

# National AIDS Spending Assessment (NASA) (2016-2017)

Financing Flows and Spending in the HIV

National AIDS Programme,  
Department of Public Health,  
Ministry of Health and Sports, Myanmar







## **Technical Note**

National AIDS Spending Assessment (NASA) for the period 2016-2017 in Myanmar

The Republic of The Union of Myanmar Ministry of Health and Sports and the Joint United Nations Programme on HIV/AIDS, July 2019

## **NASA Team**

Dr. Htun Nyunt Oo (Program Manager, NAP)

Dr. Kay Khaing Kaung Nyunt (Assistant Director, NAP)

Dr. Marjolein Jacobs (UNAIDS Strategic Information Advisor)

Mr. Christian Aran (UNAIDS International consultant)

Dr. Chaw Yin Myint (UNAIDS National Consultant)

## **Data processing, analyses and elaboration of the report**

Chaw Yin Myint and Christian Aran.

## **Final Revision and Supervision:**

NAP – Dr. Htun Nyunt Oo

UNAIDS – Mr Oussama Tawil

## **Funding:**

UNAIDS, consultancies, editing, layout and printing of the report.

# TABLE OF CONTENTS

<b>ABBREVIATIONS</b>	1
<b>FOREWORD</b>	3
<b>ACKNOWLEDGEMENT</b>	5
<b>EXECUTIVE SUMMARY</b>	7
<b>KEY INDICATORS ON HIV EXPENDITURES</b>	9
<b>1. INTRODUCTION</b>	10
1.1. MYANMAR CONTEXT	10
1.2. STATUS OF THE EPIDEMIC	10
1.3. NATIONAL RESPONSE TO THE EPIDEMIC	12
1.4. OBJECTIVES	14
1.5. SCOPE	14
<b>2. DESIGN AND METHODOLOGY</b>	15
2.1. APPROACH	15
2.2. NASA CLASSIFICATIONS	16
2.3. DATA COLLECTION AND PROCESSING	19
2.6. LIMITATIONS OF ASSESSMENT	21
<b>3. RESULTS OF NASA</b>	23
3.1. FINANCING SOURCES 2016 AND 2017	23
3.2. TRENDS OF EXPENDITURE IN HIV AND AIDS	25
3.3. FINANCIAL FLOWS AND FUNDING MODALITIES	26
3.4. PROGRAMMATIC DESCRIPTION OF EXPENSES IN HIV AND AIDS	28
3.5. PREVENTION SPENDING TARGETING KEY POPULATIONS	37
3.6. BENEFICIARIES	40
3.7. PROVIDERS	44
3.8. PRODUCTION FACTORS	46
3.9. DATA COLLECTED DETAILS	47
3.10. SUB NATIONAL ALLOCATION OF HIV SPENDING (PILOT STUDY)	49
<b>4. CONCLUSIONS AND RECOMMENDATIONS</b>	51
<b>APPENDIX 1: LIST OF INSTITUTIONS WHICH REPORTED DATA</b>	53
<b>APPENDIX 2: METHODOLOGICAL NOTES</b>	55
<b>APPENDIX 3: DATA COLLECTION FORMS</b>	61
<b>APPENDIX 4: 2017 SELECTED NASA MATRIXES</b>	62

## LIST OF FIGURES

Figure 1	PLHIV, New Infections and AIDS-related deaths estimates, 1990 – 2018	10
Figure 2	Trends of HIV prevalence among total adults (15+ years), national and by state/region.	11
Figure 3	Coverage of people receiving ART (all ages) and AIDS related deaths, 2010 - 2017	13
Figure 4	HIV treatment cascade and GAP to reach 90-90-90 targets, 2018	13
Figure 5	Transactions	17
Figure 6	“Bottom up” and “Top down” approach	18
Figure 7	HIV expenditures by Funding Sources 2012 - 2017	25
Figure 8	Financing Sources for the period, cumulative 2012 – 2017	25
Figure 9	Financing Sources 2012 – 2017	26
Figure 10	Main Flows of Funding in the HIV Response to HIV in 2017	27
Figure 11	Flow of Funds of National Response in 2017	28
Figure 12	HIV spending per programmatic area in 2016 and 2017	29
Figure 13	Trends of HIV spending on programmatic interventions 2012 – 2017 – chart	30
Figure 14	Funding source per Spending Category in 2017	31
Figure 15	Donor dependency on Selected Key programmes in 2017	32
Figure 16	HIV prevention spending in 2017 –chart	33
Figure 17	Care and treatment spending in 2017 –chart	34
Figure 18	Programme management and administration in 2017–chart	35
Figure 19	Prevention Programmes targeting Key populations at higher risk in 2017 – chart	37
Figure 20	Prevention programmes for sex workers and their clients - chart	38
Figure 21	Prevention programmes for men who have sex with men - chart	39
Figure 22	Harm-reduction programmes for people who inject drugs	40
Figure 23	Beneficiary Populations in 2017 - chart	42
Figure 24	Beneficiary Populations per Funding Source in 2017 – chart	43
Figure 25	Funding Source allocation of resources by Beneficiary Population in 2017 - chart	43
Figure 26	Data collection, type and source for 2017	49

## LIST OF TABLES

Table 1	NASA dimensions and categories	19
Table 2	Timeline of the NASA III implementation in Myanmar	20
Table 3	Organizations contacted during data collection	21
Table 4	Financing Sources 2016 and 2017	23
Table 5	Financing Sources 2016 and 2017 (3rd digit analysis)	24
Table 6	HIV spending per programmatic area in 2016 and 2017	29
Table 7	Funding Flows of the main funding sources in Myanmar in 2017	31
Table 8	HIV prevention spending in 2017	32
Table 9	Care and treatment spending in 2017	34
Table 10	Programme management and administration in 2017	35
Table 11	Human resources, Social protection, Enabling environment and HIV Research in 2017	36
Table 12	Prevention programmes for sex workers and their clients	38
Table 13	Prevention programmes for men who have sex with men	39
Table 14	Harm-reduction programmes for people who inject drugs	39
Table 15	Beneficiary Populations in 2016 and 2017	41
Table 16	Beneficiary Populations per Funding Source in 2017	42
Table 17	Providers of services in 2017	44
Table 18	AIDS Spending Category by Service Provider in 2017	45
Table 19	AIDS Spending Production Factors in 2016 and 2017	46
Table 20	Data Collection for 2017	48
Table 21	Type of data for 2017	48
Table 22	Source of Data for 2017	48
Table 23	HIV spending by region 2016 and 2017	49
Table 24	HIV spending by region and Financing Source 2016 and 2017	50
Table 25	HIV spending by region and AIDS Spending Category 2016 and 2017	50





## ABBREVIATIONS

ART	Antiretroviral Therapy
ASC	AIDS Spending Categories
BCC	Behaviour change communication
BP	Beneficiary Populations
ADB	Asian Development Bank
CSO	civil society organization
DAC	Development Assistance Committee (of the OECD)
DFID	Department for International Development (of the United Kingdom)
EU	European Union
FA	Financing Agent
FBO	Faith-based organization
FS	Financing Source
FSW	Female Sex Workers
GDP	Gross Domestic Product
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immune deficiency virus
IDU	Injecting Drug Users
KPs	Key populations
MDG	Millennium Development Goals
MOE	Ministry of Education
MoHS	Ministry of Health and Sports
MSM	Men who have sex with men
NAP	National AIDS Program
NASA	National AIDS Spending Assessment
n.e.c.	Not elsewhere classified
NGO	Non-Governmental Organizations
OI	Opportunistic Infections
OOPE	Out-of-pocket expenditure
OVC	Orphans and vulnerable children

PEP	Post-exposure prophylaxis
PF	Production Factors
PLHIV	people living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Purchasing Parity Power
PR	Principal recipient of GFATM
PS	Providers of services
PWID	People who Inject Drugs
RTS	Resource Tracking System
SR	Sub recipient Of GFATM
STI	Sexually transmitted infections
SW	Sex Workers
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDOC	United Nations Office on Drugs and Crimes
UNOPS	United Nations Office for Project Services
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

## FOREWORD

The HIV response in Myanmar has had a significant progress in HIV prevention and control with 11,000 people newly infected with HIV in 2018, which represents more than 50% reduction from 2010, and HIV related deaths steadily decreasing since 2010, with 8,400 HIV related in 2018. About 70% of people living with HIV received ART treatment in 2018, showing a dramatic increase from a coverage of just 13% in 2010. These accomplishments were possible thanks to the financial support of the international community, and the increased investment in the HIV response by the government of Myanmar.

Fast-tracking the AIDS response in order to reach the 90-90-90 targets and achieving zero discrimination will require additional investments and focused efforts. Not reaching these targets would negatively impact to the AIDS response and resulting in a reverse effect on the currently positive trends in the epidemic control. In addition, investing in the epidemic now would help save resources over the long term— UNAIDS estimates that \$24 billion would be saved in future treatment costs worldwide by reaching the FastTrack targets by 2020 and 2025.

Myanmar has been committed to monitoring the national spending on HIV/AIDS since the first national AIDS Spending Assessment (NASA) exercise back in 2005, conducting a second one in 2014 for the years 2012-2013, a third assessment in 2016 for the years 2014-2015, and finally the current exercise conducted in 2018 for the years 2016 and 2017. These efforts provide indicators on the financing of AIDS, allowing international comparability, and providing key data to monitor the country defined goals by AIDS program managers/policy and decision makers. Moreover, this current exercise assessing National AIDS Expenditure 2016-2017 will be supportive for the mid-term evaluation of National Strategic Plan.

On behalf of the NAP, I strongly recommend that the information in this report will be used in improving the financial allocation of the HIV response and to show the importance of sustaining an adequate financial support to the HIV/AIDS response in Myanmar in years to come. It is my sincere hope that all stakeholders in the multi-sectorial HIV/AIDS response from donors to service providers will use this report to inform their planning and resource allocation for the upcoming activities to be implemented to come in our joint effort to end HIV and AIDS as a public threat in Myanmar by 2030.



