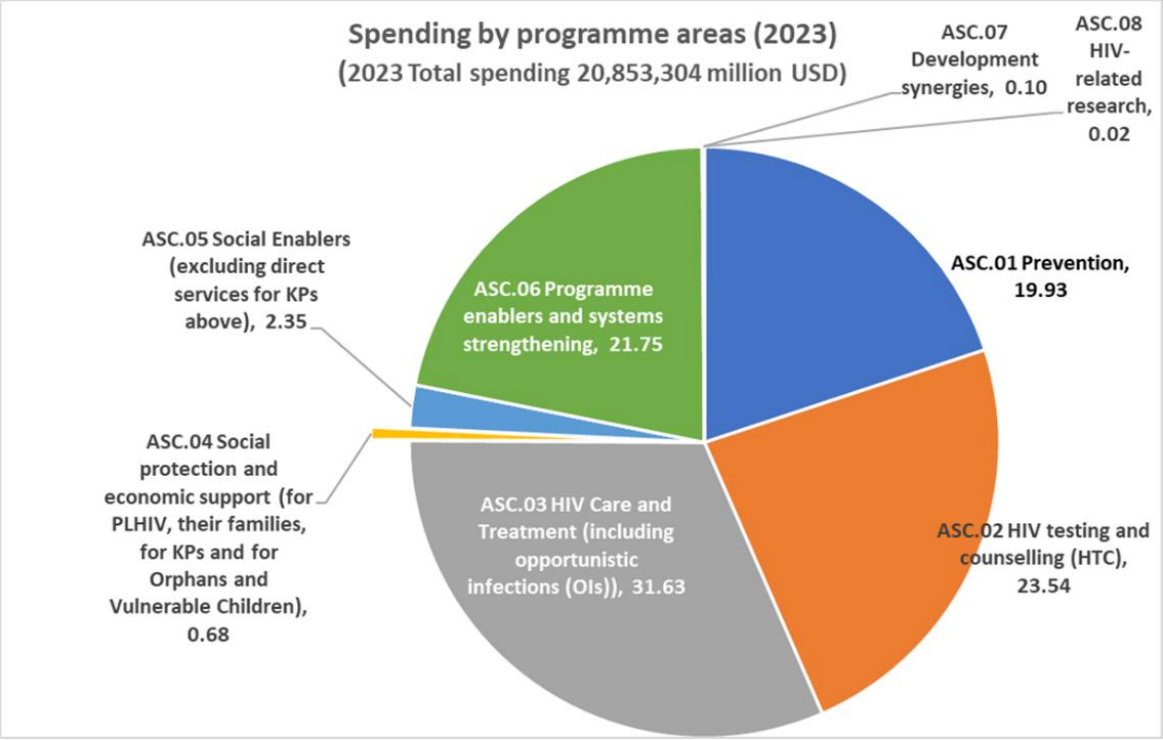
5.7 Spending on key programmatic areas (ASC)

Key programmatic areas (Aids Spending Category - ASC) describe the services provided by the HIV spending. The eight broad HIV/AIDS spending categories include prevention, HIV testing and counselling, care and treatment, and other

health and non-health services related to HIV and AIDS. Within each of these categories are several sub-categories which provide greater insight into the type of HIV interventions, presented in section 5.8.1 below and following sections.

The emphasis of the spending is clearly on HIV care and treatment (32%) followed by HIV testing and counselling (24%). Prevention package shared nearly 20% of total spending. The spending on Programme enablers and system strengthening consumed 22% to total resource. High HTC expenditure is largely driven by innovative and incentivised testing approaches to track the limited number of infections in widely scattered geographical areas.

Figure 9: Spending by programme areas (ASC)



Yearly detail also shows similar pattern of spending (Figure 10). HIV testing and counselling, and Care and treatment consistently received bigger share of spending, reflecting the priority of the programme in treatment. Areas like HIV research, social protection and Development synergy appeared low priority interventions where less than 1% of resources were spent.

The higher spending reported in category ASC 06. Programme enablers and system strengthening was largely due to laboratories construction in two provinces (Global Fund financing, labelled as ASC.06.04.02 Laboratory system strengthening) and the management cost.

Figure 10: Yearly spending in programme areas (ASC)

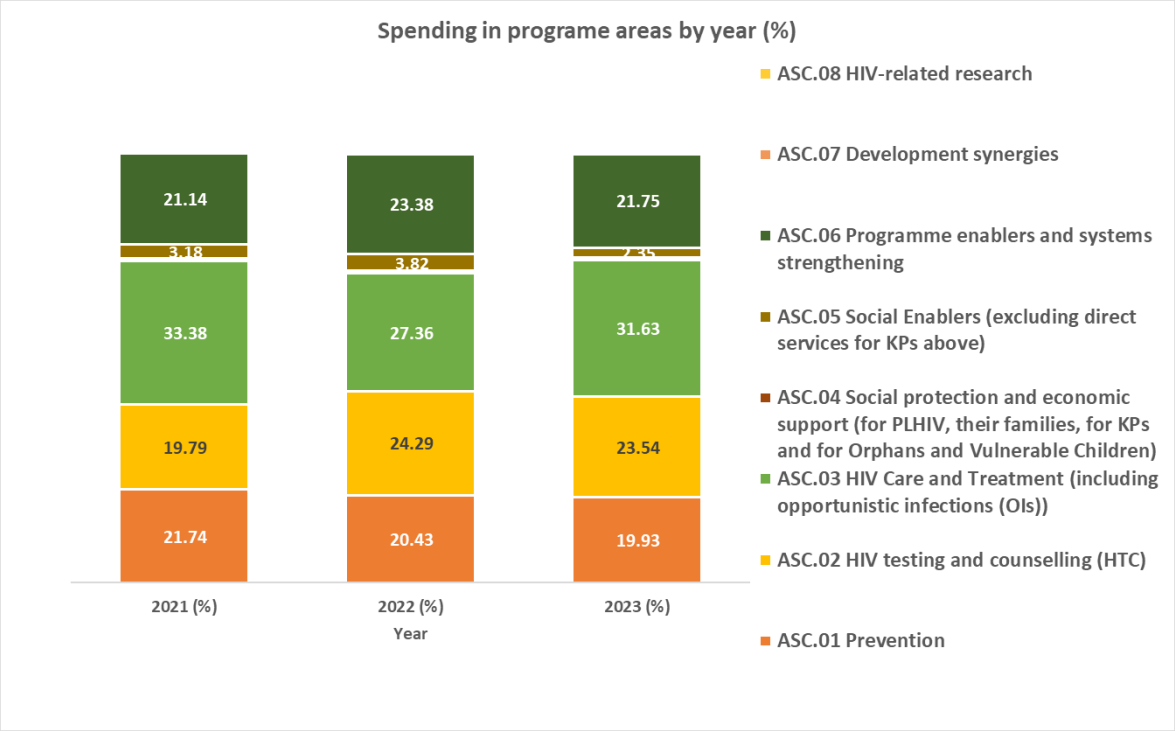


Table 11: ASC spending by year (in USD)

Programme areas	2021	%	2022	%	2023	%
Prevention	3,625,737	21.70	4,065,241	20.43	4,155,541	19.93
HIV testing and counselling (HTC)	3,300,514	19.79	4,833,154	24.29	4,908,423	23.54
HIV Care and Treatment	5,568,270	33.38	5,444,414	27.36	6,596,293	31.63
Social protection, economic support	126,770	0.76	121,103	0.61	141,126	0.68
Social Enablers	530,893	3.18	760,675	3.82	490,758	2.35
Programme enablers	3,527,020	21.14	4,652,476	23.38	4,536,077	21.75
Development synergies	2,169	0.01	20,891	0.10	19,914	0.10
HIV-related research	-	-	-	-	5,172	0.02
Grand Total (USD)	**16,681,373**		**19,897,954**		**20,853,304**	

The distribution of contributions by financing entities across programme areas (Table 12) indicates that public financing entities demonstrate a strong commitment to HIV care and treatment—accounting for approximately 32 percent of total expenditure in this category—while donor funding still constitutes around 68 percent of care and treatment spending. A similar financing pattern is evident across other programme areas, where international sources consistently

provide the majority of resources, except for Development Synergies which were wholly paid for by the government financing entities. No spending from international entities in this category could be most probably due to the spending data recorded and reported under Programme enablers.

Table 12: Financing entity by programme areas (ASC) 2023 (USD)

Programme areas	Public Entities	%	International Entities	%	Total (2023)
ASC.01Prevention	215,769	5	3,939,772	95	4,155,541
ASC.02HIV testing and counselling (HTC)	1,171,996	24	3,736,427	76	4,908,423
ASC.03 HIV Care and Treatment	2,102,885	32	4,493,408	68	6,596,293
ASC.04 Social protection and economic support	8,699	6	132,427	94	141,126
ASC.05 Social Enabler	90,622	18	400,136	82	490,758
ASC.06 Programme enablers and system strengthening	243,417	5	4,292,660	95	4,536,077
ASC.07 Development synergies	19,914	100		-	19,914
ASC.08 HIV-related research		-	5,172	100	5,172
Grand Total (USD)	**3,853,302**	18	**17,000,002**	82	**20,853,304**

The following sections explore in more detail the spending on interventions within each of these eight programme areas.

5.7.1 Spending on key prevention activities

The data indicate a moderate upward trend in overall prevention spending, increasing from USD 3.63 million in 2021 to USD 4.16 million in 2023, with growth slowing between 2022 and 2023. Within this, prevention services for key populations remain the dominant investment priority, consistently accounting for the largest share of resources.

PrEP exhibits the most notable growth over the period, increasing nearly threefold from USD 236,688 in 2021 to USD 622,853 in 2023. This steady and substantial scale-up signals a strategic shift toward more biomedical prevention approaches and likely reflects program expansion and increased uptake (Table 13). In 2023 users PrEP cost is approximately USD 125 (user reported in 2023 was nearly 5000 KPs).

The persistence of around 10% of prevention spending that could not be disaggregated by intervention suggests ongoing limitations in expenditure reporting and thus their classification by intervention. From an efficiency and

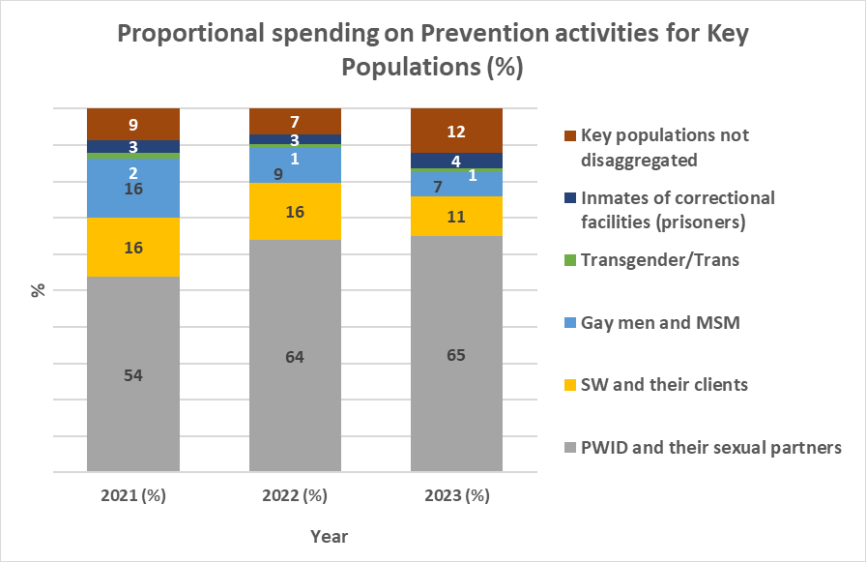
accountability perspective, this reduces transparency on how prevention resources are allocated across specific interventions and populations.

Table 13: Spending on key prevention activities by year (in USD)

Prevention interventions	2021	2022	2023
ASC.01.01 Five Pillars of Prevention			
Prevention services for key populations	2,045,656	2,380,126	2,257,388
Condoms (for HIV prevention) for the general population	95,867		54
Pre-Exposure Prophylaxis (PrEP)	236,688	449,911	622,853
ASC.01.02 Other(non-Five Pillars) prevention activities			
Prevention of vertical transmission of HIV infection (PMTCT)	123,730	60,770	68,357
Programmatic activities for other vulnerable and accessible populations	520,526	671,525	625,540
Prevention for children and youth (excluding for AGYW)	4,230		45,526
Prevention activities to PLHIV & their partners (including SDC			4,989
SBCC for general population			7,131
STI prevention and treatment prog for general population	142,766	138,695	119,790
ASC.01.98Preventionactivitiesnotdisaggregated	**456,274**	**364,214**	**403,913**
Grand Total	**3,625,737**	**4,065,241**	**4,155,541**

Further disaggregation of prevention expenditure (Figure 11) for key populations indicates that people who inject drugs (PWID) consistently received the largest and increasing share of resources across all three years. The higher cost is also associated with opioid substitution therapy (OST) delivery site expansion and increased uptake of OST. Expenditure allocated to sex workers (SW) and men who have sex with men (MSM) shows a declining trend between 2021 and 2023. Spending classified under "key populations not disaggregated" fluctuated during the assessment period accounting for approximately 6 to 12 percent of total key population prevention expenditure. Although not allocated to specific groups, this category supports cross-cutting prevention activities that benefit multiple key populations, including those that may have received relatively lower levels of direct, population-specific investment.

Figure 11: Proportional spending on prevention activities for key populations

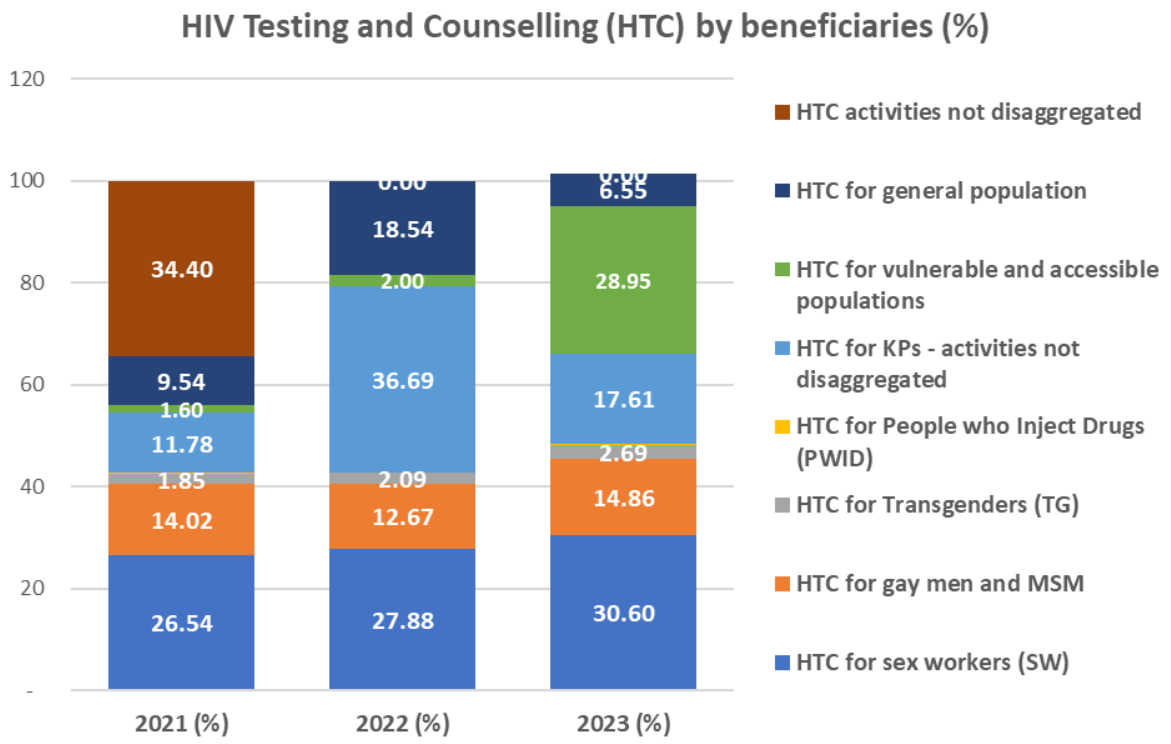


5.7.2 Spending on HIV Testing and Counselling

Total expenditure on HIV Testing and Counselling (HTC; ASC.02) amounted to USD 3.3 million in 2021, USD 4.8 million in 2022, and USD 4.9 million in 2023, accounting for approximately 19 to 23 percent of total HIV/AIDS spending in Nepal during the period (Figure 12). The observed year-to-year fluctuations in some category of beneficiaries are due to public procurement processes for key commodities—such as HIV test kits and related medical supplies—particularly by government agencies. Although procurement is intended to follow an annual cycle, delays, procedural complexities, and occasional carry-over of purchases into subsequent fiscal years result in uneven expenditure patterns across years, rather than indicating substantive shifts in programmatic priority or service delivery.