Dr. Thar Htun Kyaw

Permanent Secretary

Ministry of Health and Sports, Myanmar



## ACKNOWLEDGEMENT

The National AIDS Spending Assessment (NASA) for the years 2016 and 2017 in Myanmar was made under the leadership of the National AIDS Program (NAP), Department of public health, Ministry of Health and Sports, Myanmar.

This report is the major collaborative effort of many institutions, organizations and individuals. The data presented in this report could not have been collected without their contributions.

We would like to express the gratefulness to H.E Dr. Myint Htwe, Union Minister, Ministry of Health and Sports, Myanmar for his commitment and support to HIV epidemic response in Myanmar.

We would like to appreciate Dr. Thar Htun Kyaw, Permanent Secretary, Ministry of Health and Sports and Dr. Thandar Lwin, Deputy Director General, Department of Public Health for their encouragement and guidance.

We would like to thank representatives from Ministries of the Government of Myanmar, Donors, bilateral and multilateral partners, NGOs, faith-based organizations and associations of people living with HIV for their active participation during the preparatory meetings, and for sharing the data that served as input to this NASA.

Special appreciation is due to the Joint United Nations Programme on HIV/AIDS (UNAIDS) for providing both financial and technical support in carrying out the study.



Dr. Htun Nyunt Oo

Program Manager

National AIDS Program

Department of Public Health

Ministry of Health and Sports



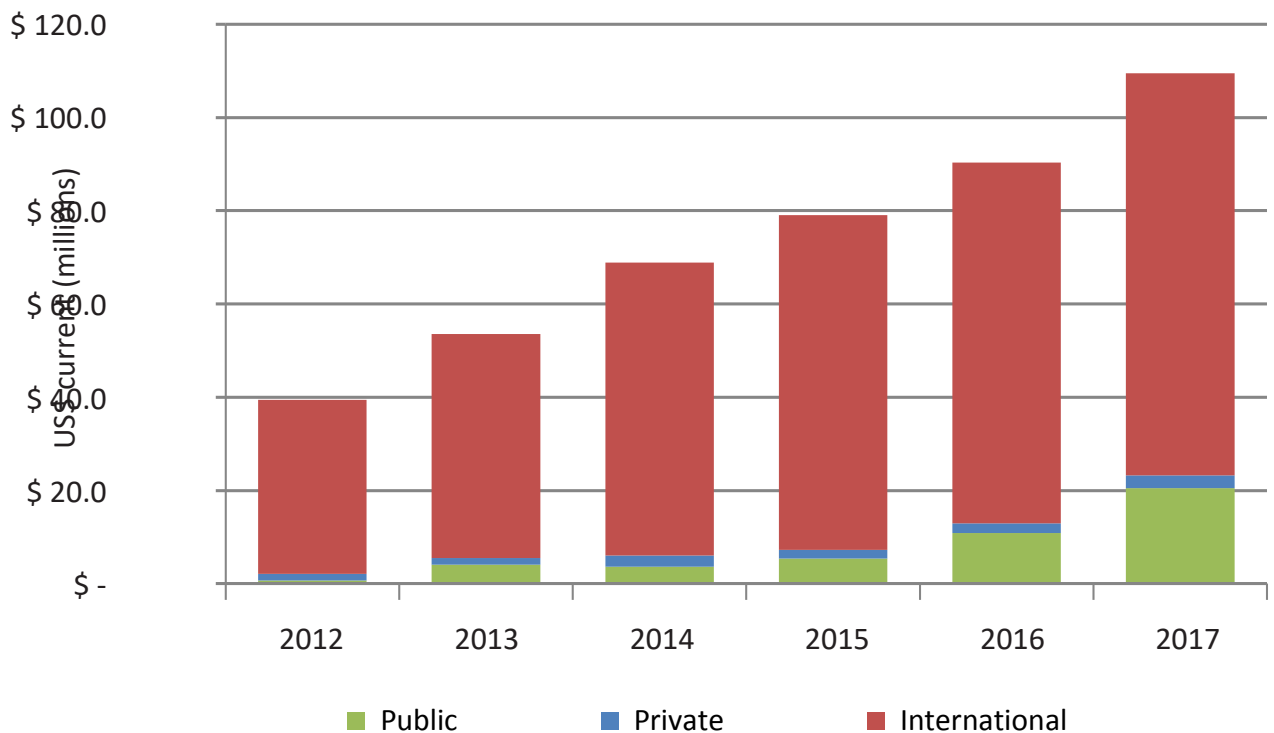
## EXECUTIVE SUMMARY

HIV spending in Myanmar has been constantly increasing, reaching a record US\$109.5 million in 2017, which represents a 21% increase of the 2016 amount (US\$ 90.3 million).

Public spending has increased both in absolute and in relative terms of the national HIV spending, increasing from 2% of total HIV funding in 2012 to 19% in 2017.

Despite this significant increase in public funding, the country depends largely on international funding to maintain its national HIV response, with international funds covering 80% of the national HIV spending in 2017 and being the main funding source for all HIV programmatic areas.

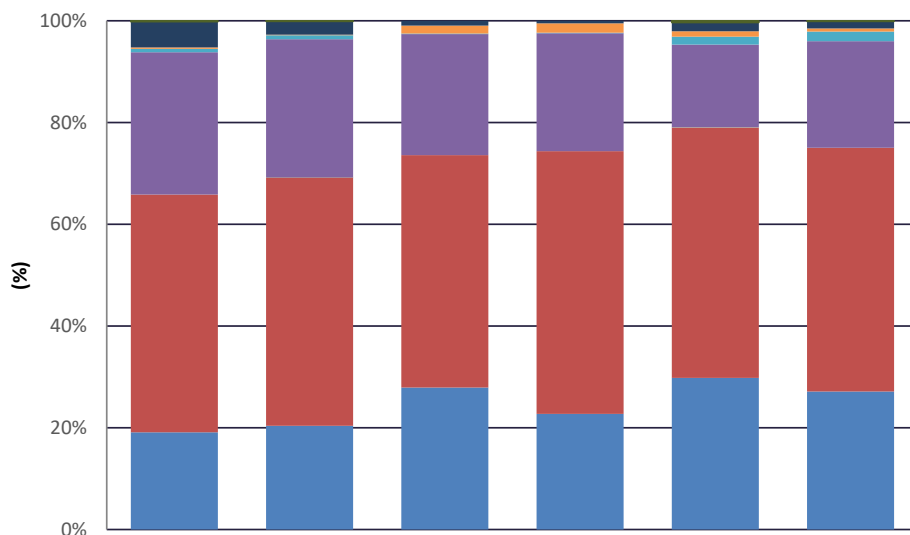
**HIV funding sources in Myanmar 2012 - 2017**



Care and Treatment represents 49% in 2016 and 48% in 2017 of total HIV spending. Followed by Prevention (30% and 27%) and Programme management and administration (16% and 21%).

The HIV response in Myanmar has, over the years, improved the allocation of its resources into programmes that have the higher impact in the national Epidemic. An example of this is the fact that prevention programmes targeting Key populations reached in 2017 20% of overall HIV spending as well as Antiretroviral therapy, which also represented 20% of total HIV spending in 2017.

### HIV spending by programmatic areas in Myanmar 2012 - 2017



ASC (USD IN MILLIONS)	2012	2013	2014	2015	2016	2017
ASC.01 PREVENTION	7.53	10.92	19.09	18.99	26.91	29.71
ASC.02 CARE AND TREATMENT	18.41	26.10	31.25	43.24	44.44	52.43
ASC.03 ORPHANS AND VULNERABLE CHILDREN		0.02			0.01	
ASC.04 PROGRAMME MANAGEMENT AND ADMINISTRATION	11.04	14.54	16.27	19.36	14.70	22.97
ASC.05 INCENTIVE FOR HUMAN RESOURCES	0.26	0.42	0.11	0.09	1.40	2.05
ASC.06 SOCIAL PROTECTION AND SOCIAL SERVICES	0.11	0.05	1.06	1.53	0.97	0.68
ASC.07 ENABLING ENVIRONMENT	1.99	1.40	0.64	0.44	1.55	1.54
ASC.08 HIV-RELATED RESEARCH	0.07	0.06			0.31	0.12

People living with HIV benefit from 52% in 2016 and 49% in 2017 of total HIV spending in 2016 and 2017 respectively. Civil society organizations and NGOs implemented in 2017 more than half of the HIV response in Myanmar (55%). Non targeted interventions represented 17% of the HIV spending in 2016 and 23% in 2017. Key populations, together, represented 20% of total HIV spending in both years.

In order to reach the Fast Track targets and Universal Health Coverage, public funding needs to continue its expansion, as the current international funding environment is expected to decline or stagnate.

Public findings should be prioritized on key population and ART programs, and human rights program, the critical enabler of the response, the programs which have the biggest impact on the country's HIV response but are heavily dependent on external funding at the moment. To smooth the shift from external to public funding, a detailed financial transition plan is crucial.

As the country shows different epidemic pattern at the sub-national level, to ensure the appropriate resource allocation by region, a sub-national monitoring of HIV spending is highly



recommended. This requires the more strengthened analysis process demanding expanded time and efforts with more comprehensive data collection. Moreover, inclusion of HIV related spending data from private corporate sector would produce a complete and all-inclusive NASA in the next round.

Finally, building the national capacity to institutionalize the NASA exercise should be a priority to ensure the efficiency, effectiveness and sustainability of NASA over time.

## KEY INDICATORS ON HIV EXPENDITURES

HIV spending and Key Macro indicators	2016	2017
HIV spending - US\$	\$ 90,294,971	\$ 109,500,896
GDP <sup>1</sup> - US\$	\$ 63,256,184,700	\$ 67,068,745,521
Health Spending - US\$	\$ 3,090,976,176	\$ 3,319,402,208
HIV spending as a share of GDP	0.14%	0.16%
HIV spending as a share of Health Spending	2.92%	3.30%
HIV spending per capita	\$ 1.7	\$ 2.1
HIV spending per PLHIV <sup>2</sup>	\$ 383	\$ 462
HIV and AIDS Expenditure by Funding Sources	2016	2017
Public HIV Spending - US\$	\$ 10,873,474	\$ 20,464,340
Private HIV Spending - US\$	\$ 2,069,474	\$ 2,744,331
International HIV Spending - US\$	\$ 77,352,023	\$ 86,292,225
Public HIV Spending - % over total HIV spending	12%	19%
Private HIV Spending - % over total HIV spending	2%	3%
International HIV Spending - % over total HIV spending	86%	79%
HIV and AIDS Expenditure by Programmatic Area %	2016	2017
ASC.01 Prevention	30%	27%
ASC.02 Care and treatment	49%	48%
ASC.03 Orphans and vulnerable children (OVC)	0%	0%
ASC.04 Programme management and administration	16%	21%
ASC.05 Incentives for Human resources	2%	2%
ASC.06 Social protection and social services	1%	1%
ASC.07 Enabling environment	2%	1%
ASC.08 HIV and AIDS-related research	0%	0%
HIV Expenditure by Beneficiary %	2016	2017
BP.01 People living with HIV	52%	49%
BP.02 Key populations	20%	20%
BP.03 Other key populations	3%	2%
BP.04 Specific "accessible" populations	1%	1%
BP.05 General population	6%	5%
BP.06 Non-targeted interventions	17%	23%

<sup>1</sup> Source of GDP and Health Spending: World Bank online Data, accessed on March 2019

<sup>2</sup> Based on the AEM-Spectrum estimate April 2019

# 1. INTRODUCTION

## 1.1. MYANMAR CONTEXT

Myanmar is a country with high HIV burden in specific locations and population groups and one of the 35 countries that account for 90% of new HIV infections globally. Consequently, it is one of the six countries in South East Asia identified by UNAIDS as a priority for the Fast Track strategy<sup>3</sup>.

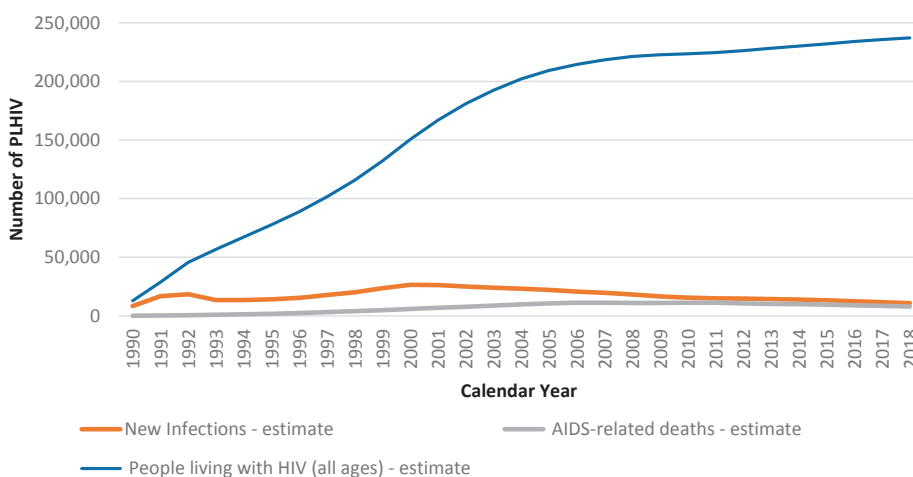
In recent year Myanmar has made significant progress in responding to HIV: the government of Myanmar has recognized HIV as a priority public health issue. New infections and deaths are declining, and treatment programmes have been scaled up dramatically reaching 70% of all estimated people living with HIV by the end of 2018. These accomplishments reflect the Government's strong commitment, improved partnerships among public, community and private sectors, and an increase in domestic funding supported by dedicated and strong international funds for the HIV response.

Nonetheless, serious challenges remain: the estimated HIV prevalence while stable at national level along with the success of care and treatment program, is not decreasing in all locations<sup>4</sup>, and the HIV response remains highly dependent on donor funding.

## 1.2. STATUS OF THE EPIDEMIC

According to UNAIDS estimates, 240,000 people were living with HIV in Myanmar in 2018. An estimated 7,800 people died from AIDS-related illnesses and there were 11,000 new infections in the same year<sup>5</sup>. New infections are mostly found in urban areas or areas where injecting drug use is endemic.

Figure 1 PLHIV, New Infections and AIDS-related deaths estimates, 1990 – 2018



<sup>3</sup> UNAIDS launched their Fast-Track strategy in 2014 with the aim to end AIDS as a public health threat by 2030. To do this they have introduced key targets for prevention and treatment, including the "90-90-90" targets.

[http://www.unaids.org/sites/default/files/media\\_asset/201506\\_JC2743\\_Understanding\\_FastTrack\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf)

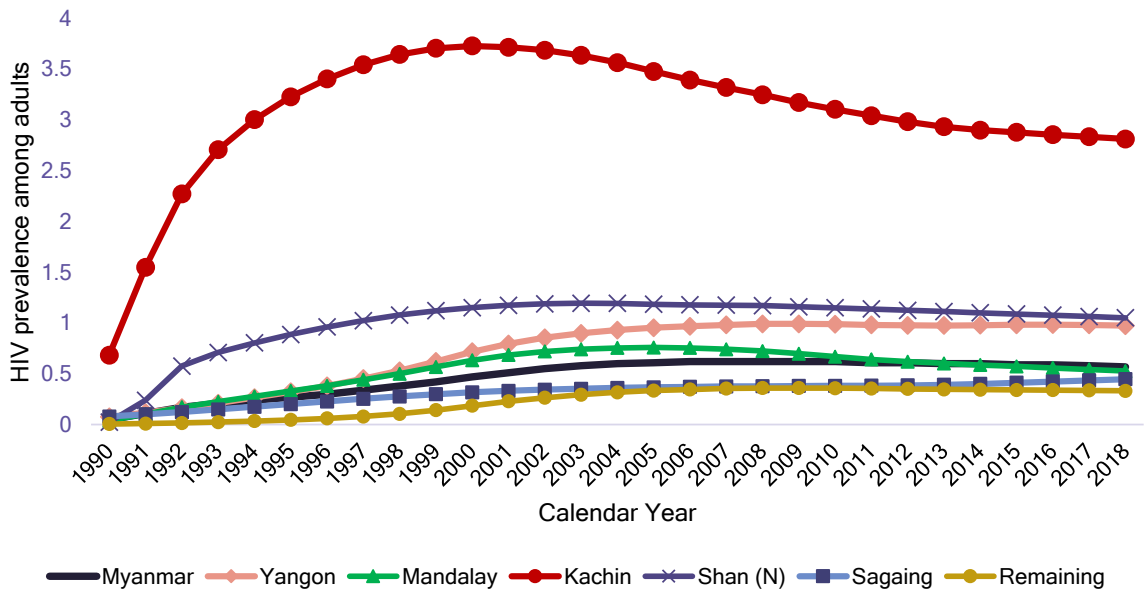
<sup>4</sup> Global AIDS Monitoring country Progress Report 2016-2017 National AIDS Program, Ministry of Health and Sports. Myanmar, 2019.

<sup>5</sup> Myanmar HIV estimates AEM-Spectrum April 2019

Myanmar has high HIV prevalence at 0.57% among adults (15+ years). HIV prevalence in Myanmar reached its peak around the year 2000 and thereafter followed a gentle downward trend until early 2010 and become plateau to an estimated 0.57% of HIV prevalence among adults (15+ years) in 2018.

It is estimated that in 2018, Kachin State is experiencing very high HIV prevalence among adults at 2.81% followed by Shan N (1.05%) and Yangon (0.98%) while the other state/regions have lower HIV prevalence than national average with Mandalay at 0.53%, Sagaing at 0.45% and all the remaining states/regions combined at 0.33%. Since 2010 it is estimated that new adult HIV infections have declined by 31%— but the decrease in new HIV infections among adults during recent years has been less prominent.<sup>6</sup>

Figure 2 Trends of HIV prevalence among total adults (15+ years), national and by state/region.



Myanmar has a concentrated HIV epidemic, which ranks among the most severe ones in the Asia and Pacific region: HIV prevalence remains high among Key populations: 34.9% among PWID (IBBS 2017), 11.6% among MSM (IBBS 2015) and 14.6% among FSW (IBBS 2015). Prevention programmes reach among people who inject drugs (PWID) is reported to have increased between 2016 and 2017 and to have declined slightly among female sex workers (FSW) and men who have sex among men (MSM). Significant achievements were documented in HIV testing service (HTS), methadone (MMT) and needle syringe programmes (NSPs). While there seems to be an

<sup>6</sup> Myanmar HIV estimates AEM-Spectrum April 2019

overall improvement in the HIV prevention program among PWID, more focused interventions are needed to reduce further HIV sexual transmission not only among key populations, but also among other priority population such as mobile and migrant people and people in closed settings. The HIV epidemic in northern areas (Kachin, Shan North and Sagaing) is fuelled by injection drug use. In Yangon, the HIV epidemic is driven by male to male and heterosexual transmission.

Co-infection of tuberculosis (TB) and HIV remains a serious public health issue. Myanmar is one of top 14 countries that carry triple high burden (i.e. highest TB, TB-HIV and MDR-TB).<sup>7</sup>

### 1.3. NATIONAL RESPONSE TO THE EPIDEMIC

HIV is recognised by the Myanmar Government as a national priority disease, alongside tuberculosis and malaria. The National AIDS Programme (NAP) under the Ministry of Health and Sports (MoHS) is responsible for the coordination of national and international support for HIV response.