Overall spending on HTC increased steadily between 2021 and 2023 across population groups. Among key populations, sex workers (SW) consistently received the largest share of HTC-related expenditure in all three years, followed by HTC for MSM, while spending on PWID and other KPs remained comparatively limited. In 2021, a notably high proportion (34 percent) of HTC spending was reported under the category "HTC activities not disaggregated." This pattern was not observed in subsequent years and is likely attributable to disruptions caused by the COVID-19 pandemic, which may have affected routine reporting and the systematic disaggregation of service delivery data despite continued implementation of HTC services. Besides, high spending (28%) on accessible and vulnerable people in 2023 is likely to be result of post COVID high demand for test kits and reagents. While 'not disaggregated' spending reduces transparency and limits assessment of equity in resource allocation, it is important to note that by 2023, the HTC not disaggregated spending had reduced significantly.

Figure 12: Spending on HIV Testing and Counselling (%)



5.7.3 Expenditure on care and treatment related activities

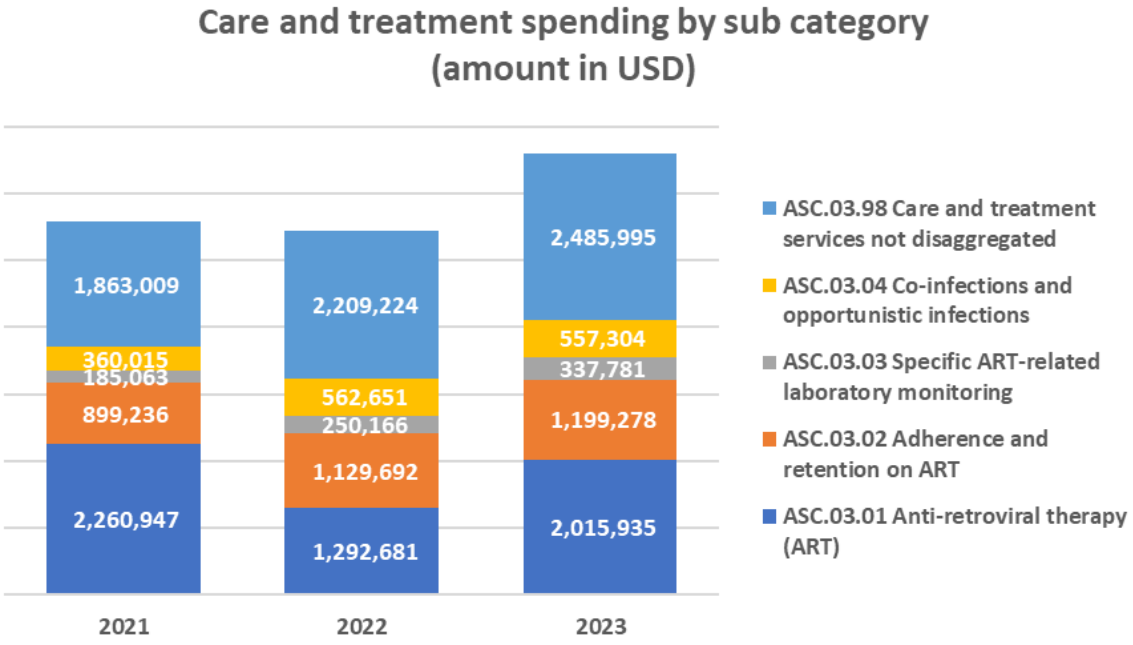
Care and Treatment (ASC.03) represents a core component of the HIV response in Nepal and accounted for a substantial share of total HIV/AIDS spending during the review period. Expenditure in this category constituted 33% of total HIV/AIDS spending in 2021, declined to 27% in 2022, and increased by 21% to USD 6.6 million in 2023 to make up 31% of total HIV spending (Table 14).

Table 14: Spending on Care and Treatment (in USD)

Care and Treatment activities	2021	2022	2023	2021(%)	2022(%)	2023(%)
ASC.03.01 Anti-retroviral therapy (ART)	2,260,947	1,292,681	2,015,935	40.60	23.74	30.56
ASC.03.02 Adherence and retention	899,236	1,129,692	1,199,278	16.15	20.75	18.18
ASC.03.03 Specific ART-related laboratory monitoring	185,063	250,166	337,781	3.32	4.59	5.12
ASC.03.04 Co-infections and opportunistic infections	360,015	562,651	557,304	6.47	10.33	8.45
ASC.03.98 Care and treatment services not disaggregated	1,863,009	2,209,224	2,485,995	33.46	40.58	37.69
Grand Total (in USD)	**5,568,270**	**5,444,414**	**6,596,293**	**100**	**100**	**100**

Within Care and Treatment, Antiretroviral Therapy (ART) absorbed the largest proportion of resources, reflecting its central role in sustaining treatment outcomes (Table 14; Figure 13). This was followed by spending on adherence and retention–related activities, which are essential to ensure continuity of treatment and viral suppression. However, a significant share of expenditure was recorded under the "Care and Treatment not disaggregated" sub-category. This highlights limitations in programmatic disaggregation and underscores the need for more systematic recording and reporting. This sub-category also includes clinical care and treatment services provided under US Government funded EpiC Nepal project supported programmes, where the PEPFAR reporting framework labels all these as 'HIV clinical services' with no further detail. Refer to section 7.2 which explores the technical efficiencies of the ART programme in terms of the annual spend per person on ART.

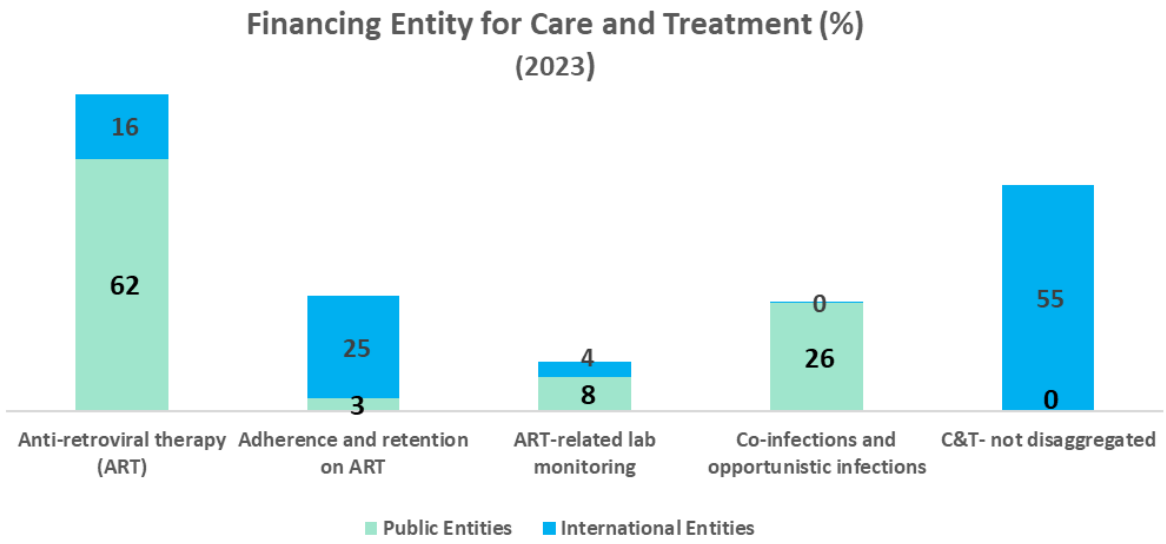
Figure 13: HIV Care and Treatment spending by subcategory (in USD)



5.7.4 Financing entities for care and treatment

Among the financing entities, public entities are leading on ART, treating Co-infection and opportunistic infections, and ART related lab monitoring – which is integrated into the existing public health care delivery system, while international entities provide financing in other areas (adherence and retention, and the not disaggregated category which was primarily the PEPFAR funds, as explained above), Figure 14

Figure 14: Financing entity for care and treatment



5.7.5 Spending on programme enablers and system strengthening

The expenditure in the category includes activities aimed at strengthening health systems, improving infrastructure, enhancing human resources capacity, and developing policies and guidelines to ensure a comprehensive and sustainable response to HIV (UNAIDS 2025).

Total spending in this category was recorded at USD 3.5 million (2021), 4.6 million (2022) and 4.5 million (2023). Within this expenditure category, two components emerge as the primary cost drivers: **Programme Administration and Management and Health System Strengthening** (

Figure 15). Programme Administration and Management accounted for approximately 72–76% of total spending over the period. The consistently high share of expenditure over three-year period in this sub-category reflects the complexity of planning, coordination, and oversight required to deliver HIV services in Nepal, particularly for reaching diverse key populations with varying levels of vulnerability, geographic dispersion, and service needs. These costs capture essential cross-cutting functions such as programme coordination, monitoring and evaluation, procurement management, and partner oversight, which are critical to effective programme implementation but do not translate directly into service delivery outputs.

Health System Strengthening represented the second largest share of spending, accounting for approximately 9–12% of expenditure in this category. This higher level of investment is primarily attributable to the construction and equipping of two laboratory facilities in two provinces, financed by the Global Fund. Although reflected under HIV-related spending in NASA, these investments contribute more broadly to laboratory and health system capacity beyond HIV alone. In contrast, expenditure on Human Resources (above-site programme costs) appears relatively low, as personnel costs are often apportioned across multiple programme areas and therefore distributed proportionately rather than being fully captured under this specific expenditure category. Moreover, the HR cost above service site often categorised under programme administration and management.

Figure 15: Programme enablers and system strengthening expenditure (%)

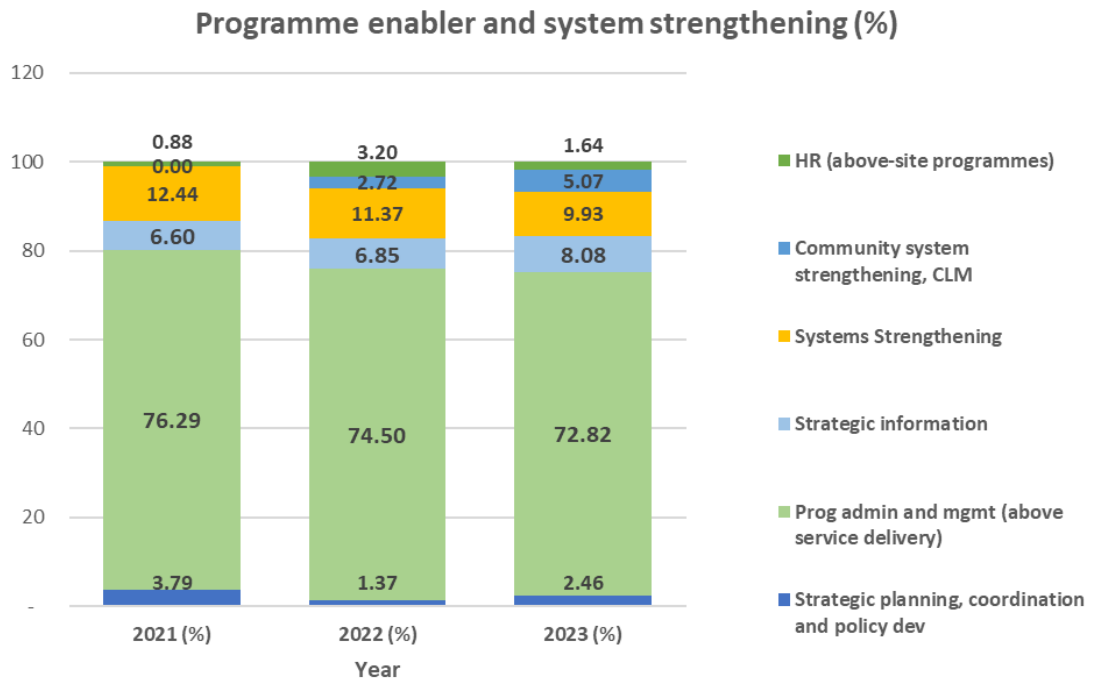


Table 15: Financing entity for Programme enablers and system strengthening

Financing entity for programme enablers and system strengthening	2021	2022	2023
FE.01Public Entities	203,864	238,173	243,417
FE.03 International Entities	3,323,156	4,414,303	4,292,660
Grand Total (USD)	**3,527,020**	**4,652,476**	**4,536,077**

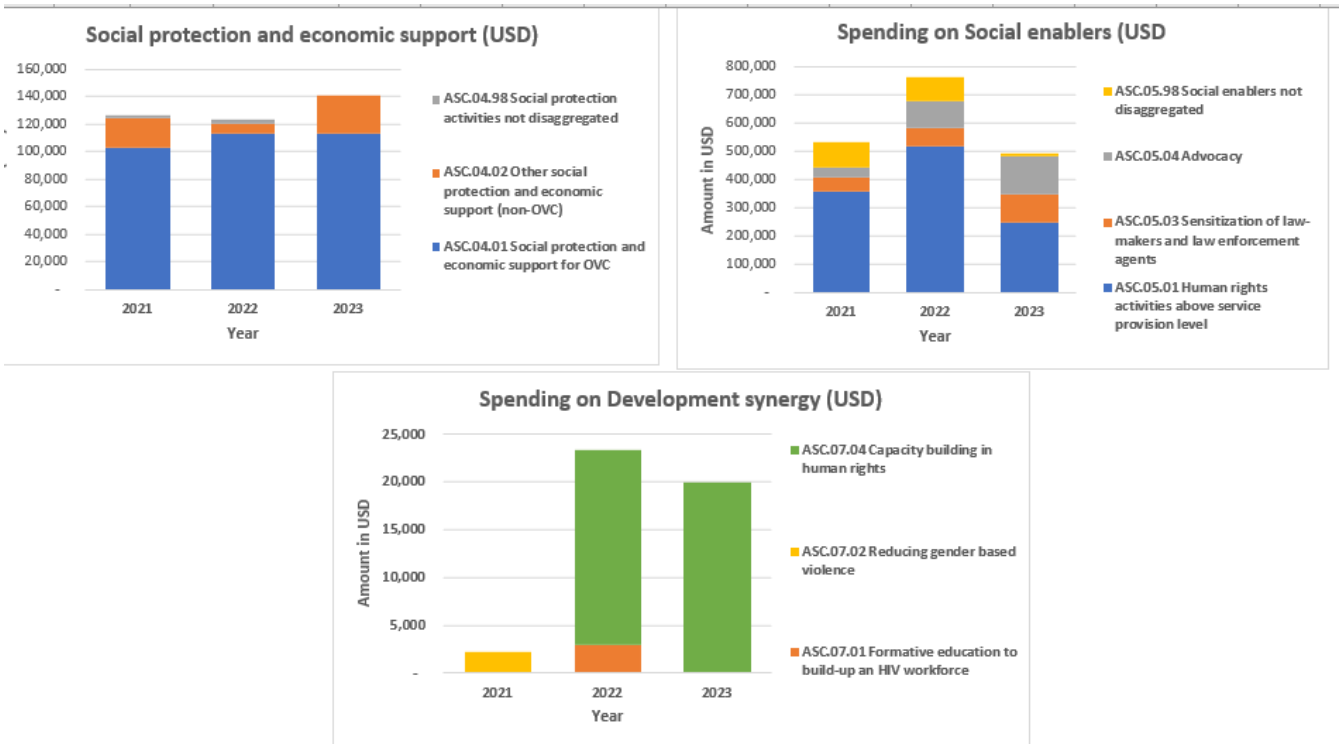
Note: Amount in USD

Bulk of the spending in the programme enabler category (
Table 15) is financed by international entity approximately 95% whereas public spending is recorded at 5%.

5.7.6 Expenditure on other key programme areas

Analysis of expenditure across other key programme areas indicates notable differences in the scale and consistency of investment (Figure 16). Social Protection and Economic Support and Social Enablers (ASC categories) demonstrate relatively stable spending patterns over the three-year period compared to Development Synergies, which remains limited and sporadic. Within Social Protection and Economic Support, spending on Orphans and Vulnerable Children (OVC) is particularly prominent, with expenditures of USD 126,770 in 2021, USD 121,103 in 2022, and USD 141,126 in 2023, underscoring sustained attention to mitigating the social and economic impact of HIV on vulnerable households.