Since the national HIV response commenced in the early-1990s, it has grown considerably and been strengthened under the previous two strategic plans covering the periods from 2006 to 2010 and 2011 to 2016. Currently, the response is guided by the National Strategic Plan III on HIV and AIDS 2016-2020 in line with the National Health Plan 2017-2021.

The NSP III builds on the successes-to-date and aims to further the progress by differentiating the HIV response to each local context, taking into consideration geographic and population prioritisation.

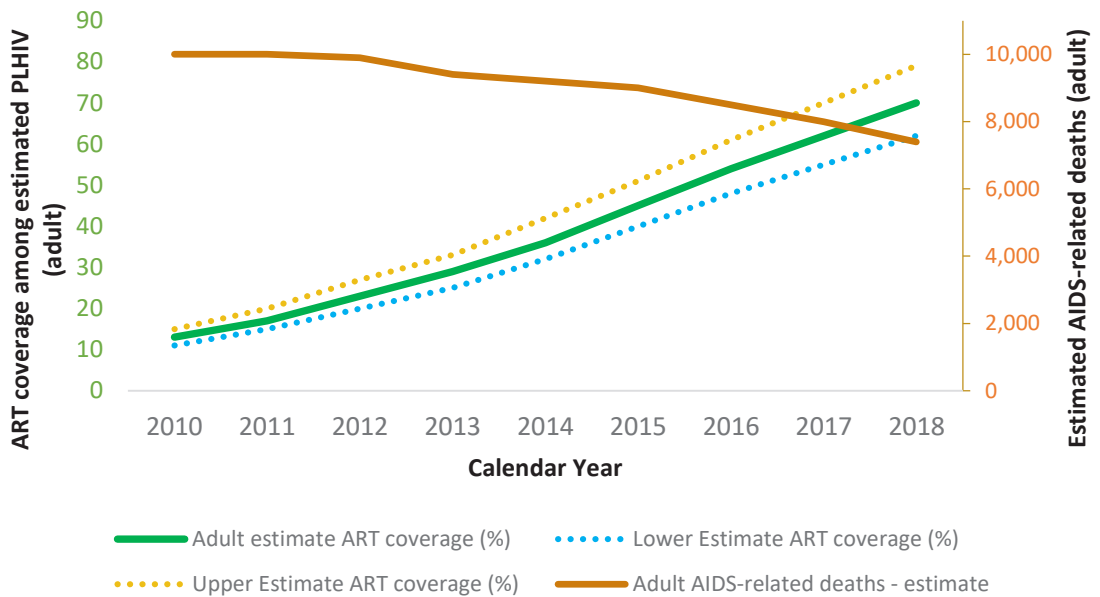
The country started in 2014 a transition between the private non for-profit (NGOs) to the public sector for the provision of ART. By the end of 2020, it is planned that 80% of all Antiretroviral treatment (ART) patients will be treated by the public sector.

There were 174 ART centres operated by NAP and partners and 172 decentralized ART sites (DC sites) served by the public sector across the country by the end of 2017.

The number of facilities providing ART has been increasing in the last years. The increased number of DC sites in all states and regions relieved the burden of main ART centres and allowed ART patients to acquire ART at a convenient distance, improving the efficiency of the ART program. With the ART transition plan, an increased number of public ART centres and DC sites were opened while the number of ART centres run by implementing partners decreased.

<sup>7</sup> [http://www.who.int/tb/publications/global\\_report/MainReport\\_18Sept2018.pdf?ua=1](http://www.who.int/tb/publications/global_report/MainReport_18Sept2018.pdf?ua=1)

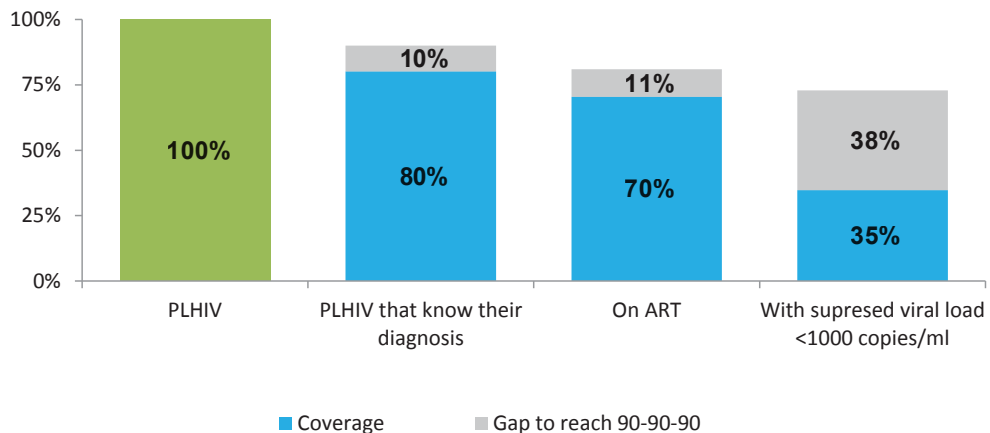
Figure 3: Coverage of people receiving ART and AIDS related deaths, 2010 – 2018 (Adults, aged  $\geq 15$  years)



Source: National AIDS Program estimates and projections and ART program data, 2018

By the end of 2017, 146,826 (or 66%) of all people living with HIV in Myanmar have access to ART. This figure has more than tripled (from 19%) in 2011 and has brought the country up to speed with the treatment rate of people living with HIV in the rest of the Southeast Asia region. Consequently, the country has witnessed the number of AIDS-related deaths fall by an estimated 49% since 2010. Second-line ART has been available in Myanmar since 2008.

Figure 4 HIV treatment cascade and GAP to reach 90-90-90<sup>8</sup> targets, 2018



<sup>8</sup> 90-90-90 targets aim to diagnose 90% of all HIV-positive persons, provide antiretroviral therapy for 90% of those diagnosed and achieve viral suppression for 90% of those treated by 2020.

Despite improvements in treatment access, there is a need for a higher availability of viral load and HIV drug resistance testing for ART patients, and, in particular, the need to reach higher levels of viral load suppression among people on treatment.

## 1.4. OBJECTIVES

The first HIV resource tracking efforts in Myanmar started in 2005 in preparation for the 2006 United Nations General Assembly Special Session (UNGASS) Global AIDS Response Progress Report. It aimed to collect HIV-related spending data for the years 2000-2004 using a data collection matrix for tracking resource flows between different financing sources (including those outside the country) and implementing partners.

In 2015 the National AIDS Programme with the technical and financial support of UNAIDS in Myanmar, conducted the first HIV resource tracking study using the NASA methodology, for the years 2012 and 2013.

In 2016, a second NASA was completed for the years 2014 and 2015, although its results were not published at the time, they are incorporated in this third NASA report.

The overall objective behind performing National AIDS Spending Assessment is to better understand spending patterns on national AIDS response and analyse HIV spending priorities.

More specifically, the measurement objectives are:

1. Monitor the allocation of HIV and AIDS funds from origin to the last point of service for different financial sources (public, external and private to the extent possible), providers, beneficiaries or target groups and production factors (any resource needed for the creation of a good or service).
2. Generate the necessary data to analyse the allocation of expenditures on AIDS in relation to the objectives and goals outlined in the National Strategic Plan III (2016-2020).
3. Synthesize the data into strategic information for decision-making and national strategic planning.
4. Catalyse and facilitate actions to enhance the country's capabilities on HIV resource tracking.
5. Examine the feasibility of fully doing provincial level spending assessments on a future NASA.

## 1.5. SCOPE

This assessment focused on the monitoring of national expenditure in response to HIV in 2016 and 2017. Data collection covered domestic, external and private, including funds channelled through the government.

The assessment did not fully cover out-of-pocket expenditure (OOPE) related to HIV and AIDS. OOPE to purchase condoms in pharmacies has not been estimated in previous NASAs nor in the present. OOPE to purchase ARVs was, however, partially estimated based on available data.

It is worth mentioning that analysis of Production Factors for spending were conducted for the first time in Myanmar in this assessment, and that there was a first effort to disaggregate data at the provincial level to the extent possible.

## 2. DESIGN AND METHODOLOGY

### 2.1. APPROACH

The National HIV and AIDS Spending Assessment (NASA) is a resource-tracking framework that seeks to monitor the annual flow of funds used to finance the response to HIV/AIDS in a given country. NASA's classification scheme and framework are presented in two associated UNAIDS documents, namely *the National AIDS Spending Assessment (NASA): Classification Taxonomy and Definitions and Guide to produce National AIDS Spending Assessment (NASA) 2009*<sup>9</sup>.

NASA was developed by UNAIDS between 2005 and 2009, drawing from the principles of a number of accounting frameworks, mainly based on the International Classification of Health Accounts (ICHA). NASA approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. The tool tracks the consumption of goods and services (public, private and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprises the National Response to HIV and AIDS and aims to serve as an assessment and planning tool.

NASA is expected to provide information that will contribute to a better understanding of a country's financial absorptive capacity, as well as on issues about the equity, the efficiency and the effectiveness of the resource allocation process.

In addition to establishing a continuous information system of the financing of HIV and AIDS, NASA facilitates a standardized reporting of indicators monitoring progress towards the achievement of the target of the Declaration of Commitment adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS)<sup>10</sup>.

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

<sup>9</sup> UNAIDS, 2006: National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV/AIDS financing flows and expenditures at country level.

[http://data.unaids.org/pub/basedocument/2009/20090406\\_nasa\\_notebook\\_en.pdf](http://data.unaids.org/pub/basedocument/2009/20090406_nasa_notebook_en.pdf)

[http://files.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090916\\_nasa\\_classifications\\_edition\\_en.pdf](http://files.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090916_nasa_classifications_edition_en.pdf)

<sup>10</sup> Declaration of Commitment adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS)



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

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

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

NASA is the recommended methodology to report on the Global AIDS Monitoring on the 2016 Political Declaration on Ending AIDS for its indicator on in-country HIV spending<sup>11</sup>.

## 2.2. NASA CLASSIFICATIONS

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

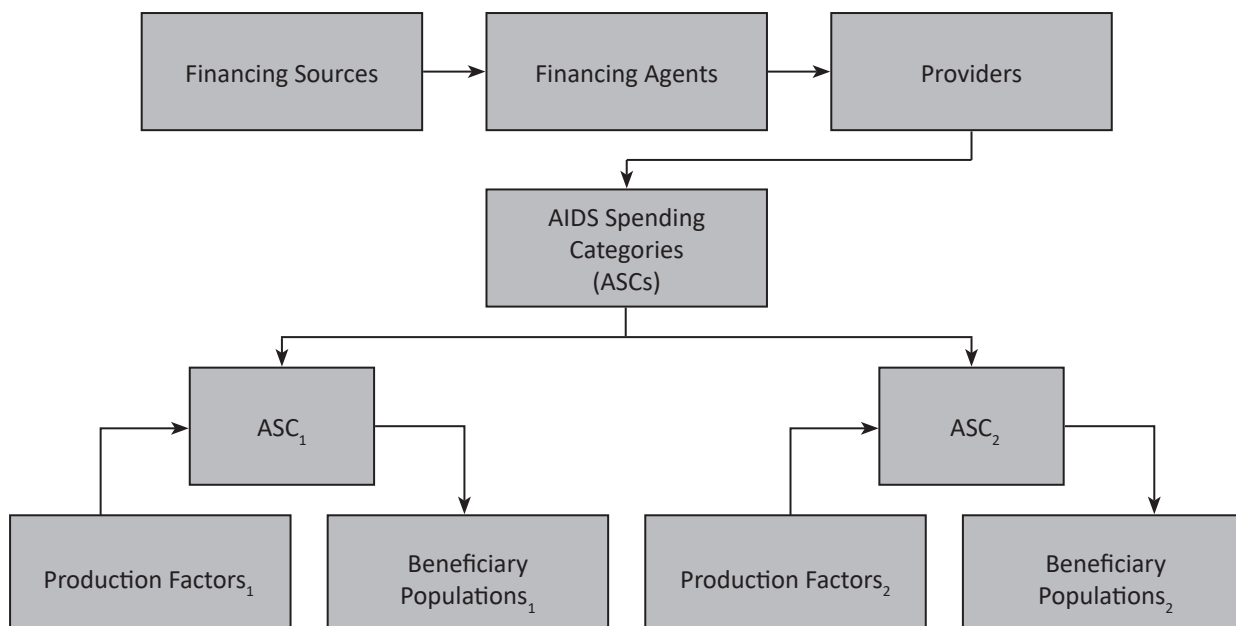
The financial flows refer to the dimension in which financing agents obtain resources from the financing sources to “purchase” the transformation of those resources into goods and services by providers.

The NASA uses the concept of the “transaction” (figure 1) to reflect the transfer of resources from a financing source to financing agent and finally to a provider of goods or services, who invests in different production factors to generate programmatic interventions, named in NASA AIDS Spending Categories (ASC) or, intended to benefit specific beneficiary populations (BP). A transaction is a transfer of resources between different economic agents. The unit of observation to reconstruct the flows from the origin to its ends is the transaction.

<sup>11</sup> [http://www.unaids.org/sites/default/files/media\\_asset/global-aids-monitoring\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf)



Figure 5 Transactions



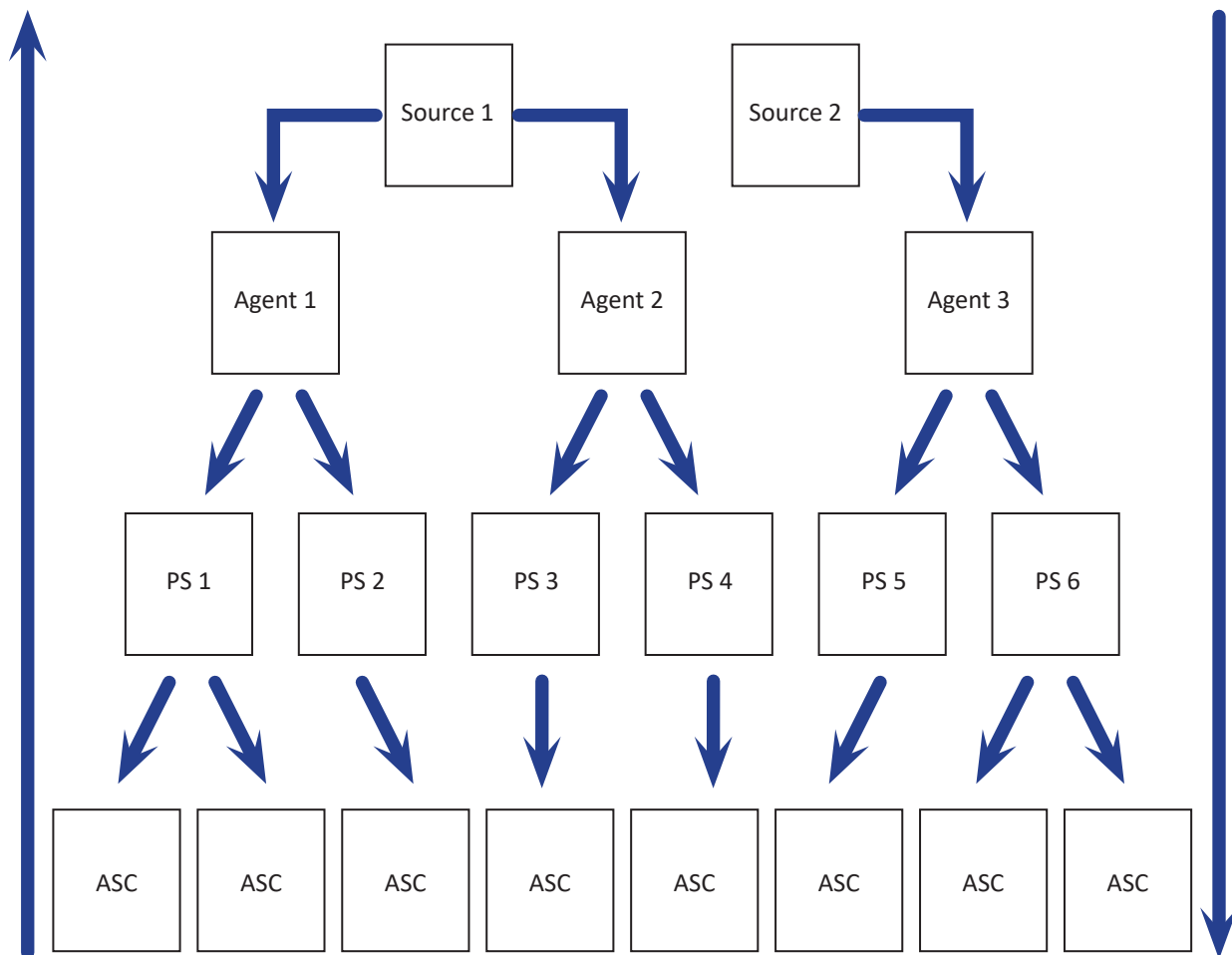
The illustration shows the financing flow linking the financing source with the financing agent and the provider. The provider can produce several ASC (two in this example: ASC<sub>1</sub> and ASC<sub>2</sub>). Each ASC is produced by a specific combination of resources consumed: production factors<sub>1</sub> and production factors<sub>2</sub>. Also, each of the ASC is produced to reach one or more specific intended beneficiary populations: beneficiary population<sub>1</sub> and beneficiary population<sub>2</sub>.

Central to the resource tracking work is the comprehensive reconstruction of all transactions to follow the money flows from the financing sources, through buyers and providers and finally to the beneficiaries, in order to minimize the risk of double counting resources.

An extremely important fact to be considered during any resource tracking assessment is to avoid double counting. Especially on HIV responses, where there are several layers of intermediary institutions before the resources reach the provider of services. Care must be taken to avoid double counting expenditures because disbursements of one entity may be the income of another one, and these flows must be handled so as to capture the resources only when they are finally incurred. Identifying the Source-Agent-Provider relation is a fundamental mechanism for doing so.

During data analysis all transactions are completed and crosschecked doing a “bottom up” and “top down” reconciliation to avoid double counting and to ensure that the amounts inputted to the transaction reflect actual spending of resources consumed (figure 6).

Figure 6 “Bottom up” and “Top down” approach.



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

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

*Table 1 NASA dimensions and categories.*

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

### 2.3. DATA COLLECTION AND PROCESSING

The Ministry of Health and Sports in collaboration with the UNAIDS office in Myanmar, conducted the National AIDS Spending Assessment (NASA) for the years 2016 and 2017 on a four-month period, between November 2018 and February 2019.

The AIDS spending assessment was performed by the NASA team, working under the leadership of the National AIDS Program (NAP) and the support of UNAIDS. The team had the technical responsibility to collect, clean, and process the data, technically validate the data, carry out analyses, and produce reports.

NASA core team for the assessment in Myanmar:

1. Dr. Htun Nyunt Oo (Program Manager, NAP)
2. Dr. Kay Khaing Kaung Nyunt (Assistant Director, NAP)
3. Dr. Marjolein Jacobs (UNAIDS Strategic Information Advisor)
4. Mr. Christian Aran (International consultant)
5. Dr. Chaw Yin Myint (National consultant)

The NASA process started with a launch meeting on November 9th, 2018. The purpose of the meeting was to sensitize and advocate with key partners to facilitate the data collection process. Data collection forms were distributed to all key HIV/AIDS national response actors. Soft copies in spreadsheets were used for data collection. These were the same forms used in the previous NASA with minor adjustments. It was agreed that the deadline for data collection was November 30<sup>th</sup>, 2018.