Figure 16: Expenditure on other key programme areas (ASCs)



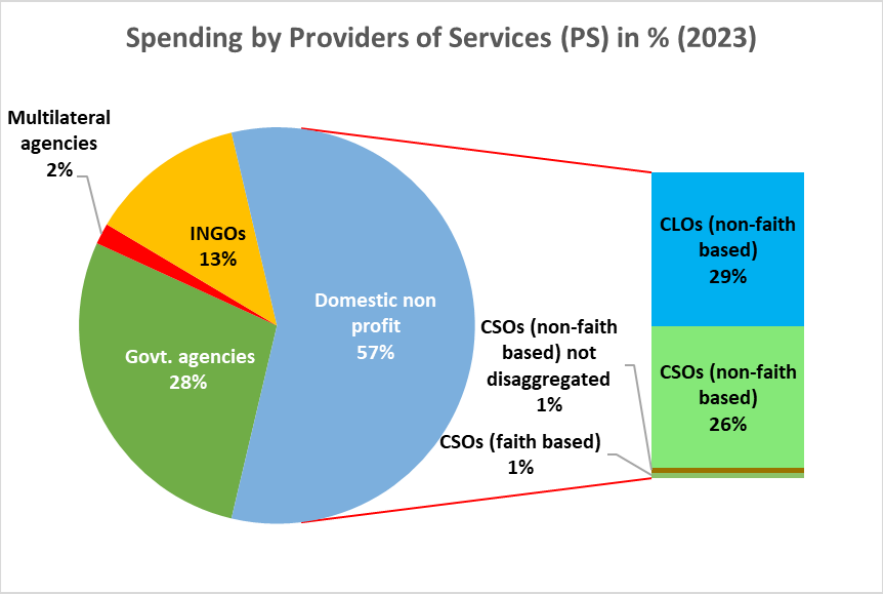
Within the Social Enablers category, investments related to human rights consistently received a larger share of resources compared to other sub-components, reflecting the continued emphasis on addressing stigma, discrimination, and legal barriers affecting key populations. Total spending under the social enabler category amounted to USD 530,893 in 2021, increased to USD 760,675 in 2022, and declined to USD 490,758 in 2023. Despite year-to-year fluctuations, the overall level of investment suggests a sustained commitment to enabling environments that support access to and utilization of HIV services.

In contrast, expenditure under Development Synergies appears limited and irregular, with no clear spending pattern observed across the assessment period. Cumulative spending over the three years totalled only USD 45,476, which is substantially lower than allocations for Social Protection and Social Enablers.

5.8 Providers of HIV services (PS)

As indicated by the HIV spending data (Figure 17), Government providers spends almost one third of total HIV resources in the country – which primarily constitute the ART services through ART sites within government health facilities (Hospitals, Health Centres). Similarly, around a half of the total fund was spent by domestic non-profit providers (CLOs and CSOs). Figure 17 is from 2023 data which largely represents the similar spending pattern of 2021 and 2023 (not shown in the figure). This highlights the important role that non-profit organisations, especially community-led organisations, play in the delivery of HIV services in Nepal.

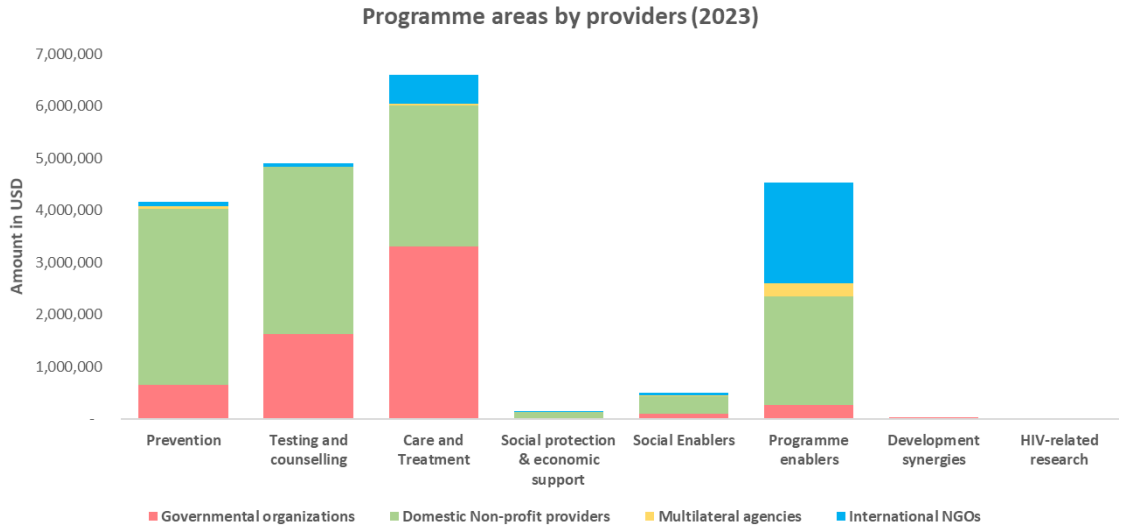
Figure 17: Spending by Provider of Services (PS)



5.8.1 Providers (PS) by the Programme areas

HIV care and treatment services were delivered primarily by government providers and not for profit organisations (NGO/CSOs), while prevention services were largely delivered by not-for-profit organisations. NGOs and CBOs also played a key role in delivering HIV testing and counselling services.

Figure 18: Spending in programme areas by providers (2023) in USD



The figure and table (Figure 18 and Table 16) shows that domestic non-profit providers are the largest service providers, managing over USD 11.8 million in 2023, or more than half of total HIV spending across all programme areas. Of these, community-led organisations absorbed half of the spending in service delivery. Their role is particularly prominent in prevention, testing and counselling, and programme enablers, highlighting their central position in community-based service delivery and program implementation. Governmental organizations are the second-largest providers, with spending concentrated mainly on care and treatment, followed by testing and counselling, reflecting the public sector's responsibility for clinical and treatment services.

International NGOs play a significant role in programme enablers and care and treatment, while multilateral agencies manage a comparatively smaller share of direct service delivery, with most of their spending directed toward programme enablers. Overall, the distribution of spending by providers and programme areas indicates a division of roles in Nepal's HIV response: government institutions lead clinical service delivery, domestic non-profits drive prevention and community services, and international actors primarily support coordination, programme management, systems strengthening, and enabling functions.

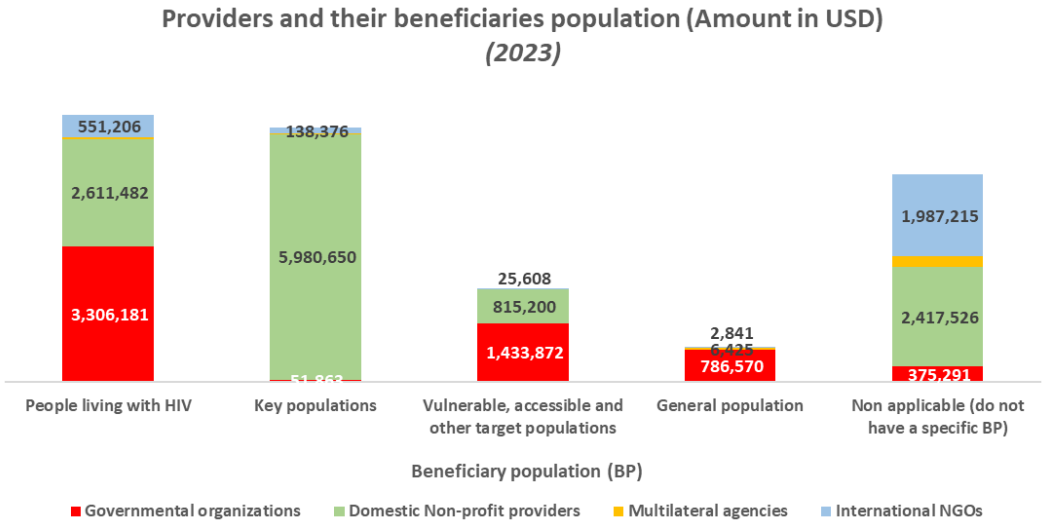
Table 16: Providers by the programme areas In USD (2023)

ASC 01 - Programme areas	Government agencies	Domestic non-profit providers	Multilateral agencies	International NGOs	Total USD (2023)
Prevention	647,402	3,372,489	60,526	75,124	4,155,541
Testing and counselling	1,616,204	3,220,396		71,823	4,908,423
Care and Treatment	3,306,181	2,699,855	32,853	557,404	6,596,293
Social protection economic support	8,699	118,747		13,680	141,126
Social Enablers	92,078	333,094	21,780	43,806	490,758
Programme enablers	263,299	2,086,702	242,667	1,943,409	4,536,077
Development synergies	19,914				19,914
HIV-related research			5,172		5,172
Grand Total (USD)	**5,953,777**	**11,831,283**	**362,998**	**2,705,246**	**20,853,304**
%	**28.55**	**56.74**	**1.74**	**12.97**	**100.00**

5.8.2 Providers (PS) spending by the beneficiary population (BP)

The HIV spending data (Figure 19) clearly shows that People Living with HIV (PLHIV) and Key Populations were the primary recipients of funding, together accounting for nearly 60% of the total budget. A distinct trend is visible in how different sectors prioritize these groups: Domestic non-profit providers directed the vast majority of their resources—nearly USD six million —toward Key Populations, whereas governmental organizations prioritized spending on PLHIV and vulnerable groups. Additionally, a significant portion of the spending (approximately 10 million) was categorized as "non-applicable," which represents cross-cutting systemic investments or indirect costs including management cost (including human resources and other operational cost) that support the broader service delivery arrangements, and do not directly target specific beneficiaries.

Figure 19: Providers spending by the beneficiary population (2023) in USD



5.9 HIV service delivery modality (SDM)

Analysis of SDM provide information on the most used modality to reach the beneficiaries. The SDM refers to the different settings and methods used to deliver HIV services to beneficiaries. It describes the structure and approach taken by providers to reach target populations, encompassing both the physical location and the delivery process (UNAIDS 2025).

Two modalities (facility based and home and community based) appeared most commonly used with larger share of spending. But at the same time, non-applicable (for interventions that are not directly served to beneficiaries) and not disaggregated categories also seen with higher spending. Investment in Self-service by the client modality has increased over the period indicating popular and preferred delivery model by the KPs. This modality is particularly applied for self-testing purpose for key population who prefer this modality against visiting HTC site.

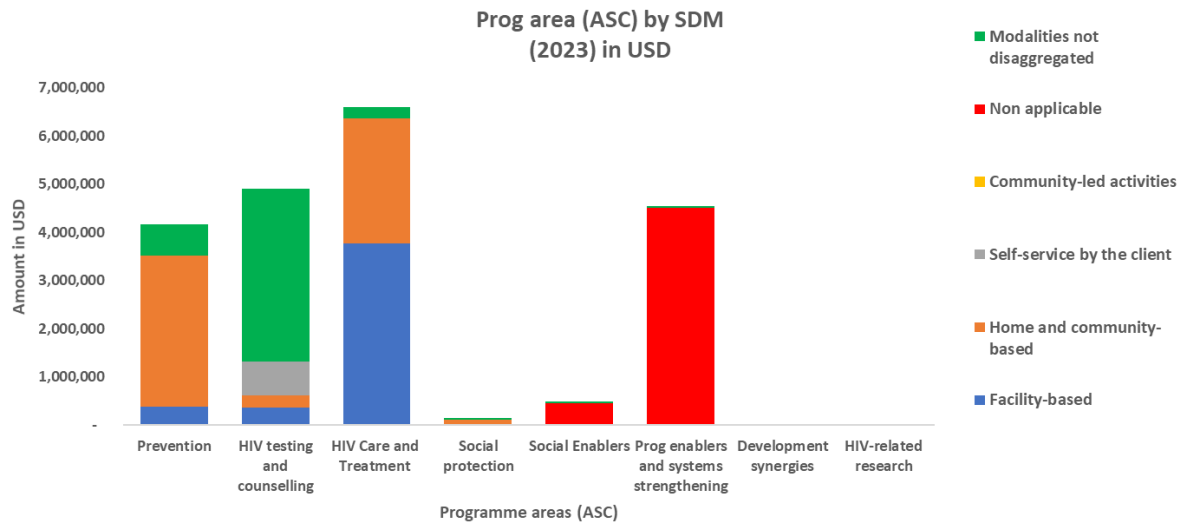
Table 17: Spending by Service delivery modality (SDM) in USD

SDM	2021	(%)	2022	(%)	2023	(%)
Facility-based service	4,250,197	25	4,156,369	21	4,514,735	22
Home and community-based service	5,609,037	34	5,853,864	29	6,072,974	29
Self-service by the client	462,882	3	612,249	3	718,098	3
Community-led activities		-	2,998	0	16,490	0
Non applicable	4,060,082	24	5,431,044	27	4,981,889	24
Not disaggregated	2,299,175	14	3,841,430	19	4,549,118	22
Grand total (Amount in USD)	**16,681,373**	100	**19,897,954**	100	**20,853,304**	100

Analysis of Service Delivery Modalities (SDM) by programme intervention shows distinct patterns in how HIV services are delivered. Prevention interventions are predominantly implemented through home- and community-based modalities, reflecting the outreach-oriented nature of prevention activities and their focus on reaching key and vulnerable populations in non-facility settings. In contrast, Care and Treatment interventions rely heavily on a combination of facility-based and home- and community-based modalities, underscoring the complementary role of clinical service delivery and community-level follow-up in ensuring treatment initiation, adherence, and retention (Figure 20).

For HIV Testing and Counselling (HTC), a substantial proportion of expenditure is classified under "modality not disaggregated." Given the service delivery characteristics of HTC—which typically involve facility-based testing, community outreach, or a mix of both—this pattern suggests limitations in modality-level reporting rather than the nature of the intervention itself. The high share of non-disaggregated modality spending reduces the analytical value of the SDM classification and highlights the need for improved recording and reporting practices to better reflect actual service delivery arrangements. Note that most social and programme enablers activities are not directly delivered to beneficiaries and hence the SDM is not applicable to these.

Figure 20: Programme areas (ASC) by SDM (2023) in USD

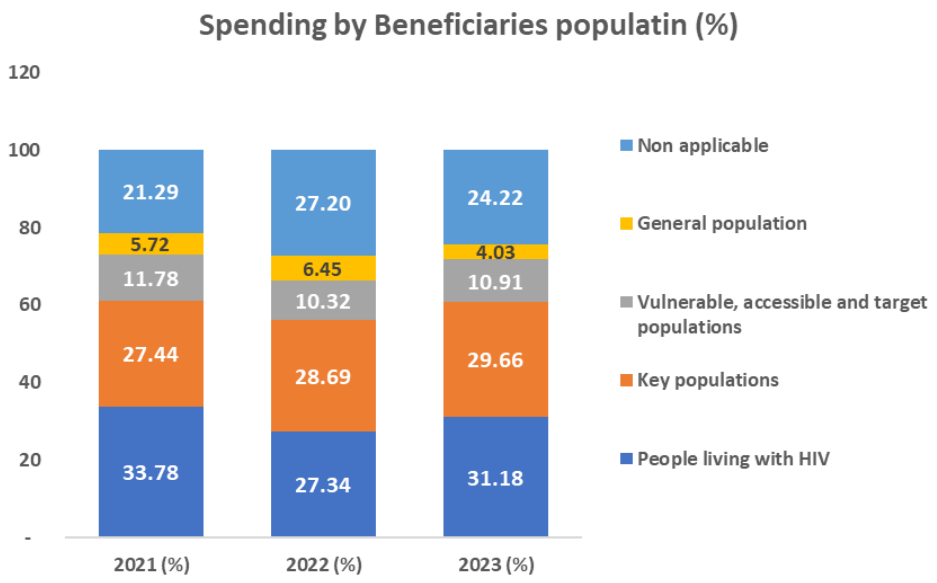


5.10 Beneficiaries' (BP) analysis

Analysis by Beneficiary Population (BP) reveals clear and consistent spending patterns that align with the priority populations identified in the National Strategic Plan (NSHP). People Living with HIV (PLHIV) accounted for nearly 30 percent of total HIV/AIDS spending across the three years, with allocations ranging from 27 to 33 percent, reflecting sustained prioritization of treatment and care services. Key populations received a comparable share of resources, representing approximately 27 to 28 percent of total expenditure, consistent with the prevention-focused strategy of the national response (Figure 21).

Expenditure targeting vulnerable and accessible populations remained stable at around 11 percent in each year. These patterns indicate a relatively consistent allocation of resources across beneficiary groups in line with national HIV response priorities.

Figure 21: Spending by beneficiary population (BP)



Within the broader category of Beneficiary Population (BP), there are specific groups that needs careful targeting of the resources. Analysis of such sub-groups reveals some useful insight on how the resources are being targeted.

5.10.1 BP analysis with sub-group spending

Analysis of spending by Beneficiary Population (BP) shows a clear concentration of resources on priority populations identified in the national HIV response. People Living with HIV (BP.01) and Key Populations (BP.02) together accounted for the majority of HIV/AIDS spending across all three years, jointly representing around 55–61 percent of total expenditure. Spending on PLHIV remained substantial but fluctuated over time, declining in relative terms in 2022 before increasing again in 2023, reflecting changes in the scale and composition of care and treatment interventions. Within this group, the largest share was directed to adult and young people living with HIV, while expenditure on children living with HIV remained comparatively low. The presence of a sizeable PLHIV not disaggregated category, particularly in 2021 and 2023, indicates scope for improving beneficiary-level reporting and classification (Table 18).

Spending on Key Populations increased steadily over the period, rising from 27.4 percent in 2021 to nearly 30 percent in 2023, driven mainly by higher allocations to sex workers, people who inject drugs, and MSM. Expenditure on vulnerable, accessible and other target populations remained relatively stable at around 10–12 percent, with the largest share directed to populations vulnerable due to TB, hepatitis, or cervical cancer, followed by mobile and migrant populations. Allocations to the general population were modest and declined in 2023, consistent with a more targeted epidemic response. A notable proportion of spending was recorded under BP.05 (non-applicable), reflecting investments in programme enablers, system strengthening, and other interventions that cannot be attributed to specific beneficiary groups under the NASA framework.