Table 2 Timeline of the NASA III implementation in Myanmar

Id.	Task	Starting date	End date	Length	Nov 2018			Dec 2018			Jan 2019			Feb 2019			Mar 2019			Apr 2019							
					11/11	18/11	25/11	2/12	9/12	16/12	23/12	30/12	6/1	13/1	20/1	27/1	3/2	10/2	17/2	24/2	3/3	10/3	17/3	24/3	31/3	7/4	14/4
1	NASA Launch	09/11/2018	09/11/2018	1d																							
2	Data Collection	12/11/2018	10/12/2018	21d																							
3	Data cleansing, interviews, data processing	10/12/2018	19/12/2018	8d																							
4	Validation meeting with key informants	19/12/2018	19/12/2018	1d																							
5	Additional data collection	17/12/2018	25/01/2019	30d																							
6	Presentation of preliminary results	17/01/2019	17/01/2019	1d																							
7	Data analysis and elaboration of report	25/01/2019	14/02/2019	15d																							
8	Presentation of final results	26/02/2019	26/02/2019	1d																							
9	Final report	15/04/2019	24/05/2019	30d																							

Each organization was asked to allocate spending, using various criteria, into different programmes to enable a functional classification of HIV and AIDS expenditures. The expenditure data collected was first captured in spreadsheets and checked and balanced. All the information obtained/collected was verified to the extent possible, to ensure the validity of data from the records.

NASA classification codes were assigned to all expenditures reported. Each amount spent cannot have more than one code from the same classification. Additional details were requested from the organisations, as necessary.

The spending data was used to reconstruct each transaction. The transactions were then traced by cross-checking the data collected from multiple sources, agents and providers to avoid double counting. All data collected and accounted in transactions was adjusted to reflect actual spending (goods and services delivered) to the extent possible.

When needed, costing techniques were used to estimate some of the expenditures of HIV and AIDS related activities using the best available data and most suitable assumptions.

The NASA team contacted 85 organizations, 54 provided the required data, 14 did not, and 17 confirmed they had not invested nor implemented HIV related programmes in 2016 or 2017. Although 20% of the organizations did not fill the data collection form, we collected their spending data through the Financial Source, Agent or Provider, hence completing the missing transactions.

*Table 3 Organizations contacted during data collection*

Organizations	Contacted	Provided data	No HIV related activities	Did not provide data
Ministries	3	3		
Government institutions	8	7	1	
Bilateral	4	1	3	
Multilateral/UN	14	9	5	
International NGO	24	20	2	2
NGO/CBO	21	9	1	11
Pharmaceutical comp	4	2	1	1
Medical equipment comp	3	1		2
Private Lab	1	-		1
Private hospital/ pharmacy	1	1		
Inc	2	1	1	
<b>Total</b>	<b>85</b>	<b>54</b>	<b>14</b>	<b>17</b>

For the list of institutions visited to collect HIV expenditure data and a detailed explanation of data processing, assumptions and, refer to Annexes 1 and 2.

Spreadsheets were used to build the NASA databases for 2016 and 2017 were all the transactions and spending data was aggregated. The NASA team used the pivot table function in Excel to manage the data, analyze and produce the results.

NASA preliminary results were presented to key stakeholders in different meetings in order to validate results, minimize possible errors and share and discuss assumptions applied during data processing. After the validation, additional data collection was required. The final results of NASA were used to report to GAM 2019<sup>12</sup> indicator on HIV spending.

## 2.6. LIMITATIONS OF ASSESSMENT

Despite the improvements mentioned above, such as the inclusion of Production Factors data, the assessment faced some limitations:

### Absence of data:

- OOPE Purchase of condoms in pharmacies and OOPE procurement of PMTCT services in private clinics was not included since there was not enough information available to produce an estimation on these expenditures.
- OOPE procurement of ARV in private clinics was only partially measured.
- OOPE for Specific HIV-related laboratory monitoring.

<sup>12</sup> Global AIDS Monitoring 2019 Indicators for monitoring the 2016 Political Declaration on Ending AIDS. <http://www.unaids.org/en/resources/documents/2018/Global-AIDS-Monitoring>

- Pre-op HIV testing cost both in public and private health facilities.
- Due to the MoHS reform and changes in information systems it is more difficult to get the expenditure of ART/ DC site at STD clinic, urban health centre and rural health centre cost.

#### **Data quality:**

- Some data were reported in aggregated figures, mixing different ASCs (mainly for the prevention programmes targeting Key populations, reporting aggregate figures for more than one Key population, which required additional follow up when possible).
- 30% and 41% of the expenditure for 2016 and 2017 respectively was only obtained “top down”, without being able to validate the actual expense of spending at the provider level.
- The cost for antiretroviral, OI drugs, Methadone and STI drugs were estimated from procurement data rather than consumption. This is consistent with the way it was done in previous NASAs in Myanmar, but the National Health Accounts (NHA) and NASA methodology recommends using consumption data in order to reflect the actual implementation of programmes, –more efforts to cost the consumption of ARVs and other key drugs in order to follow the recommended principles for national health accounting.
- It was not possible to disaggregate the procurement of ARV between first- and second-line treatments, so most of ARV expenditure was classified as “ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment.”
- Similarly, due to lack of costing data, some usage of medicines was difficult to properly account between OI or STI (e.g. Metronidazole, Ciprofloxacin, Clindamycin, etc.).
- Blood safety human resource costs of screening blood units outside the National Health Laboratory were not estimated.
- Some organizations reported PWID spending that includes non-injecting drug users. This may have pumped up the overall spending for PWID. However, since the previous NASA round has encountered the same issue in the organizations’ data collection forms and reports, the overall results are compatible across all NASA rounds in Myanmar.
- All data was processed following the calendar year, except for all US funding figures which were reported and accounted in NASA based on the US fiscal 16/17 and 17/18.

#### **Delays in the implementation of the study:**

- In a few cases data was reported after the agreed deadline.
- The original planned dates for the data validation and final data presentation had to be postponed due to agenda conflicts of key partners.

### 3. RESULTS OF NASA

Total HIV spending for 2016 has been estimated at US\$ 90.3 million and US\$ 109.5 million for 2017<sup>13</sup>.

#### 3.1. FINANCING SOURCES 2016 AND 2017

International funds remain the major source of funding, financing 79% of total HIV spending in 2017. Total HIV spending increased by 21% between 2016 and 2017. Public funds almost doubled between 2016 and 2017, increasing by 88% in the period.

Table 4 Financing Sources 2016 and 2017

FS 1st Digit	2016	%	2017	%	Var. 2017-2016	Var. %
FS.01 Public funds	\$ 10,873,474	12%	\$ 20,464,340	19%	\$ 9,590,866	88%
FS.02 Private Funds	\$ 2,069,474	2%	\$ 2,744,331	3%	\$ 674,858	33%
FS.03 International funds	\$ 77,352,023	86%	\$ 86,292,225	79%	\$ 8,940,202	12%
<b>Total</b>	<b>\$ 90,294,971</b>	<b>100%</b>	<b>\$ 109,500,896</b>	<b>100%</b>	<b>\$ 19,205,925</b>	<b>21%</b>

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the government of Myanmar and the government of the US are the three main funding sources, who combined finance up to 79% of the national HIV spending. Médecins sans Frontières is the biggest international non for-profit funding source in Myanmar, and it financed 9% of the response in 2016 and 8% in 2017. The “3 Millennium Development Goal Fund (3MDG)<sup>14</sup>”, a fund created to strengthen the national health system in Myanmar, financed 8% of the response in 2016 and 6% in 2017.

<sup>13</sup> The results of the assessment are presented in US Dollars. When the data was reported in the local currency – Myanmar Kyat (MMK). The following exchange rate has been applied to convert the amounts in to US Dollars: in 2016 1 US Dollar = 1,232.3 MMK and in 2017 1 US Dollar = 1,360.3 MMK.

Source: <https://forex.cbm.gov.mm/index.php/fxrate/history>

<sup>14</sup> By pooling the contributions of seven bilateral donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America, 3MDG promotes the efficient and effective use of development funds. With commitments totalling more than \$284 million for the period July 2012 to December 2017. <https://www.3mdg.org/>

Table 5 Financing Sources 2016 and 2017 (3rd digit analysis)

Financing Sources		2016	%	2017	%
<b>FS.01 Public funds</b>	FS.01.01.01 Central government revenue	\$ 10,873,474	12%	\$ 20,464,340	19%
<b>FS.01 Public Funds Total</b>		<b>\$ 10,873,474</b>	<b>12%</b>	<b>\$ 20,464,340</b>	<b>19%</b>
<b>FS.02 Private Funds</b>	FS.02.01 For-profit institutions and corporations	\$ 86,425	0%	\$ 20,329	0%
	FS.02.02 Households' funds	\$ 1,333,439	1%	\$ 1,222,641	1%
	FS.02.03 Not-for-profit institutions (other than social insurance)	\$ 649,610	1%	\$ 1,501,361	1%
<b>FS.02 Private Funds Total</b>		<b>\$ 2,069,474</b>	<b>2%</b>	<b>\$ 2,744,331</b>	<b>3%</b>
<b>FS.03 International funds</b>	FS.03.01.07 Government of France	\$ 44,502	0%	\$ 192,539	0%
	FS.03.01.12 Government of Japan	\$ 151,550	0%	\$ 117,470	0%
	FS.03.01.14 Government of Netherlands	\$ 207,142	0%	\$ 256,135	0%
	FS.03.01.21 Government of United Kingdom	\$ 19,519	0%		0%
	FS.03.01.22 Government of United States	\$ 8,847,886	10%	\$ 12,773,900	12%
	Sub Total Bilateral	\$ 9,270,599	10%	\$ 13,340,044	12%
	FS.03.02.06 Asian Development Bank (ADB)	\$ 417,845	0%	\$ 2,254,132	2%
	FS.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	\$ 50,015,486	55%	\$ 52,798,381	48%
	FS.03.02.08 UNAIDS Secretariat	\$ 754,694	1%	\$ 621,774	1%
	FS.03.02.09 United Nations Children's Fund (UNICEF)	\$ 935,792	1%	\$ 971,820	1%
	FS.03.02.17 United Nations Population Fund (UNFPA)	\$ 25,207	0%		0%
	FS.03.02.19 World Food Programme (WFP)	\$ 537,806	1%	\$ 181,025	0%
	FS.03.02.20 World Health Organization (WHO)	\$ 92,186	0%	\$ 24,297	0%
	FS.03.02.99 Millennium Development Goal Fund (3MDG)	\$ 7,176,142	8%	\$ 7,052,424	6%
	Sub Total Multilateral	\$ 59,955,159	66%	\$ 63,903,854	58%
	FS.03.03.20 Médecins sans Frontières	\$ 7,918,365	9%	\$ 8,772,170	8%
	FS.03.03.99 Other International not-for-profit organizations and foundations n.e.c. <sup>15</sup>	\$ 207,901	0%	\$ 276,157	0%
	Sub Total International not-for-profit organizations and foundations	\$ 8,126,266	9%	\$ 9,048,328	8%
<b>FS.03 International funds Total</b>		<b>\$ 77,352,023</b>	<b>86%</b>	<b>\$ 86,292,225</b>	<b>79%</b>
<b>Total</b>		<b>\$ 90,294,971</b>	<b>100%</b>	<b>\$109,500,896</b>	<b>100%</b>

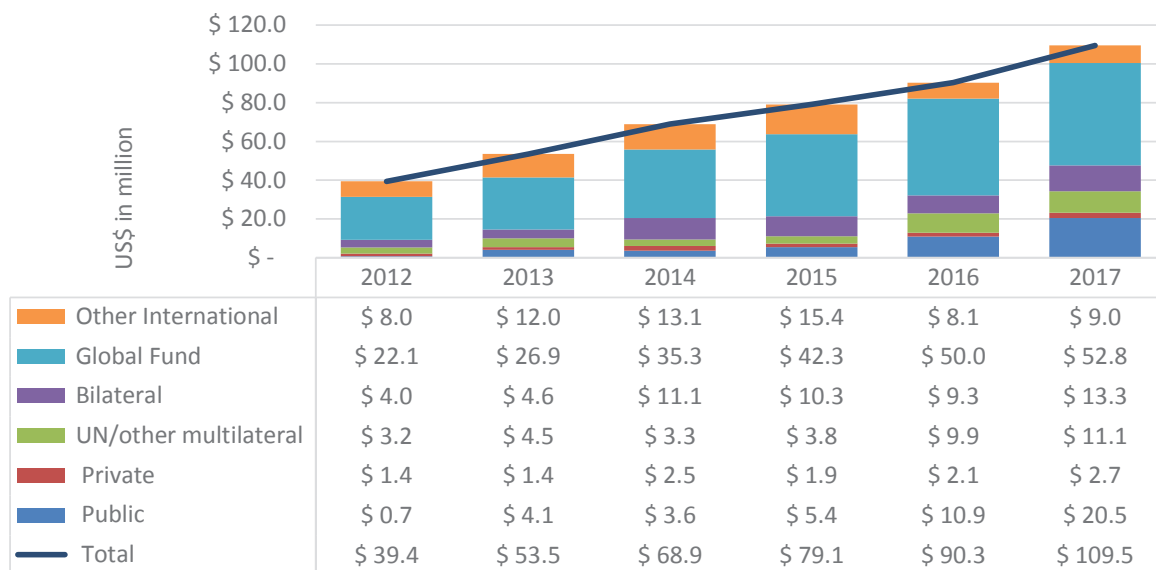
<sup>15</sup> n.e.c.: not elsewhere classified



### 3.2. TRENDS OF EXPENDITURE IN HIV AND AIDS

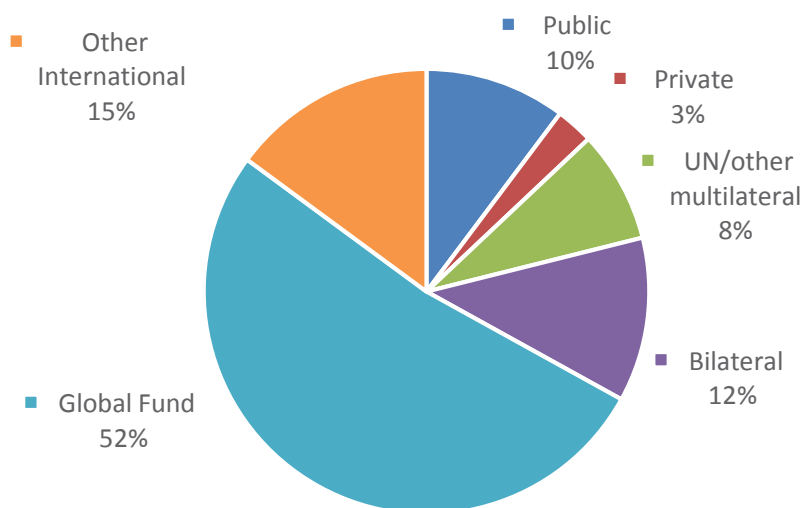
HIV spending in Myanmar has shown a steady increase since spending started being measured in 2012. HIV spending almost tripled during this period, from US\$ 39.4 million in 2012 to US\$ 109.5 million in 2017.

Figure 7 HIV expenditures by Funding Sources 2012 - 2017



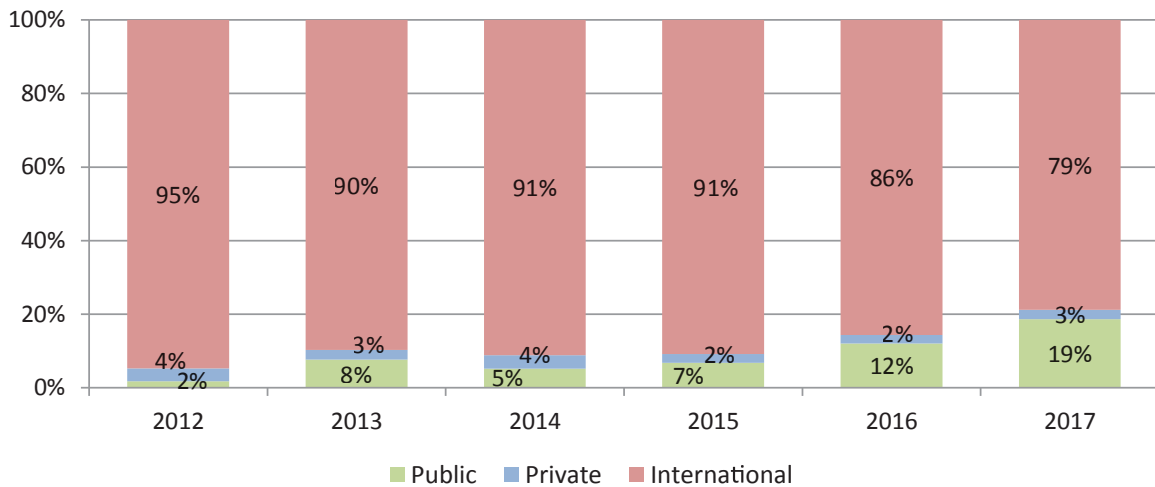
During this period US\$ 440.7 million have been allocated to the HIV response and the GFATM has been the main financing source, financing more than half of all the funding allocated in the HIV response in Myanmar between 2012 and 2017 (US\$ 229.4 million).

Figure 8 Financing Sources for the period, cumulative 2012 – 2017



Myanmar remains a highly donor dependent country to maintain its national HIV response. However, the share of public funding has increased significantly from 2% in 2012 up to 19% in 2017. In this period, public spending increased 29 times, from U\$S 0.7 million to US\$ 20.5 million.

Figure 9 Financing Sources 2012 – 2017



Although HIV spending in Myanmar has been increasing steadily since 2012, it is assumed that spending stagnated in 2018. International funding sources have started to diminish their funding contribution, and even if public funds are expected to continue expanding, the country will have to focus on efficiency and the impact of its interventions in the upcoming years. Future spending analysis will be essential to provide clarity on this funding transition.