Disaggregating the spending data specific to women and children revealed 11% – 12% of total HIV spending was for this category[6] of the beneficiaries. Of this, the highest spending was noted on sex workers (and their clients) which clearly reflects the spending priority where there is higher HIV prevalence. Next highest spending was noted among the children living with HIV (6-9%). Orphan and vulnerable children, and female adult population also received 6% of spending of the category in 2021 which declined in subsequent years 5 and 3 percentage respectively.

[6] In the current NASA, under this category of BP, captured spending data for Children living with HIV, Sex workers (SW) and their clients, Orphans and vulnerable children (OVC), New born - un-determined HIV (born to HIV+ women), Female adult population and Children and Youth

Table 18: BP analysis with sub-group spending (USD)

BP - sub groups	2021	2022	2023	2021 (%)	2022 (%)	2023 (%)
BP.01 People living with HIV	**5,635,131**	**5,440,358**	**6,501,722**	**33.78**	**27.34**	**31.18**
Adult and young people living with HIV	3,723,202	4,510,270	4,623,611	22.32	22.67	22.17
Children living with HIV	166,267	151,509	150,820	1.00	0.76	0.72
People living with HIV not disaggregated	1,745,662	778,579	1,727,291	10.46	3.91	8.28
BP.02 Key populations	**4,576,558**	**5,709,127**	**6,185,889**	**27.44**	**28.69**	**29.66**
PWID and their sexual partners	1,273,605	1,527,483	1,484,831	7.63	7.68	7.12
Sex workers (SW) and their clients	1,365,880	2,035,122	2,126,260	8.19	10.23	10.20
Gay men and MSM	852,474	925,012	1,022,363	5.11	4.65	4.90
Transgender/Trans	108,239	160,454	197,012	0.65	0.81	0.94
Inmates of correctional facilities (prisoners)	67,519	68,910	99,335	0.40	0.35	0.48
Key populations not disaggregated	908,841	992,146	1,256,088	5.45	4.99	6.02
BP.03 Vulnerable, accessible and other target populations	**1,964,704**	**2,053,700**	**2,274,680**	**11.78**	**10.32**	**10.91**
Orphans and vulnerable children (OVC)	102,570	113,402	112,668	0.61	0.57	0.54
New borns - un-determined HIV (born to HIV+ women)	36,000			0.22	0.00	0.00
Mobile and migrant populations (MMPs)	545,368	764,690	723,446	3.27	3.84	3.47
People attending STI clinics	142,766	138,695	119,790	0.86	0.70	0.57
Persons made vulnerable by TB, Hepatitis, Cervical Cancer	1,138,000	1,036,913	1,306,194	6.82	5.21	6.26
Vulnerable, accessible and other not disaggregated			12,582	0.00	0.00	0.06
BP.04 General population	**953,401**	**1,282,630**	**841,362**	**5.72**	**6.45**	**4.03**
General adult population	194,053	56,805	68,357	1.16	0.29	0.33
Children and Youth	4,230		45,526	0.03	0.00	0.22
General population not disaggregated	755,118	1,225,825	727,479	4.53	6.16	3.49
BP.05 Non applicable (ASC which do not have a specific BP)	**3,551,579**	**5,412,139**	**5,049,651**	**21.29**	**27.20**	**24.22**
Grand Total (USD)	**16,681,373**	**19,897,954**	**20,853,304**	**100**	**100**	**100**

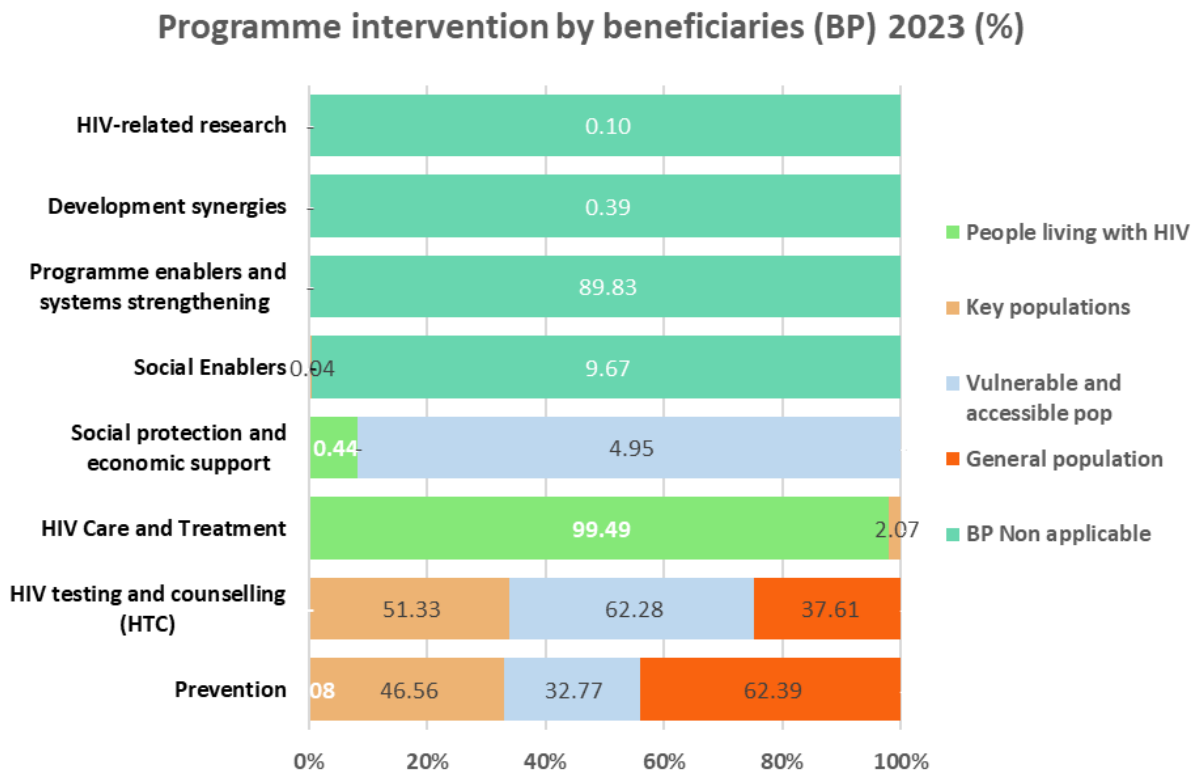
5.10.2 Programme intervention by BP

The distribution of spending by HIV intervention areas (ASC) and beneficiary populations (BP) demonstrates a clear functional alignment between programme objectives and target groups. HIV care and treatment is directed to people living with HIV, who account for nearly 99 percent of expenditure in this category. In contrast, prevention and HIV testing and counselling (HTC) spending is primarily focused on key populations and vulnerable and accessible populations, which together absorb the majority of resources in these areas, consistent with a concentrated epidemic and targeted risk-based programming approach. HTC shows a particularly strong orientation toward vulnerable and key populations, underscoring its role as a gateway intervention for early diagnosis among higher-risk groups (Figure 22).

Programme enablers and systems strengthening expenditure is largely classified as BP non-applicable, accounting for over 88 percent of spending in this category, as these investments—such as management, infrastructure, and system-wide inputs—cannot be attributed to specific beneficiary groups.

Overall, the spending pattern reflects a differentiated response: clinical services targeted to PLHIV, prevention and testing focused on populations at higher risk, and cross-cutting investments captured under non-applicable beneficiaries, in line with NASA classification principles.

Figure 22: Spending by programme interventions by BP (%)



5.11 Production factor (PF) of HIV /AIDS spending

Analysis of expenditure in Production Factor (PF) shows that 97% of spending is on current and direct expenditure which clearly reflects the expenses required to deliver complex and widespread HIV services to KP population with varied characteristics and geographical dispersion. Among the current expenditure most resources were used on three main categories; Personnel costs (29% 9in 2023), Operational and programme management (34%), and Products and supplies (including medical, non-medical) (20% in 2023) together accounting for 92-94% of current expenditure.

Table 19: Spending on production factor (PF) by its subcategory (in USD)

PF 02	2021	2022	2023	2021 (%)	2022 (%)	2023 (%)
PF.01 Current direct and indirect expenditures	**16,141,407**	**19,348,084**	**20,438,763**	**96.76**	**97.24**	**98.01**
PF.01.01 Personnel costs	4,657,002	5,351,491	6,007,594	28.85	27.66	29.39
PF.01.02 Operational and programme management	5,020,927	7,274,452	7,030,551	31.11	37.60	34.40
PF.01.03 Products and supplies (including medical, non-m	5,502,061	5,346,507	5,963,527	34.09	27.63	29.18
PF.01.04 Contracted external services	70,361	145,519	176,630	0.44	0.75	0.86
PF.01.05 Transportation related to beneficiaries	25,847	31,308	29,417	0.16	0.16	0.14
PF.01.06 Housing/accommodation for beneficiaries	88,438	132,872	131,572	0.55	0.69	0.64
PF.01.07 Financial support for beneficiaries	143,963	174,918	192,620	0.89	0.90	0.94
PF.01.08 Training costs (incl per diems/transport/other)	496,425	825,164	856,763	3.08	4.26	4.19
PF.01.09 Logistics of events, including catering services	43,317	54,936	39,870	0.27	0.28	0.20
PF.01.10 Indirect costs	93,066	7,958	9,491	0.58	0.04	0.05
PF.01.98 Current direct and indirect not disaggregated		2,959	728	0.00	0.02	0.00
PF.02 Capital expenditures	**539,966**	**549,870**	**414,538**	**3.24**	**2.76**	**1.99**
PF.02.01 Building	57,331	25,961	15,041	10.62	4.81	2.79
PF.02.02 Vehicles	485		234	0.09	0.00	0.04
PF.02.03 Information technology (hardware and software	100,548	97,626	16,291	18.62	18.08	3.02
PF.02.04 Laboratory and other medical equipment	371,596	370,711	370,607	68.82	68.65	68.64
PF.02.05 Non medical equipment and furniture	10,006	55,572	12,365	1.85	10.29	2.29
Grand Total	**16,681,373**	**19,897,954**	**20,853,304**	**100**	**100**	**100**

Under capital expenditure, key cost drivers are Information technology (hardware and software) and Laboratory and other medical equipment. The first category is primarily equipping the service delivery system with computer and other IT related expenses including building strong digital recording and reporting system. The Lab and other medical equipment cost comprise of construction of fully equip two laboratory buildings in two provinces as a part of larger health system strengthening.

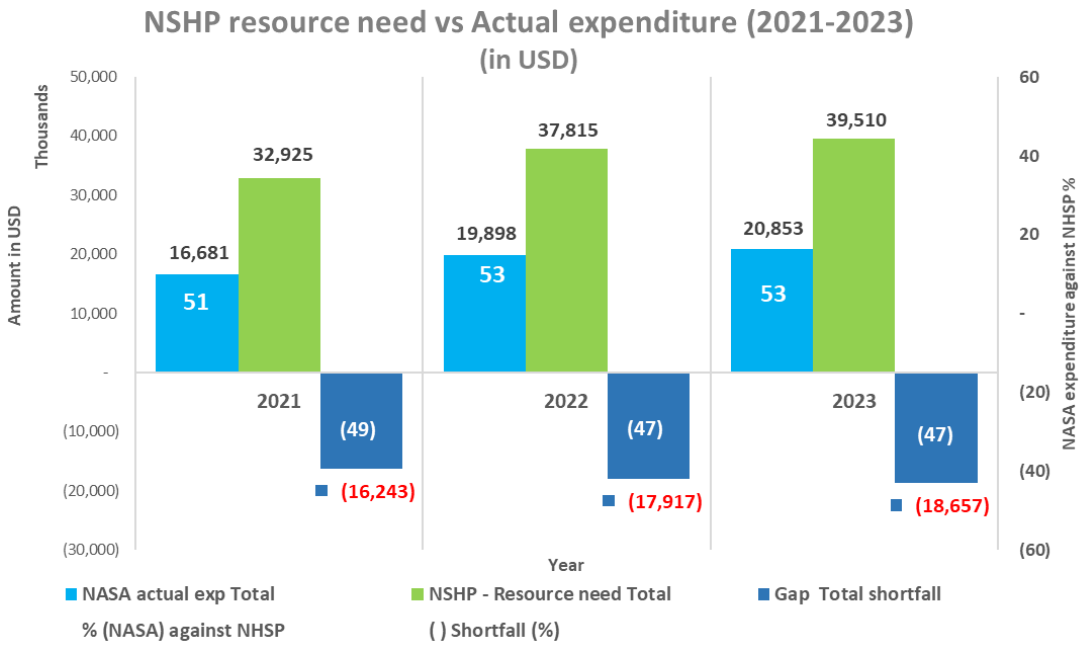
6. NASA Expenditure and the NHSP cost projections

6.1 NASA and NHSP cost projection

HIV spending in Nepal increased modestly from about USD 17.5 million in 2021 to USD 20.7 million in 2023. However, this covered only around 51–53 percent of the estimated National HIV Strategic Plan (NHSP)[7] resource needs, leaving a consistent financing gap of 47–49 percent each year (Figure 23). This indicates that resource mobilization may not have kept pace with planned targets, or the targets were achieved with fewer resources.

If the programmatic targets have been achieved over the period, despite spending less than what was estimated as needed, this may suggest a need to revisit NHSP projections, priority setting, and/or adjust unit prices - if outdated. Over-ambitious target setting might be curtailed by limited implementation capacity and slow scale-up rates. Indeed, strong programme achievements—particularly in prevention—raise questions about whether some cost estimates may be overstated. A review of costing assumptions is therefore recommended to improve alignment, credibility, feasibility and efficiency of future planning. Overall, a recalibration of resource needs, grounded in empirical spending patterns and program performance, is recommended to strengthen strategic alignment and ensure more efficient use of available resources.

Figure 23: NHSP resource need vs actual spending (2021-2023)



[7] NHSP and the costing is for the period 2021-2026. For the purpose of NASA analysis and comparison only NHSP costing for 2021 to 2023 is taken.

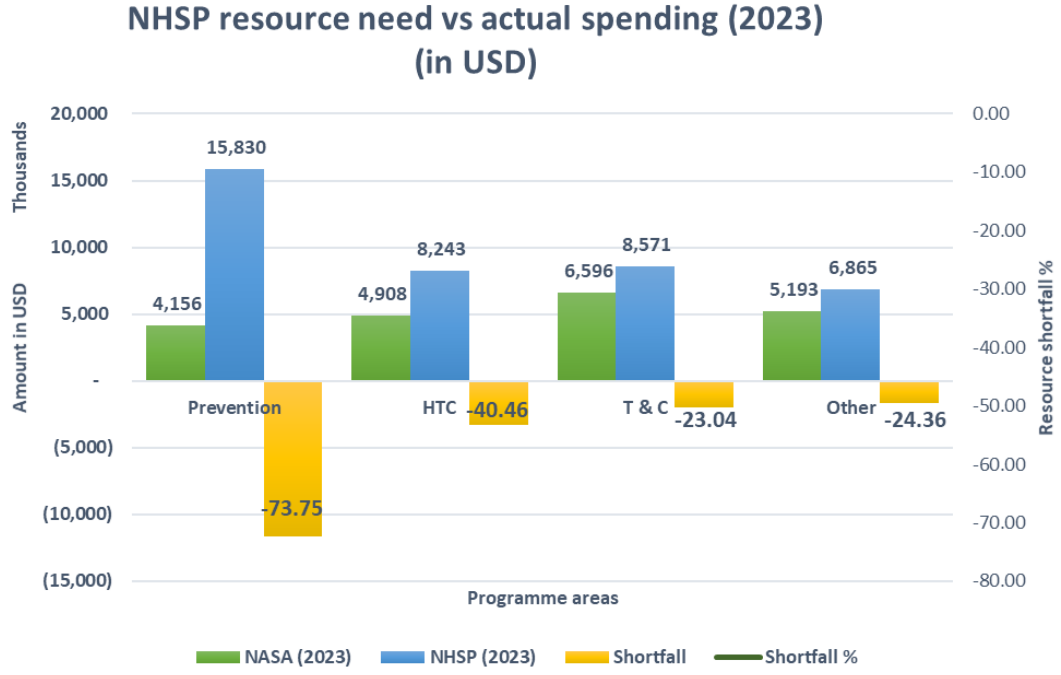
6.2 Resource need vs actual spending by programme

The comparison between actual expenditure (NASA data 2023) and the resource needs articulated in the National HIV Strategic Plan (NHSP projection data 2023) reveals substantial allocative gaps across all intervention areas, indicating partial financing of planned programme priorities. Overall, only about 53% of the total NHSP resource requirement was met, resulting in a financing gap of USD 18.7 million (47.2%) in 2023.

At the programme level, prevention (ASC.01) exhibits the most pronounced underfunding, with only USD 4.16 million spent against a requirement of USD 15.83 million, corresponding to a gap of 73.8% in 2023. This might suggest a major misalignment between strategic planning and resource needs, and actual resource allocation. However, given the successful reduction in new infections (Figure 1), Nepal appears to have achieved its prevention targets through more strategic and focused investments.

HIV Testing and Counselling (ASC.02) also shows a considerable shortfall of 40.5%, indicating constraints in scaling up case identification services in line with NHSP targets. In contrast, Care and Treatment (ASC.03) demonstrates relatively better alignment, with a smaller gap of 23.0%, reflecting prioritization of treatment continuity and service delivery obligations, such as antiretroviral therapy (Figure 24). This is also reflected in the NHSP treatment targets being met with 82% of PLHIV were on treatment.

Figure 24: NHSP projection vs actual spending by intervention (2023) in USD



Spending under other programme components (including programme enablers and system strengthening) shows a similar moderate gap of 24.4%, suggesting that while these cross-cutting investments are comparatively better funded than prevention and testing, they may still fall short of planned levels. It is however to be noted that its very hard to accurately cost these cross-cutting investments, and to align correctly to the same spending categories.

Overall, this discrepancy highlights critical review of NHSP priorities and underscores the need to strengthen strategic alignment between planned resource needs and actual financing flows to optimize the effectiveness and sustainability of the HIV response, especially to reduce new infections through effective prevention spending.

Strategic recommendations for resource realignment

Despite reduction of new HIV infection over the period, it is crucial to maintain and augment high quality prevention programme to sustain the current epidemiological gain and reduction in new HIV infection.

NASA evidence, especially by providing updated and realistic units of expenditure, provides an important basis for recalibrating resource projections in the forthcoming NHSP. As such, ensure the future planning is grounded in strategic achievements made so far (i.e., declining trend in new infection), observed expenditure patterns and implementation realities.

Equity and efficiency

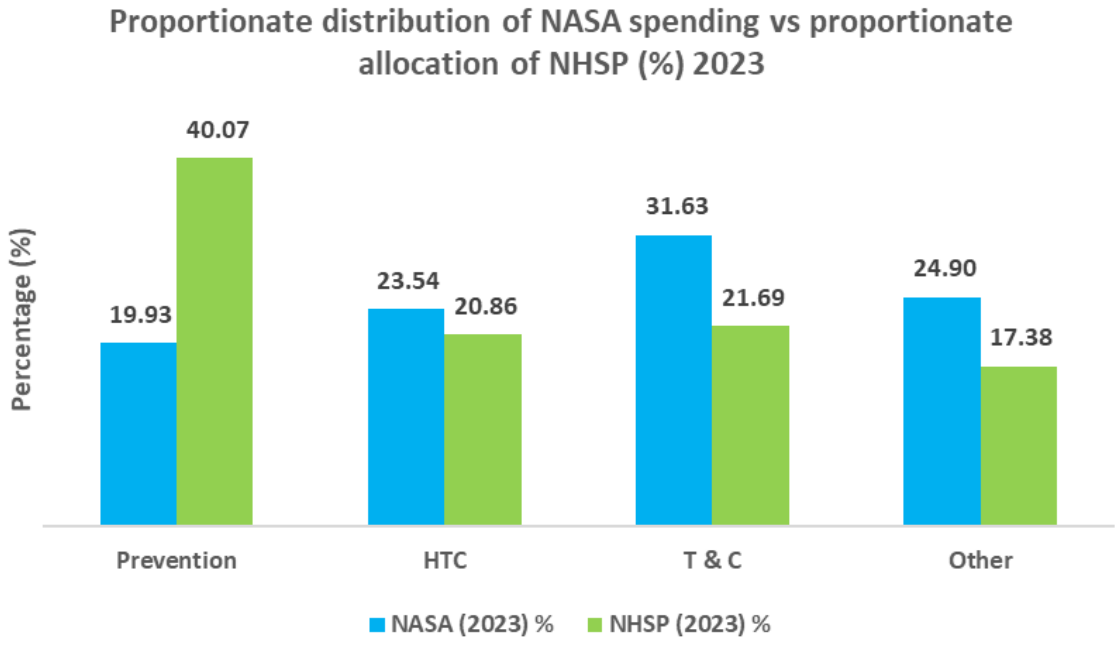
7. Equity and efficiency

7.1 Allocative efficiency: NASA vs NHSP

The proportionate distribution of funds across AIDS Spending Categories (ASC) reveals some misalignment between strategic intent (NHSP) and actual implementation (NASA).

Under the NHSP, Prevention (ASC.01) was intended to be the dominant spending area, accounting for 40% of the resource need. In contrast, actual spending on prevention remained low at 20%. This shortfall suggests that the primary prevention of HIV infections is significantly under-resourced. However, as explained previously, despite this apparent under-spending, Nepal has managed to reduce its new HIV infections significantly, hence this mismatch may have been due to exaggerated estimates of needed resources. In contrast, for HIV testing and counselling, NHSP accorded second highest priority with 21% of resource need while actual spending also shows good match with 23% of spending. There was a higher investment in treatment and care with 32% spending against 22% needed in NHSP indicating possible shifting priority and growing demand for treatment. In other intervention areas (including social enablers, social supports, M and E, strategic planning) some misalignment was noticed between needed and spending efficiency (Figure 25), which may call for revisiting NHSP resource needs projection method and criteria.

Figure 25 : Proportionate spending of NASA vs NHSP allocation 2023 (%)

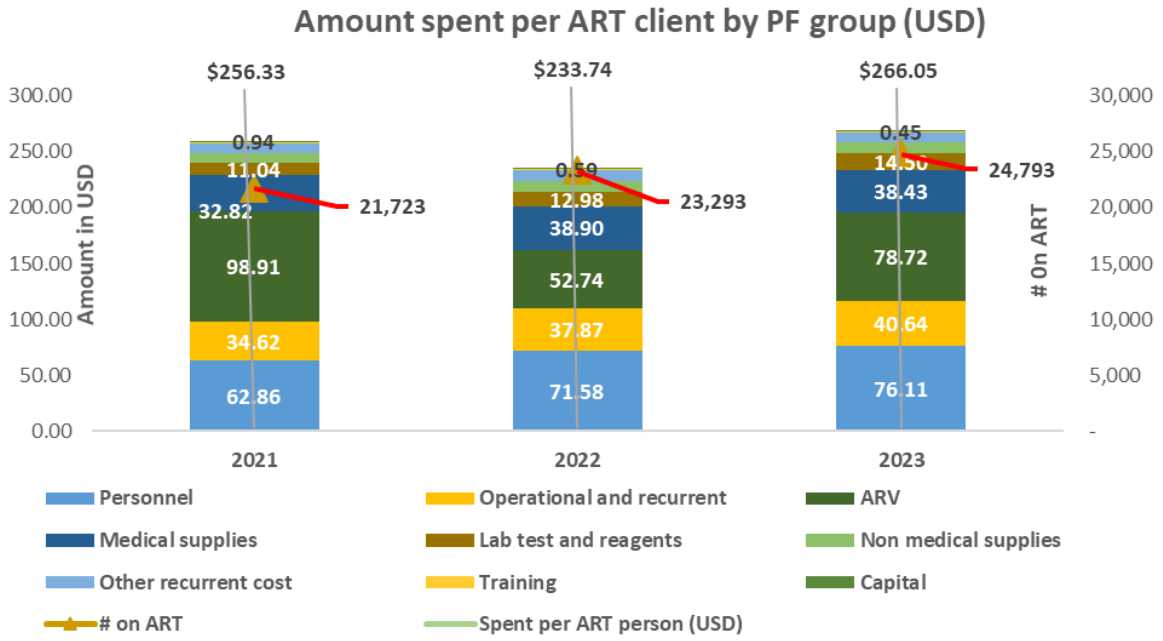


Conversely, Testing and Counselling (ASC.02) and Treatment & Care (ASC.03) consumed 23.54% and 31.63 respectively, combined 56.7% of the total budget in three-year period, exceeding the NHSP's planned allocation of 42.7%. This reflects a "priority-response" spending modality, where resources were prioritized toward achieving 93% of PLHIV knowing their status, and 82% accessing and maintaining patients on ART (Antiretroviral Therapy) with 73% virally suppressed to ensure survival and viral suppression.

7.2 Technical efficiency in ART intervention

The analysis of the annual ART expenditure per person on ART can provide some insights into potential technical efficiency gains in ART service delivery alongside rapid programme expansion. The scale-up to over 90 ART sites integrated into the public health system, and the increase in clients from 21,723 (2021) to 24,793 (2023), reflect enhanced coverage and utilization. This expansion coincided with a temporary and slight reduction in unit cost per ART client (USD 256 to USD 234 in 2022), but increasing again to USD 266 in 2023, despite increasing numbers on treatment[8] (Figure 26).

Figure 26: Amount spent per ART client by PF group (USD)



However, the rise in unit cost to USD 266 in 2023 points to emerging cost pressures. This was primarily driven by fluctuations in the ARV cost per patient (declining in 2022 and increasing again in 2023) and a steady increase in personnel (USD 63 to USD 76) and operational costs (USD 35 to USD 41), implying a shift toward more resource-intensive service delivery, and the growing reliance on

[8] Calculation basis: Production Factors (PF) under ASC.03 was filtered and regrouped under nine convenient categories. HTC and other enabling costs are excluded.

human resources and recurrent system costs as services expand, which could imply diseconomies of scale.

Overall, of the 30,000 estimated people living with HIV, 24,793 are on ART and over 95% viral load suppression reflects an impressive gain in treatment cascade[9]. With minimal capital investment, the programme relies heavily on recurrent inputs, underscoring the need to strengthen procurement efficiency and manage rising input costs (human resources, ART cost) to sustain technical efficiency.

7.3 Technical efficiency in OST intervention

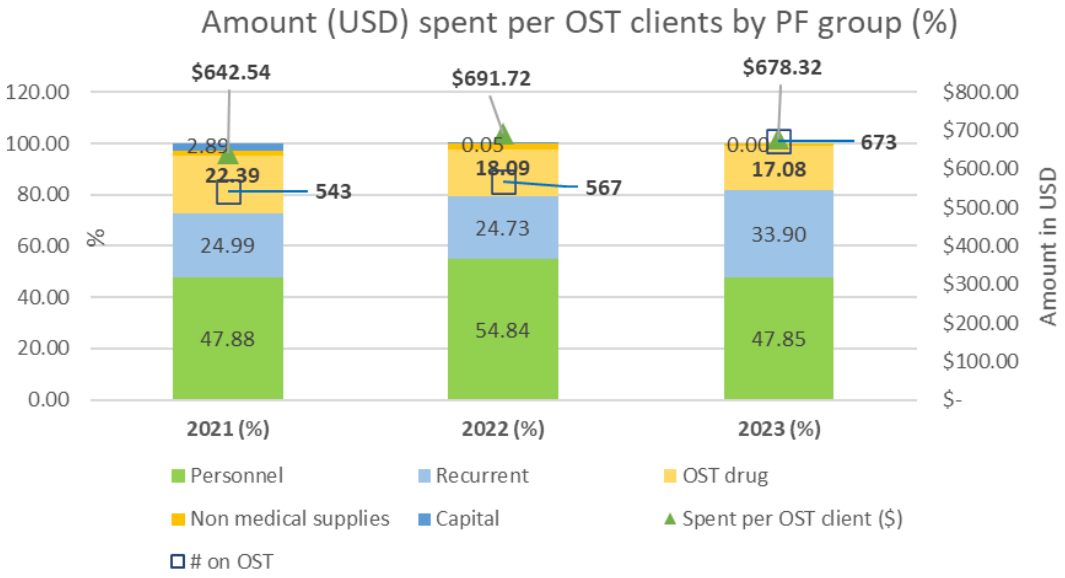
Opioid Substitution Therapy (OST) services are currently delivered through 12 sites within government hospitals, complemented by key population (KP)–led civil society organizations that operate social support units to facilitate access and strengthen linkages with outreach services.

Programme data indicate a steady increase in service uptake alongside site expansion, with the number of clients rising from 543 in 2021 to 673 in 2023. While client numbers grew modestly by 4% between 2021 and 2022 and more substantially by 19% in 2023, the cost per client also increased by 8% and 2% over the same periods. This pattern suggests moderate gains in technical efficiency; however, rising personnel and recurrent costs indicate growing cost pressures, which may affect the sustainability and future scale-up of OST services (

Figure 27). Importantly, the OST drug costs per person appeared to have reduced over the period from USD 22 to USD 17, and if continue to reduce could lead to important cost savings. In order to operate the OST programme at technically efficient scale, it is important to increase number of clients in OST service and retain the clients.

Figure 27: Amount (USD) spent per OST clients by PF group (in %)

[9] For further reading refer to NCASC Fact sheet (2024) National AIDS and STD Control Center, Kathmandu, Teku



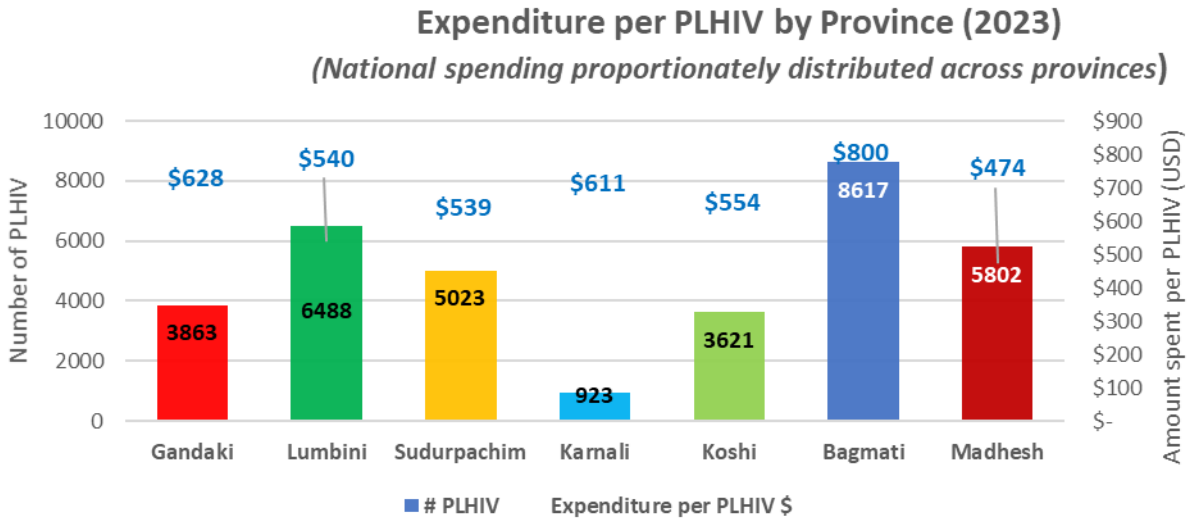
7.4 Equity in spending: Provincial variation

Analysis of provincial expenditure patterns for 2023 shows substantial variation in both expenditure per PLHIV and per capita expenditure, reflecting possible differences in HIV burden, population size, service delivery intensity, and programmatic focus across provinces. At the national level, average expenditure per PLHIV was USD 607, while per capita expenditure stood at USD 0.72, serving as reference points for inter-provincial comparison[10].

Per PLHIV expenditure was highest in Bagmati Province (USD 800), followed by Gandaki (USD 628) and Karnali (USD 611). Bagmati's higher per PLHIV spending is consistent with its role as a service hub, hosting tertiary-level facilities, referral services, and a concentration of programme enablers and treatment-related interventions that benefit PLHIV from multiple provinces. In contrast, Madhesh (USD 474) and Sudurpaschim (USD 539) recorded the lowest per PLHIV expenditure despite having relatively high numbers of PLHIV.

Figure 28: Expenditure per PLHIV by province (in USD) 2023

[10] Calculation basis: For Per PLHIV, total HIV spending of provinces divided by total number of PLHIV of the province, for Per capita spending, total HIV spending of provinces divided by total number of population of the province.



When assessed through a per capita expenditure lens—calculated using the total provincial population—the disparities are equally pronounced. Bagmati (USD 1.13) and Sudurpaschim (USD 1.00) reported the highest per capita spending, indicating a higher overall intensity of HIV investment relative to population size. Conversely, Madhesh (USD 0.45), Karnali (USD 0.33), and Koshi (USD 0.40) exhibited the lowest per capita expenditure, reflecting limited resource allocation in provinces with large populations or geographic and service-delivery challenges (Figure 28).

The differences between per PLHIV and per capita expenditure across provinces point to uneven, and possibly inequitable, allocation of HIV resources at the subnational level. Provinces with higher per PLHIV spending—often those with more established service centres—may benefit from concentration of services and referral roles, which can justify relatively higher investments.

However, provinces with a notable HIV burden but consistently low spending—both per PLHIV and per capita—suggest a misalignment between resource allocation and epidemiological need. This indicates potential inequities in how resources are distributed. Strengthening needs-based planning and refining subnational allocation criteria will be essential to ensure a more balanced, equitable, and impact-oriented distribution of HIV resources.

Table 20: Per PLHIV and Per Capita expenditure by province

Province	Expenditure per PLHIV	Per capita expenditure
Bagmati	800	1.13
Lumbini	540	0.68
Sudurpaschim	539	1.00
Gandaki	628	0.98

Madhesh	474	0.45
Koshi	554	0.40
Karnali	611	0.33

Conclusions

8. Conclusions

1. Overall level and adequacy of HIV financing

The NASA 2021–2023 analysis shows that while total HIV/AIDS spending in Nepal increased steadily over the three-year period. Despite better performance and spending in certain programmatic areas like HTC, T&C, the overall level of financing remains insufficient to meet national strategic projections. Actual expenditure of approximately USD 57.4 million during 2021–2023 covered only about half of the total resource requirements projected under the National HIV Strategic Plan (NHSP) for the same period. This potential financing gap could pose risks to achieving and sustaining epidemic control, particularly in prevention and community-based interventions. Nevertheless, Nepal managed to achieve reductions in new HIV infections and high ART treatment coverage and viral suppression.

2. High dependence on international financing and sustainability risks

Nepal's HIV response continues to rely heavily on international financing, which accounted for approximately 65–75 percent of total HIV/AIDS spending in this assessment period, with the government's contribution declining from 24% in 2021 to 18% in 2023. International purchasing organizations and international NGOs managed the majority of resources, largely through off-budget and off-treasury mechanisms. While these funds remain well aligned with national priorities, the continued dominance of external financing exposes the programme to significant sustainability risks, especially in the context of evolving global funding environments. Government financing decreased slightly in 2022, then increased in 2023, but not its 2021 level, in nominal terms. Government spending has increased for care and treatment but remains insufficient to offset potential reductions in donor support.

3. Government financing: progress but limited scope

Public sector financing played an important role in HIV care and treatment, including antiretroviral therapy and facility-based services. The introduction of Social Health Insurance (SHI) for People Living with HIV (PLHIV)—through premium waivers reimbursed by the government—represents a positive step toward domestic financing and financial risk protection. However, SHI coverage remains largely limited to clinical services and does not address broader prevention, social enablers, or community-led interventions. Provincial and local government contributions from own-source revenues remained minimal and uneven, reflecting limited prioritization of HIV within sub-national budgets.

4. Allocation by programme areas and allocative efficiency

Spending patterns broadly reflect the structure of Nepal's HIV response, with care and treatment accounting for around one-third of total expenditure, followed by

HIV testing and counselling and prevention. However, comparison with NHSP cost projections reveals relative underinvestment in prevention, which received substantially less funding than planned, despite its central role in reducing new infections among key and vulnerable populations. A significant share of resources was allocated to programme enablers and systems strengthening, driven largely by programme administration and management costs and major laboratory infrastructure investments. While these expenditures are essential, their scale highlights the need to continuously assess efficiency and balance between direct service delivery and system-level costs.

Overall, there was some misalignment between NASA expenditure and NHSP resource need projections in terms of allocative efficiency, particularly regarding inadequate prioritization of prevention investments.

The NASA findings also imply a limited technical efficiency both in ART and OST programme. Despite expansion of services and increased uptake along with the global reduction of ARV drug cost, the technical efficiency is limited, except with some efficiency gain in 2022. In OST programme, the cost per client has modestly decreased in 2023 compared to 2022, and more importantly, the OST drug costs per person appeared to have reduced over the period from USD 22 to USD 17, indicating cost savings. With minimal capital investment, the programme relies heavily on recurrent inputs, underscoring the need to strengthen procurement efficiency and manage rising input costs (human resources, ART and OST cost) to sustain technical efficiency and scale up the services

5. Beneficiary populations and equity considerations

Analysis by beneficiary population indicates that spending largely aligns with national priorities. PLHIV and key populations together received nearly 60 percent of total HIV/AIDS expenditure, reflecting the concentrated nature of the epidemic and the treatment needs of PLHIV. Provincial analysis reveals wide variation in per PLHIV and per capita expenditure, suggesting inconsistencies in resource allocation relative to HIV burden, population size, and service delivery needs across provinces.

Women and children accounted for about 11–12% of total HIV spending during 2021–2023. The largest share was directed to sex workers and their clients, reflecting higher HIV burden, followed by children living with HIV (6–9%). Spending on orphan and vulnerable children and the general female adult population declined over the period.

6. Service delivery modalities and health system investments

Prevention services were predominantly delivered through community- and home-based modalities, while facility-based modalities dominated care and treatment, complemented by community-based adherence and retention support. This mix of modalities reflects an appropriate differentiation of service delivery. Investments in laboratory system strengthening, though often recorded under TB budgets, contributed significantly to HIV-related system capacity. At the same time, high spending on programme administration and management underscores the complexity of service delivery in a federalized context and the importance of efficiency gains.

7. Community-led response and non-monetary contributions

The assessment of Community-Led Organizations (CLOs) indicates that non-monetary contributions remain minimal and have declined since the COVID-19 pandemic. Additionally, since the pilot CLO resource tracking in 2022, this updated assessment (in 2024) found a reduction in the number of active CLOs, as well as a narrowing of their programmatic activities since the earlier assessment. CLOs continue to rely almost entirely on major donors, with very limited success in mobilizing additional resources from local governments or alternative sources. Structural and regulatory barriers, particularly affecting female sex worker–led organizations, further constrain the community response. This limits the sustainability and autonomy of community-led HIV interventions.

Recommendations

9. Recommendations

Nepal's HIV response continues to rely heavily on international development partners, who contribute an estimated 76% to 85% of total HIV spending. This high dependence creates substantial sustainability risks—especially given the current volatility in global aid flows. To ensure long-term continuity of HIV programs and services, the Government of Nepal must strengthen its domestic financing efforts and explore diversified, sustainable funding options. Priority actions include the following:

1. Strengthen Domestic and Sustainable HIV Financing

- Gradually increase government budget allocations for HIV, with a clear medium-term plan to reduce reliance on international financing.
- Expand the scope of Social Health Insurance to better integrate HIV-related services beyond clinical care, where feasible.
- Encourage provincial and local governments to allocate dedicated resources for HIV within their own budgets, aligned with local epidemiological needs.

2. Improve Alignment Between Planning and Actual Expenditure

- Conduct a systematic review of NHSP costing and budgeting assumptions to ensure realistic projections and improved budget credibility.
- Strengthen mechanisms to align annual budgets and actual expenditure with NHSP priorities, particularly for prevention and key population programmes.
- Building on the NASA findings, it is important to sustain and further strengthen areas where resource allocation has demonstrated strong alignment with national priorities and measurable results. Continued investment in key populations (KPs), particularly through community-led organizations (CLOs), who remains critical given their central role in delivering targeted, high-impact services. Likewise, maintaining adequate funding for HIV Testing and Counselling (HTC) is essential to preserve the gains made toward achieving the 95–95–95 targets. These areas reflect efficient use of resources and should be protected and scaled, where feasible, to ensure continued progress and stability in the national HIV response.

3. Sustain and Consolidate Effective Investment Patterns

Building on the NASA findings, it is important to sustain and further strengthen areas where resource allocation has demonstrated strong alignment with national priorities and measurable results.

- Continued investment in key populations (KPs), particularly through community-led organizations (CLOs), who remains critical given their central role in delivering targeted, high-impact services.
- Likewise, maintaining adequate funding for HIV Testing and Counselling (HTC) is essential to preserve the gains made toward achieving the 95–95–95 targets.
- These areas reflect efficient use of resources and should be protected and scaled, where feasible, to ensure continued progress and stability in the national HIV response.

4. Enhance Allocative Efficiency Across Programme Areas

- Reexamine the investment plan towards addressing any underfunded prevention interventions, especially those targeting key and vulnerable populations.
- Regularly review the scale and composition of programme administration and management costs to identify opportunities for efficiency gains without compromising service quality.

5. Promote Equity in Provincial Resource Allocation

- Use per PLHIV and per capita expenditure indicators systematically in planning and monitoring to guide more equitable resource allocation across provinces.
- Strengthen provincial-level planning capacity to link HIV spending more closely with local HIV burden and service delivery needs.

6. Diversify Financing and Strengthen Community-Led Responses

- Support CLOs and national networks to diversify funding sources, including through engagement with INGOs, philanthropic foundations, and corporate social responsibility initiatives.
- Address regulatory and structural barriers affecting female sex worker–led organizations, enabling their formal recognition and access to funding.
- Institutionalize mechanisms to recognize and track non-monetary contributions of CLOs within the national HIV response.

7. Institutionalize NASA for Policy and Planning

- Integrate NASA more systematically into national and sub-national planning, budgeting, and review processes. As such, allocate government resource to track the expenditure data.
- Strengthen data systems to improve disaggregation by beneficiary population, service delivery modality, and geography, enhancing the usefulness of future NASA exercises.

- Spending efficiency and the allocation of resources across different categories—such as non-targeted interventions, programme management, and administration—should be regularly reviewed by each funding source and implementing agent. This will help ensure cost efficiency, transparency, and better alignment with national plans. Regular deliberation and dialogue on programme expenditures and outputs are essential to maintain service quality and improve overall programme performance.

Supplement to CLO resource tracking

10. Supplement on CLO Resource Tracking

Assessment of Community-Led Organizations' Spending on HIV/AIDS, Including Non-Monetary and Non-Exchange Transactions: NASA 2024

As part of NASA 2024 Nepal, the CLO-RT aimed to examine the contribution of Community-Led Organizations (CLOs) to the national HIV/AIDS response, with particular attention to non-monetary transactions. These include in-kind contributions, volunteer labour, and other forms of support that do not involve direct financial payments. Given the complexity of identifying and valuing such contributions, the assessment required targeted methodological adjustments and substantial field engagement.

The assessment drew on the CLO mapping and screening exercise conducted in 2022 under the UNAIDS global pilot on community-led response resource tracking, in which Nepal participated. Key Population (KP) networks were consulted to validate and update this mapping previously done. These consultations indicated a reduction in the number of active CLOs, as well as a narrowing of their programmatic activities since the earlier assessment.

A self-identification form developed by UNAIDS for the Community-Led Response (CLR) resource-tracking pilots was distributed to identified CLOs through their respective networks. CLOs were requested to complete and return the form via these networks. However, the response rate was very limited (five in total in contrast to 130 responses during CLOs piloting in 2022), necessitating a revision of the data-collection approach, described below.

Data Collection

Due to the low response to the self-identification forms, the NASA team adopted a qualitative approach to data collection. Focus Group Discussions (FGDs) were conducted with identified CLOs through their respective networks during provincial and district-level data collection visits, as the application of standard data-collection tools proved impractical. KP-led organizations supported this process by facilitating invitations and organizing the FGDs.

The FGDs explored CLO engagement in HIV/AIDS-related activities, including non-monetary and non-exchange transactions, as well as any support received outside major funding streams such as the Global Fund, US Government, the Government of Nepal (GoN), and AHF Nepal.

In addition, Key Informant Interviews (KIIs) were conducted with representatives of major national KP networks based in Kathmandu. These interviews sought to determine whether national networks had facilitated or implemented initiatives

involving non-monetary or non-exchange contributions through their affiliated CLOs.

FGDs were conducted in all seven provinces except Karnali province. 30 NGOs and CLOs participated of which 24 were CLOs and the rest were other KP led NGOs. A total of eight FGD was conducted in different locations.

One FGD was conducted in each location with participation from affiliates of all listed networks except JMMS, involving 7-15 participants in each FGD. Participation from CLOs representing the Female Sex Worker (FSW) constituency was very limited and was available only in one location (Nepalgunj).

These discussions aimed to identify and document the scope and nature of non-monetary and non-exchange transactions undertaken by CLOs within the national HIV/AIDS response.

Summary of Findings from FGDs and KIIs

1. Insignificant and declining non-monetary transactions

The assessment found that CLO contributions to HIV/AIDS related activities through non-monetary transactions were minimal and had further declined following the COVID-19 pandemic. Existing non-monetary support consisted mainly of small-scale nutritional assistance provided by some local governments to the most vulnerable members of CLOs, particularly People Living with HIV (PLHIV). These supports were irregular, limited in coverage, and largely aimed at addressing general poverty rather than HIV-specific needs.

Some CLOs reported contributing indirect inputs—such as office space, furniture, or utilities—while implementing donor-supported projects. However, these projects were generally broader health or development initiatives in which HIV constituted only a minor component. As a result, apportioning costs specifically to HIV-related activities was not feasible, and the overall contribution was assessed to be negligible.

2. Limited resource mobilization beyond major donors

CLOs mobilized very limited financial resources beyond major donors such as the Global Fund and US Government. Local governments occasionally provided small annual allocations for social support to vulnerable populations, including HIV key populations. However, these funds were highly competitive, modest in size, and not earmarked for HIV-specific interventions, limiting their relevance and impact.

3. Resource-mobilization efforts encouraged but limited in practice

KIIs with national network leaders indicated that CLOs are encouraged to engage in resource mobilization, including through training on proposal development. However, in practice, CLO efforts remained largely focused on advocating for support from local governments. While some advocacy efforts were reportedly successful in getting budget included in local government annual workplan and budget, but the allocated budgets were often not fully disbursed, redirected to other programs, or only partially spent on HIV-related activities. Furthermore, detailed expenditure information was frequently unavailable, as spending was managed directly by local governments.

These limitations do not appear to stem from a lack of organizational capacity. Many CLOs serve as sub-recipients or sub-sub-recipients of the Global Fund and as IP of FHI 360 and maintain strong coordination with local authorities, provincial governments, law enforcement agencies, and NGOs/INGOs. However, these relationships have not translated into diversified or sustainable resource mobilization.

4. Limited coordination among FSW constituency

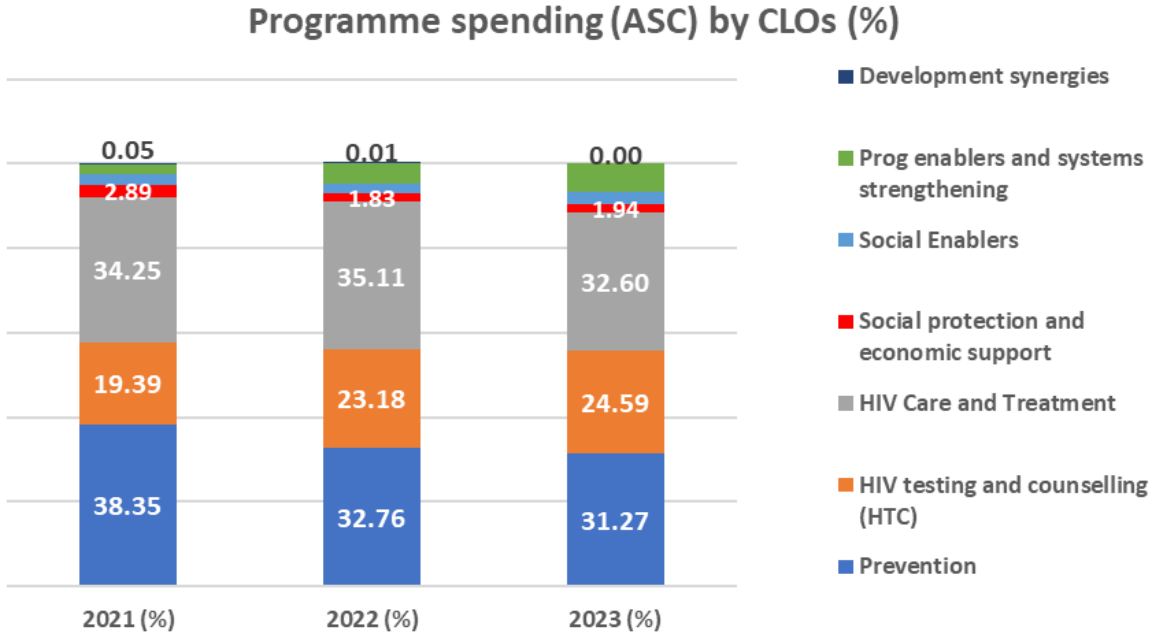
Among all key populations, the FSW constituency was found to be less valued and often out of picture at local levels which is further compounded by the weak leadership and institutional strength. Legal and administrative constraints prevent organizations from registering with names or mandates explicitly referencing female sex workers. As a result, FSW-led organizations are often registered under broader categories such as women's empowerment or gender-based programming. This has significantly reduced their visibility and advocacy capacity and has constrained their ability to mobilize resources. Any funding accessed is typically reported under non-HIV budget lines, such as sexual and reproductive health or women's empowerment.

Complementary analysis from NASA data

Spending on programme interventions

NASA data indicates that CLOs were spending approximately 25 – 30% of total HIV/AIDS spending over the period and appeared to have engaging different programme interventions (ASCs) (Please also refer to Figure 17). But most notable is their substantial engagement in prevention (31-38%), HTC (19-24%), and care and treatment (32-35%) over the years. CLOs were also engaged in social and programme enabling activities to supplement their focused work on KPs (Figure 29).

Figure 29: Programme spending (ASC) by CSOs



Spending by beneficiary populations

Table below (Table 21) indicates that CLOs spending emphasised PLHIV and Key population which reflect their comparative advantage over other NGOs in reaching KPs.

Table 21:CLO spending by beneficiary population

BP group	2021	2022	2023
PLHIV	1,433,200	1,963,196	2,002,068
Key populations	2,323,026	2,974,036	3,272,413
Vulnerable, accessible and other target populations	210,502	255,483	242,035
General population	2,454	4,815	2,996
BP Non applicable	213,626	398,543	583,585
Grand Total (in USD)	**4,182,808**	**5,596,073**	**6,103,097**

CLOs resource tracking conclusion

The assessment of non-monetary transactions among Community-Led Organizations demonstrates that their contribution to HIV/AIDS-related spending in Nepal remains extremely limited and continues to decline, particularly in the post-COVID-19 period. Existing forms of non-monetary support are small in scale, irregular, and largely oriented toward general social protection rather than targeted HIV interventions. As a result, these contributions do not significantly offset the financial needs of the national HIV response.

However, when considering their sources of financial resources, as provided by the NASA process, the data revealed that CLOs spending is consistently over 25-

30% of total HIV spending in the country during 2021 to 2023 assessment period and were focused on prevention, HTC and Care and treatment activities catering primarily to PLHIV and KPs.

CLOs remain heavily dependent on a small number of international donors, with minimal success in diversifying funding sources. While national networks actively promote resource mobilization and capacity building, structural and systemic barriers—rather than organizational weaknesses—continue to limit progress. These barriers are especially pronounced for the FSW constituency, whose limited organizational recognition further restricts access to resources and participation in HIV programming.

Overall, the findings highlight a persistent weakness in mobilising the non-monitory resources that limits the long-term effectiveness of community-led HIV responses in Nepal. Addressing these gaps will require stronger institutional support, policy-level engagement, and deliberate strategies to integrate CLO contributions—both financial and non-financial—into broader HIV financing and planning frameworks.

Recommendations regarding the funding of CLOs in Nepal

- Advocate for local governments to institutionalize and standardize social support packages specifically tailored to HIV-related needs.
- Support CLOs to diversify funding sources beyond the Global Fund and US Government by engaging alternative donors, INGOs, philanthropic foundations, and corporate social responsibility (CSR) initiatives. Promote open and fair social contracting mechanism to actively and regularly engage CLOs. Without predictable domestic and social contracting mechanisms, CLO will remain structurally dependent on donors, limiting sustainability and self-reliance.
- Provide targeted training on donor mapping, proposal development, and grant management tailored to the needs of smaller community organizations.
- Encourage national networks to broker new funding partnerships for their affiliates, building on existing relationships with local governments, health facilities, and provincial authorities.
- Promote joint proposals and consortium-based applications among CLOs to enhance visibility, coordination, and bargaining power.
- Support the formation and strengthening of FSW-led organizations and ensure their meaningful inclusion in resource-mobilization and HIV planning processes.

Appendices

11. Appendices:

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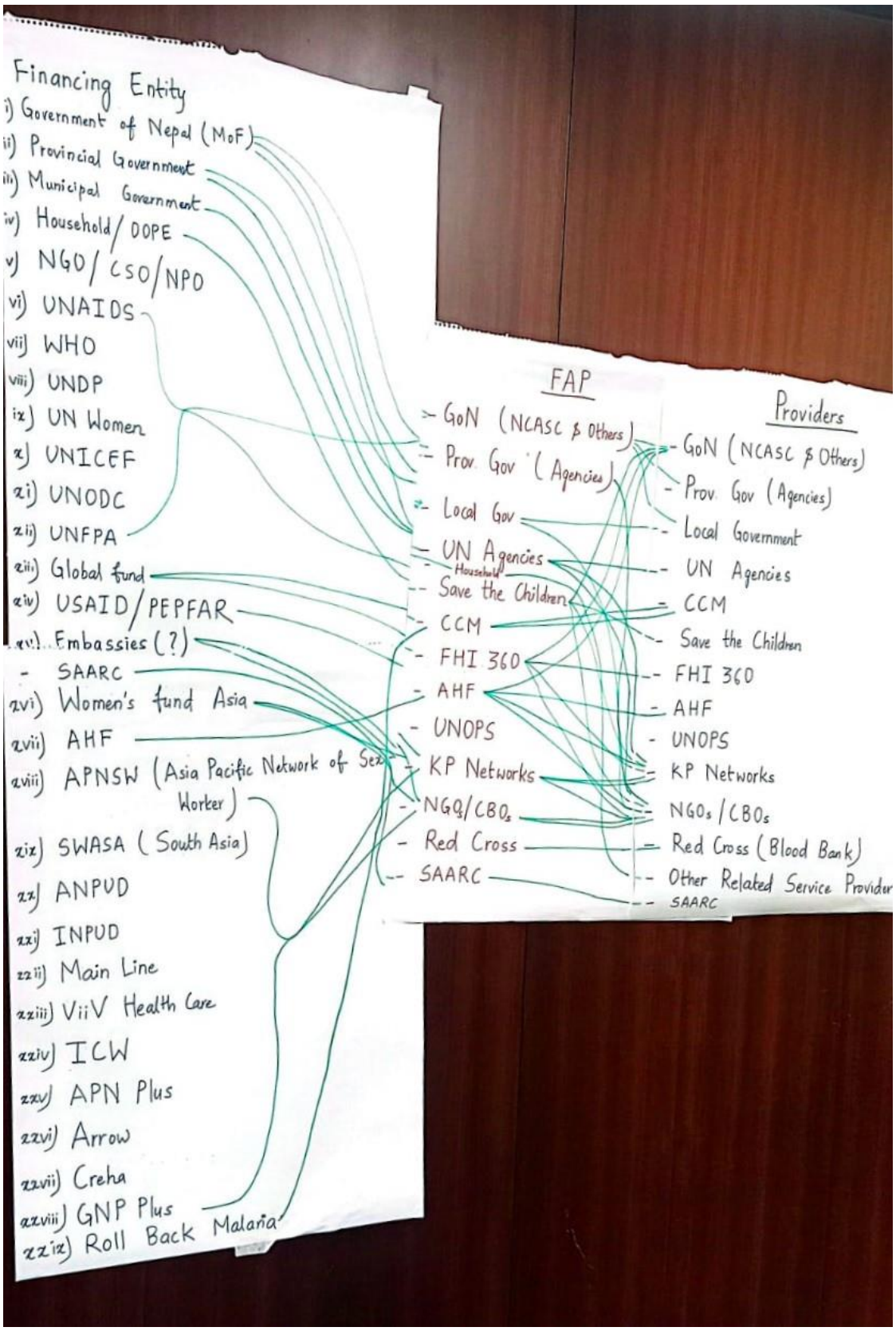
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11.2 NASA data collection template (sample)

Page 1		Please do not change the format - as it may break the link	
	Province	Please select district first	
	District		NASA Code
2022	Financing Entity (FE) 1		
	Financing Agent-Purchaser (FAP)		
	Provider (PS) name		
	Total Amount spent	-	-
Describe the intervention			
ASC 1	ASC 1		
Service Delivery Model			
Beneficiary (BP)			
Production Factor 1			
Production Factor 2			
Production Factor 3			
Production Factor 4			
Production Factor 5			
Production Factor 6			
Production Factor 7			
Production Factor 8			
Production Factor 9			
Production Factor 10			
Total Spent PF			-
Describe the intervention			
ASC 2			
Service Delivery Model			
Beneficiary (BP)			
Production Factor 1			

11.4 Agent mapping

Agent mapping – a participatory process with stakeholders



11.5 Challenges in NASA 2018 and responses in current NASA

Challenges experienced in NASA 2018 and how it is responded in current NASA (2024)

Challenges experienced in NASA 2018	Responses in current NASA (2024)
Many organizations felt providing financial data with reasonable level of details to suit that NASA classification as an additional task and a burden, therefore there were significant delays in submitting the data from few organizations. Moreover, there was feedback from stakeholders to simplify the data collection template so that providers can easily submit their expenditure data	• Similar situation was experienced in this round as well • NASA data collection tool was simplified • During training more emphasis was paced on practicing data collection tool
Some Agents (particularly multilaterals and bilateral) often were reluctant to provide detail of expenditure as well as tend to distribute or mask benefit related expenses (wages, remuneration, international trainings/visits) under different ASC/PF heading/category	• Similar situation was experienced in this round also • During data collection and one to one meeting – more detail breakdown of expenditure was collected.
Moreover, provider's interpretations and NASA coding varied enormously even for the similar nature of expenditure, therefore maintaining consistency in coding was a great challenge. Details of functions (ASC category) and PF category varied enormously even for the similar activities.....	• Extra effort was made during the training to clarify the interpretation of expenditure • NASA consultant carefully scrutinize the expenditure data and was correct any inconsistency in coding in consultation with the organization providing the data
There were significant variations in accounting systems (software used), fiscal years and the classification of spending among national institutions and donor supported projects, which created challenges for data synthesis and comparability.....	• Similar situation was experienced in this round also. • Consultant reviewed immediately the expenditure data received from partners to ensure consistency in NASA coding. • Any confusion and discrepancies were discussed with organization and resolved
Also that the spending made for 'capacity building support' to NGO was termed as institutional building (ASC.07.03 AIDS-specific institutional development) by	• NASA consultant ensured that if the activities was only a one-off training – it will be coded as "Training", but if the training was one of the activities of other institutional support

Challenges experienced in NASA 2018	Responses in current NASA (2024)
some organisation while other termed it as training (ASC.05.03 Training)	activities such training event will be coded as "institutional capacity building"
In some organisations there was lack of 'institutional memory' and adequate documentation of past expenditure and other budgetary and financial information, this resulted serious delays in identifying appropriate documentation as well as in obtaining adequate financial information and in classifying appropriate NASA category	• Such situation was inevitable as staff move around and changes in GF Principal Recipient (PR) – particularly non-government PR • NASA consultant spent considerable time with staff in such situation to ensure proper data is extracted from their achieve.

11.6 CLO FGD guide and people met

FGD guide for CLOs

- Please explain about your organisation and board structure (probe – if 60% of board member are community people, if majority of staff are community people)
- Please provide the names of the sources or donors from which your organization mobilized resources for the HIV response between 2020 and 2023.
- Have you received any in-kind contributions for the HIV response during that period? If yes, please provide the name of the source, the type and amount of the in-kind contribution, the estimated cost, and the year in which it was received.
- Have you mobilized volunteers during this period? If yes, please specify the type of voluntary labour, the duration, the estimated cost, and the year in which it was mobilized.
- Have you mobilized free space (e.g., training hall, office space, storage/godown) during this period? If yes, please provide the duration, the estimated cost, and the year in which it was mobilized.
- Have you raised money through activities such as engaging celebrities, organizing charity shows, or collecting membership fees? If yes, please indicate how much was raised and when.

National Networks Consulted

- Recovering Nepal (RN) – National Network of PWID (Male),
- Recovering Nepal – Women (RN Women)
- National Federation of Women Living with AIDS (NFWLHA)
- National Association of People Living with AIDS Nepal (NAPAN)
- Blue Diamond Society (BDS) – National Network of LGBTI

- Jagriti Mahila Mahasangh (JMMS) – National Network of Female Sex Workers

CLOS consulted

S.No.	Name of organisation	Province/district
1	NDC Banke	Lumbin_Nepalgunj
2	Junikiri Banke	Lumbin_Nepalgunj
3	NSARC Banke	Lumbin_Nepalgunj
4	Change team	Lumbin_Nepalgunj
5	WSN	Lumbin_Nepalgunj
6	DFN	Lumbin_Nepalgunj
7	BDS Biratnagar	Koshi_Biratnagar
8	Sparsha Morang	Koshi_Biratnagar
9	Sparsha Dhanusha	Madesh_Dhanusha
10	Bhushan Dhanusa NAPN	Madesh_Dhanusha
11	Bishwasilo Asha	Madesh_Dhanusha
12	BDS Janakpur	Madesh_Dhanusha
13	Lava Kush Asharam	Koshi_Jhapa
14	Dharan Positive	Koshi_Dharan
15	Makwapur Positive Group	Bagmati_Makwanpur
16	NAPAN Province 3	Bagmati_Makwanpur
17	Recovering Nepal Makwanpur	Bagmati_Makwanpur
18	Makwapur Women Group	Bagmati_Makwanpur
19	Friends Heatuda	Bagmati_Makwanpur
20	NAPN Provine 7	Sudur Paschim_Dhangadhi
21	Godawari Plus	Sudur Paschim_Dhangadhi
22	NNSWA	Sudur Paschim_Mahendranaga
23	NAWA Asha	Sudur Paschim_Mahendranagar
24	BDS Parsa	Madesh_Birgunj
25	Nepal Aradhana Samaj	Madesh_Birgunj
26	Bijam	Madesh_Birgunj
27	Sana paila	Madesh_Birgunj
28	Neeta Foundation	Madesh_Birgunj

	Name of organizations	Province/district
1.	Nagarjun Development Community Banke	Lumbin_Nepalgunj
2.	Junikiri Banke	Lumbin_Nepalgunj
3.	NSARC Banke	Lumbin_Nepalgunj
4.	Changeteam	Lumbin_Nepalgunj
5.	WSN	Lumbin_Nepalgunj
6.	DFN	Lumbin_Nepalgunj
7.	BDS Biratnagar	Koshi_Biratnagar
8.	Sparsha Morang	Koshi_Biratnagar
9.	Sparsha Dhanusha	Madesh_Dhanusha
10.	Bhushan Dhanusa NAPN	Madesh_Dhanusha
11.	Bishwasilo Asha	Madesh_Dhanusha
12.	BDS Janakpur	Madesh_Dhanusha
13.	Lava Kush Asharam	Koshi_Jhapa
14.	Dharan Positive	Koshi_Dharan
15.	Makwapur Positive Group	Bagmati_Makwanpur
16.	NAPAN Province 3	Bagmati_Makwanpur
17.	Recovering Nepal Makwanpur	Bagmati_Makwanpur
18.	Makwapur Women Group	Bagmati_Makwanpur
19.	Friends Heatuda	Bagmati_Makwanpur
20.	NAPN Provine 7	Sudur Paschim_Dhangadhi
21.	Godawari Plus	Sudur Paschim_Dhangadhi
22.	NNSWA	Sudur Paschim_Mahendranaga
23.	NAWA Asha	Sudur Paschim_Mahendranagar
24.	BDS Parsa	Madesh_Birgunj
25.	Nepal Aradhana Samaj	Madesh_Birgunj
26.	Bijam	Madesh_Birgunj
27.	Sanapaila	Madesh_Birgunj
28.	Neeta Foundation	Madesh_Birgunj

11.7 Key data tables

Spending by Financing Entity				
Financing Entity	**2021**	**2022**	**2023**	**Grand Total**
FE.01.01.01 Central government	3,988,839	2,859,350	3,838,996	10,687,185
FE.01.01.02 State/provincial government	13,901	30,731	14,306	58,938
FE.03.01.30 Government of United States	5,223,074	6,802,190	7,378,513	19,403,777
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	6,268,520	9,044,122	8,378,567	23,691,209
FE.03.02.08 UNAIDS Secretariat	182,651	115,884	143,663	442,198
FE.03.02.09 United Nations Children's Fund (UNICEF)	15,289			15,289
FE.03.02.10 United Nations Development Fund for Women (UNIFEM)			83,388	83,388
FE.03.02.20 World Health Organization (WHO)	196,536	177,800	153,392	527,728
FE.03.03.01 International HIV/AIDS Alliance		2,998	2,270	5,268
FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	792,563	864,879	860,209	2,517,651
Grand Total	**16,681,373**	**19,897,954**	**20,853,304**	**57,432,631**

FE x ASC by years

Year	Aids Spending Category (ASC)	FE.01 Public Entities	FE.03 International Entities	Grand Total
2021	ASC.01 Prevention	356,584	3,269,153	3,625,737
	ASC.02 HIV testing and counselling (HTC)	921,744	2,378,770	3,300,514
	ASC.03 HIV Care and Treatment (including opportunistic infections (OIs))	2,281,326	3,286,944	5,568,270
	ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children)		126,770	126,770
	ASC.05 Social Enablers (excluding direct services for KPs above)	239,222	291,671	530,893
	ASC.06 Programme enablers and systems strengthening	203,864	3,323,156	3,527,020
	ASC.07 Development synergies		2,169	2,169
2021 Total		4,002,740	12,678,633	16,681,373
2022	ASC.01 Prevention	213,313	3,851,928	4,065,241
	ASC.02 HIV testing and counselling (HTC)	1,261,110	3,572,044	4,833,154
	ASC.03 HIV Care and Treatment (including opportunistic infections (OIs))	902,725	4,541,689	5,444,414

	ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children)	10,902	110,201	121,103
	ASC.05SocialEnablers (excluding direct services for KPs above)	245,913	514,762	760,675
	ASC.06Programmeenablersandsystemsstrengthening	238,173	4,414,303	4,652,476
	ASC.07Developmentsynergies	17,945	2,946	20,891
2022 Total		2,890,081	17,007,873	19,897,954
2023	ASC.01 Prevention	215,769	3,939,772	4,155,541
	ASC.02 HIV testing and counselling (HTC)	1,171,996	3,736,427	4,908,423
	ASC.03 HIV Care and Treatment (including opportunistic infections (OIs))	2,102,885	4,493,408	6,596,293
	ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children)	8,699	132,427	141,126
	ASC.05Social Enablers (excluding direct services for KPs above)	90,622	400,136	490,758
	ASC.06Programmeenablersandsystemsstrengthening	243,417	4,292,660	4,536,077
	ASC.07Developmentsynergies	19,914		19,914
	ASC.08HIV-relatedresearch		5,172	5,172
2023 Total		3,853,302	17,000,002	20,853,304
Grand Total		10,746,123	46,686,508	57,432,631

Spending by Scheme

Scheme	2021	2022	2023	Grand Total
SCH.01.01.01 Central government schemes	5,542,345	4,980,449	5,574,348	16,097,142
SCH.01.01.02 State/regional/local government sc	13,901	30,731	14,306	58,938
SCH.01.02.01 Social health insurance schemes	292,475	487,697	456,584	1,236,756
SCH.02.02.01 Not-for-profit organisation scheme	9,724,306	13,155,974	14,230,740	37,111,020
SCH.02.02.02 Resident foreign agencies schemes	348,530	441,665	558,566	1,348,761
SCH.02.02.98 Not-for-profit organisation schemes not disaggreg		798,440	18,760	817,200
SCH.04.02.02 Other schemes (non-resident)	759,816	2,998		762,814
Grand Total	**16,681,373**	**19,897,954**	**20,853,304**	**57,432,631**

Spending by Financing Agent and Procurer (FAP)				
Financing Agent and Procurer	**2021**	**2022**	**2023**	**Grand Total**
FAP.01.01.01 Central or federal authorities	5,213,930	4,938,167	5,651,095	15,803,192
FAP.01.01.02 State/provincial/regional authorities	634,791	560,710	383,951	1,579,452
FAP.02.05.01 Domestic Not-for-profit organizations which are Community-led organizations	32,747	69,437	66,086	168,270
FAP.03.02.07 UNAIDS Secretariat	87,571	165,173	285,768	538,512
FAP.03.02.08 United Nations Children's Fund (UNICEF)	36,000		52,811	88,811
FAP.03.02.09 UN Women			83,388	83,388
FAP.03.02.15 United Nations Office on Drugs and Crime (UNODC)		27,692	15,000	42,692
FAP.03.02.19 World Health Organization (WHO)	224,959	248,800	199,009	672,768
FAP.03.03.08 Care International	101,799	100,000	74,328	276,127
FAP.03.03.14 Family Health International/FHI 360	4,888,882	6,717,778	7,287,486	18,894,146
FAP.03.03.98 International not-for-profit organizations not disaggregated	1,700,032	2,383,606	1,911,123	5,994,761
FAP.03.03.99 Other International not-for-profit organizations n.e.c.	3,760,662	4,686,591	4,843,259	13,290,512
Grand Total	**16,681,373**	**19,897,954**	**20,853,304**	**57,432,631**

PS x ASC

Year	ASC 01	PS.01 Public sector providers	PS.02 Domestic Private sector providers	PS.03 International providers – in country offices	Grand Total
2021	ASC.01 Prevention	762,143	2,727,408	136,186	3,625,737
	ASC.02 HIV testing and counselling (HTC)	1,434,516	1,806,872	59,126	3,300,514
	ASC.03 HIV Care and Treatment (including opportunistic infections (OIs))	3,071,977	1,870,992	625,301	5,568,270
	ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children)		121,770	5,000	126,770
	ASC.05 Social Enablers (excluding direct services for KPs above)	242,853	228,118	59,922	530,893
	ASC.06 Programme enablers and systems strengthening	244,160	1,360,017	1,922,843	3,527,020
	ASC.07 Development synergies		2,169		2,169
2021 Total		**5,755,649**	**8,117,346**	**2,808,378**	**16,681,373**
2022	ASC.01 Prevention	554,909	3,244,703	265,629	4,065,241

Year	ASC 01	PS.01 Public sector providers	PS.02 Domestic Private sector providers	PS.03 International providers – in country offices	Grand Total
	ASC.02 HIV testing and counselling (HTC)	1,902,778	2,877,217	53,159	4,833,154
	ASC.03 HIV Care and Treatment (including opportunistic infections (OIs))	2,296,948	2,548,349	599,117	5,444,414
	ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children)	10,902	99,638	10,563	121,103
	ASC.05 Social Enablers (excluding direct services for KPs above)	278,049	389,531	93,095	760,675
	ASC.06 Programme enablers and systems strengthening	368,674	1,829,635	2,454,167	4,652,476
	ASC.07 Development synergies	20,395	496		20,891
2022 Total		**5,432,655**	**10,989,569**	**3,475,730**	**19,897,954**
2023	ASC.01 Prevention	647,402	3,372,489	135,650	4,155,541
	ASC.02 HIV testing and counselling (HTC)	1,616,204	3,220,396	71,823	4,908,423
	ASC.03 HIV Care and Treatment (including opportunistic infections (OIs))	3,306,181	2,699,855	590,257	6,596,293
	ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children)	8,699	118,747	13,680	141,126
	ASC.05 Social Enablers (excluding direct services for KPs above)	92,078	333,094	65,586	490,758
	ASC.06 Programme enablers and systems strengthening	263,299	2,086,702	2,186,076	4,536,077
	ASC.07 Development synergies	19,914			19,914

Year	ASC 01	PS.01 Public sector providers	PS.02 Domestic Private sector providers	PS.03 International providers – in country offices	Grand Total
	ASC.08 HIV-related research			5,172	5,172
2023 Total		**5,953,777**	**11,831,283**	**3,068,244**	**20,853,304**
Grand Total		**17,142,081**	**30,938,198**	**9,352,352**	**57,432,631**

ASX x PF

ASC 01	PF 02	2021	2022	2023	Grand Total
ASC.01 Prevention	PF.01.01 Personnel costs	1,589,299	1,948,930	2,082,166	5,620,395
	PF.01.02 Operational and programme management current expenditures	965,185	1,146,951	1,123,754	3,235,890
	PF.01.03 Products and supplies (including medical, non-medical and office supplies)	795,652	733,945	736,127	2,265,724
	PF.01.04 Contracted external services		36,738	82,070	118,808
	PF.01.05 Transportation related to beneficiaries	4,019	9,704	6,493	20,216
	PF.01.07 Financial support for beneficiaries	3,058	958	11,765	15,781
	PF.01.08 Training costs (including related per diems/transport/other costs)	148,731	102,197	97,432	348,360
	PF.01.09 Logistics of events, including catering services	10,862	1,916		12,778
	PF.01.10 Indirect costs	30,334	1,574	1,301	33,209
	PF.02.03 Information technology (hardware and software)	77,245	82,004	14,277	173,526
	PF.02.04 Laboratory and other medical equipment	1,352	324		1,676
	PF.02.05 Non medical equipment and furniture			156	156
ASC.01 Total		**3,625,737**	**4,065,241**	**4,155,541**	**11,846,519**
ASC.02 HIV testing and	PF.01.01 Personnel costs	835,116	1,047,967	1,219,716	3,102,799

counselling (HTC)					
	PF.01.02 Operational and programme management current expenditures	875,487	1,552,467	1,720,089	4,148,043
	PF.01.03 Products and supplies (including medical, non-medical and office supplies)	1,460,517	2,019,706	1,845,170	5,325,393
	PF.01.04 Contracted external services		51,817	23,257	75,074
	PF.01.05 Transportation related to beneficiaries	201	380	720	1,301
	PF.01.07 Financial support for beneficiaries	2,034	2,797	20,376	25,207
	PF.01.08 Training costs (including related per diems/transport/other costs)	93,369	155,633	77,758	326,760
	PF.01.09 Logistics of events, including catering services	3,456			3,456
	PF.01.10 Indirect costs	30,334	1,574	1,337	33,245
	PF.02.04 Laboratory and other medical equipment		813		813
ASC.02 Total		**3,300,514**	**4,833,154**	**4,908,423**	**13,042,091**
ASC.03 HIV Care and Treatment (including opportunistic infections (OIs))	PF.01.01 Personnel costs	1,365,552	1,667,403	1,887,063	4,920,018
	PF.01.02 Operational and programme management current expenditures	751,967	882,181	1,007,680	2,641,828
	PF.01.03 Products and supplies (including medical, non-medical and office supplies)	3,193,074	2,541,280	3,343,358	9,077,712
	PF.01.04 Contracted external services	7,734	11,140	37,775	56,649
	PF.01.05 Transportation related to beneficiaries	21,627	20,257	17,972	59,856

	PF.01.06 Housing/accommodation services for beneficiaries	88,438	132,872	131,572	352,882
	PF.01.07 Financial support for beneficiaries	26,854	46,836	30,296	103,986
	PF.01.08 Training costs (including related per diems/transport/other costs)	56,470	112,177	112,244	280,891
	PF.01.09 Logistics of events, including catering services	3,979	14,629	15,619	34,227
	PF.01.10 Indirect costs	32,147	1,984	1,496	35,627
	PF.02.01 Building	5,139	4,874	2,275	12,288
	PF.02.02 Vehicles	485		234	719
	PF.02.03 Information technology (hardware and software)	2,195	977		3,172
	PF.02.04 Laboratory and other medical equipment	3,254	2,600	2,496	8,350
	PF.02.05 Non medical equipment and furniture	9,355	5,204	6,213	20,772
ASC.03 Total		**5,568,270**	**5,444,414**	**6,596,293**	**17,608,977**
ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children)	PF.01.01 Personnel costs		-	5,000	5,000
	PF.01.02 Operational and programme management current expenditures	2,683	(242)		2,441
	PF.01.03 Products and supplies (including medical, non-medical and office supplies)	12,070	(11,854)	2,309	2,525
	PF.01.04 Contracted external services		622	3,596	4,218
	PF.01.05 Transportation related to beneficiaries		967		967

	PF.01.07 Financial support for beneficiaries	112,017	124,327	130,183	366,527
	PF.01.08 Training costs (including related per diems/transport/other costs)		(2)	38	36
	PF.01.09 Logistics of events, including catering services		7,285		7,285
ASC.04 Total		**126,770**	**121,103**	**141,126**	**388,999**
ASC.05 Social Enablers (excluding direct services for KPs above)	PF.01.01 Personnel costs	94,849	119,157	131,539	345,545
	PF.01.02 Operational and programme management current expenditures	312,008	355,990	252,206	920,204
	PF.01.03 Products and supplies (including medical, non-medical and office supplies)	12,736	35,695	3,415	51,846
	PF.01.04 Contracted external services		30,399	1,277	31,676
	PF.01.08 Training costs (including related per diems/transport/other costs)	100,928	155,731	93,887	350,546
	PF.01.09 Logistics of events, including catering services	10,372	15,928	7,274	33,574
	PF.01.98 Current direct and indirect expenditures not disaggregated		2,959	728	3,687
	PF.02.01 Building			192	192
	PF.02.04 Laboratory and other medical equipment			60	60
	PF.02.05 Non medical equipment and furniture		44,816	180	44,996
ASC.05 Total		**530,893**	**760,675**	**490,758**	**1,782,326**
ASC.06 Programme enablers and systems strengthening	PF.01.01 Personnel costs	772,094	567,545	676,938	2,016,577
	PF.01.02 Operational and programme	2,111,520	3,338,826	2,926,822	8,377,168

	management current expenditures				
	PF.01.03 Products and supplies (including medical, non-medical and office supplies)	28,012	27,664	33,148	88,824
	PF.01.04 Contracted external services	62,627	14,803	28,655	106,085
	PF.01.05 Transportation related to beneficiaries			4,232	4,232
	PF.01.08 Training costs (including related per diems/transport/other costs)	96,927	278,966	455,490	831,383
	PF.01.09 Logistics of events, including catering services	14,648	13,588	16,977	45,213
	PF.01.10 Indirect costs	251	2,826	5,357	8,434
	PF.02.01 Building	52,192	21,087	12,574	85,853
	PF.02.03 Information technology (hardware and software)	21,108	14,645	2,014	37,767
	PF.02.04 Laboratory and other medical equipment	366,990	366,974	368,051	1,102,015
	PF.02.05 Non medical equipment and furniture	651	5,552	5,816	12,019
	(blank)			3	3
ASC.06 Total		**3,527,020**	**4,652,476**	**4,536,077**	**12,715,573**
ASC.07 Development synergies	PF.01.01 Personnel costs	92	489		581
	PF.01.02 Operational and programme management current expenditures	2,077	(1,721)		356
	PF.01.03 Products and supplies (including medical, non-medical and office supplies)		71		71
	PF.01.08 Training costs (including related per diems/transport/other costs)		20,462	19,914	40,376
	PF.01.09 Logistics of events, including catering services		1,590		1,590
ASC.07 Total		**2,169**	**20,891**	**19,914**	**42,974**

ASC.08 HIV-related research	PF.01.01 Personnel costs			5,172	5,172
ASC.08 Total				**5,172**	**5,172**
Grand Total		**16,681,373**	**19,897,954**	**20,853,304**	**57,432,631**

ASC x BP by year

ASC 01	BP 01	2021	2022	2023	Grand Total
ASC.01 Prevention	BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of HIV infection)	855	3,965	4,989	9,809
	BP.02 Key populations	2,329,354	2,868,644	2,880,241	8,078,239
	BP.03 Vulnerable, accessible and other target populations	661,057	810,220	745,384	2,216,661
	BP.04 General population	583,005	382,412	524,927	1,490,344
	BP.05 Non applicable (ASC which do not have a specific BP)	51,466			51,466
ASC.01 Total		**3,625,737**	**4,065,241**	**4,155,541**	**11,846,519**
ASC.02 HIV testing and counselling (HTC)	BP.02 Key populations	1,789,131	2,823,906	3,175,360	7,788,397
	BP.03 Vulnerable, accessible and other target populations	1,179,681	1,112,988	1,416,628	3,709,297
	BP.04 General population	314,922	896,260	316,435	1,527,617
	BP.05 Non applicable (ASC which do not have a specific BP)	16,780			16,780
ASC.02 Total		**3,300,514**	**4,833,154**	**4,908,423**	**13,042,091**
ASC.03 HIV Care and	BP.01 People living with HIV (regardless	5,504,309	5,416,700	6,468,275	17,389,284

Treatment (including opportunistic infections (OIs))	of having a medical/clinical diagnosis of HIV infection)				
	BP.02 Key populations	32,109	7,232	128,018	167,359
	BP.03 Vulnerable, accessible and other target populations	11,246	20,482		31,728
	BP.05 Non applicable (ASC which do not have a specific BP)	20,606			20,606
ASC.03 Total		**5,568,270**	**5,444,414**	**6,596,293**	**17,608,977**
ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children)	BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of HIV infection)	6,487	19,693	28,458	54,638
	BP.02 Key populations	17,632	(8,600)		9,032
	BP.03 Vulnerable, accessible and other target populations	102,651	110,010	112,668	325,329
ASC.04 Total		**126,770**	**121,103**	**141,126**	**388,999**
ASC.05 Social Enablers (excluding direct services for KPs above)	BP.02 Key populations	243,202		2,270	245,472
	BP.03 Vulnerable, accessible and other target populations	1,768			1,768
	BP.04 General population	802	3,958		4,760
	BP.05 Non applicable (ASC which do not have a specific BP)	285,121	756,717	488,488	1,530,326

ASC.05 Total		**530,893**	**760,675**	**490,758**	**1,782,326**
ASC.06 Programme enablers and systems strengthening	BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of HIV infection)	123,480			123,480
	BP.02 Key populations	165,130			165,130
	BP.03 Vulnerable, accessible and other target populations	8,301			8,301
	BP.04 General population	54,672			54,672
	BP.05 Non applicable (ASC which do not have a specific BP)	3,175,437	4,652,476	4,536,077	12,363,990
ASC.06 Total		**3,527,020**	**4,652,476**	**4,536,077**	**12,715,573**
ASC.07 Development synergies	BP.02 Key populations		17,945		17,945
	BP.05 Non applicable (ASC which do not have a specific BP)	2,169	2,946	19,914	25,029
ASC.07 Total		**2,169**	**20,891**	**19,914**	**42,974**
ASC.08 HIV-related research	BP.05 Non applicable (ASC which does not have a specific BP)			5,172	5,172
ASC.08 Total				**5,172**	**5,172**
Grand Total		**16,681,373**	**19,897,954**	**20,853,304**	**57,432,631**

(End of data tables)



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