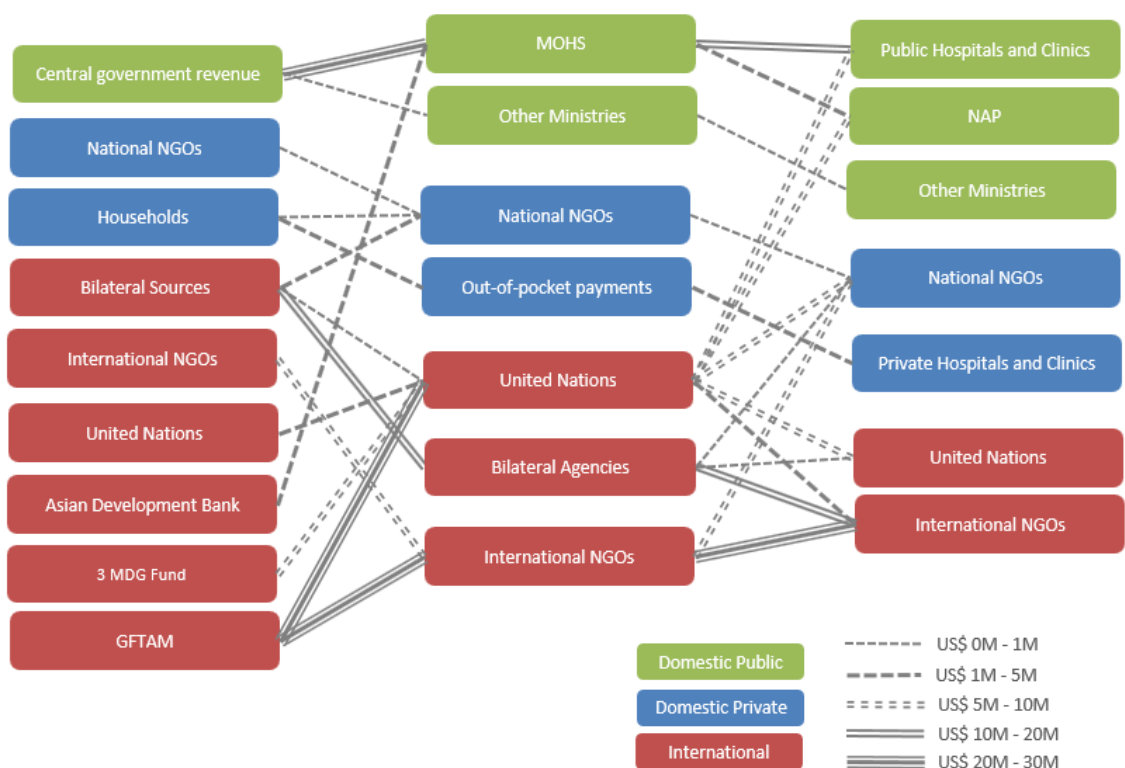
### 3.3. FINANCIAL FLOWS AND FUNDING MODALITIES

As mentioned in the chapter on methodology, the entities involved in the national response to HIV are classified as financial sources, financial agents or service providers according to the role they play in the response, in particular on each financial transaction. The same entity may carry out all three roles in different financial transactions. Financial sources are entities that provide funds to financial agents to use or distribute. Financial agents are important entities in the national response to HIV because they gather funds from various financial sources and transfer the money to providers to buy or pay for health care or other services or goods to handle activities related to HIV and AIDS. The service providers are entities that produce, provide and deliver services in exchange for a payment for their contribution.

The mapping of the HIV response and the roles played by the key entities is summarized in figure 10. The financial architecture has different levels of intermediation and a combination of

financing sources. Understanding the flow of funds between these different entities and how the financial agents distribute the funding to service providers helps decision makers adjust future allocations in line with priorities. Public funding sources channel its resources mainly through the Ministry Health and Sports (MoHS) and its implementing units, such as the National AIDS programme (NAP), hospitals and ambulatory centres, AIDS/STD Clinics, etc. Bilateral funding sources channel their funding mainly through their agencies and finally to International NGOs based in the country for the implementation of the programmes. The GFATM has two principal recipients (PRs), UNOPS (United Nations) and Save the Children (International NGOs). The PRs transfer the funds to sub recipients (SRs) for the implementation or provision of services. These are mainly International NGOs delivering ART (e.g. Médecins sans Frontières) and prevention programmes, as well as National NGOs. This is the main flow of funds for programmes targeting Key populations.

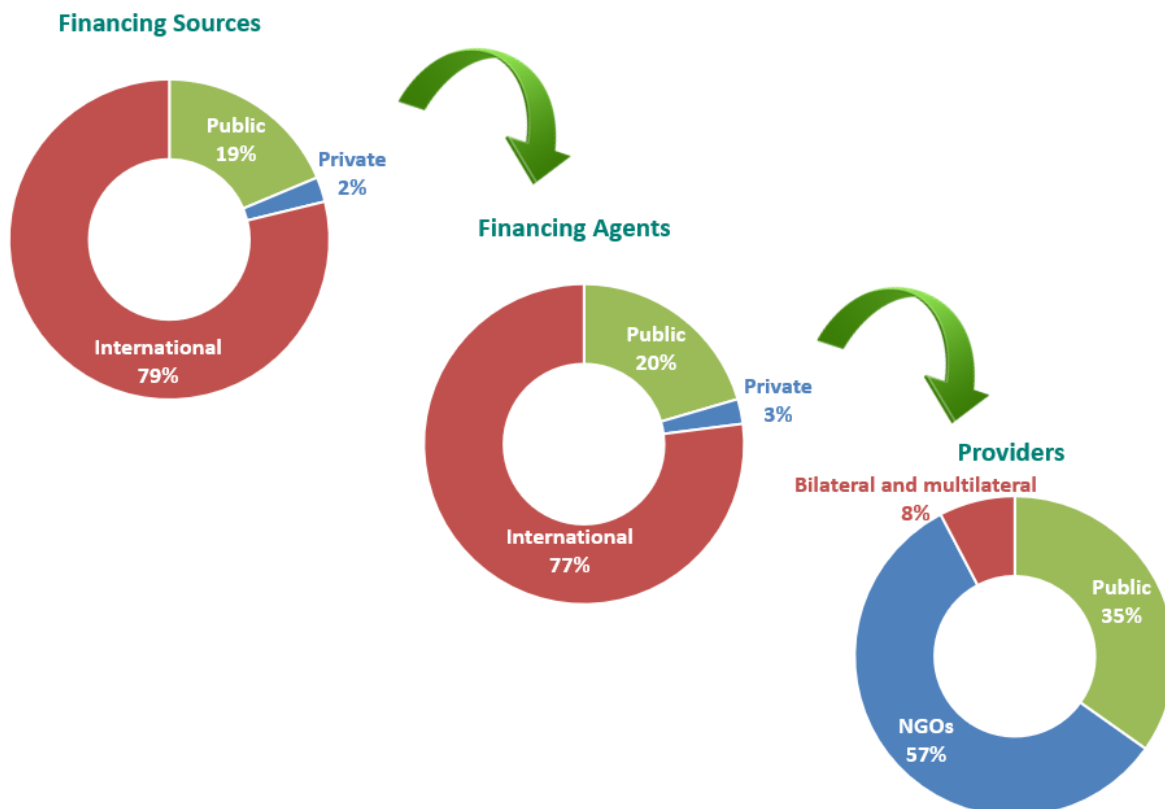
Figure 10 Main Flows of Funding in the HIV Response to HIV in 2017



As mentioned before, the majority of the funds come from international donors (79%). International Financing Agents manage 77% of the funding, Private Agents 3% and Public Agents 20%. The Funding Sources and Financing Agents share a similar financial structure. One of the main reasons for this is that the principal recipients (PRs) of the GFATM are international organizations (UNOPS and Save The Children). Consequently, the international procurement

organizations play an important role in determining the programmatic allocation of resources in the country. A small part of the funding comes from international funding sources to local NGOs and Governmental entities.

Figure 11 Flow of Funds of National Response in 2017



When it comes to the implementation of programmes, public providers deliver 35% of the services of the HIV response (MoHS, hospitals and ambulatory centres) and NGOs and civil society organizations<sup>16</sup> capture and implement 57% of the funding to the HIV response.

### 3.4. PROGRAMMATIC DESCRIPTION OF EXPENSES IN HIV AND AIDS

Care and Treatment represents almost half of total HIV spending in Myanmar, 49% in 2016 (US\$ 44.4 million) and 48% in 2017 (US\$ 52.4 million). The second biggest programmatic area of the HIV response is prevention, representing 30% and 27% in 2016 and 2017 respectively.

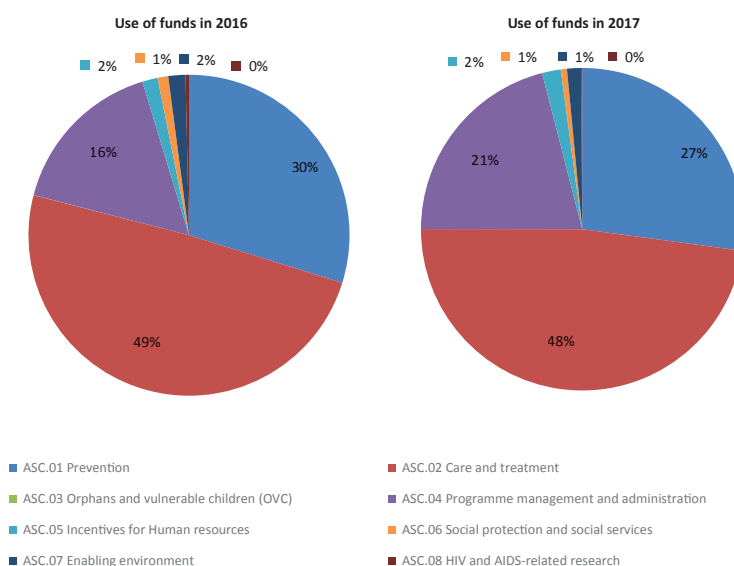
<sup>16</sup> NASA Providers classification is in line with the 2001 System of Health Accounts considering local based national and international NGOs and civil society organizations as private providers. Private providers comprise non-profit and profit actors. Private sector providers comprise private (nongovernmental) sector organizations providing goods and services in the response to HIV

Table 6 HIV spending per programmatic area in 2016 and 2017

ASC 1st Digit	2016	%	2017	%	Var. 2017-2016	Var. %
ASC.01 Prevention	\$ 26,908,255	30%	\$ 29,713,865	27%	\$ 2,805,610	10%
ASC.02 Care and treatment	\$ 44,438,518	49%	\$ 52,427,739	48%	\$ 7,989,221	18%
ASC.03 Orphans and vulnerable children (OVC)	\$ 14,284	0%	\$ -	0%	-\$ 14,284	-100%
ASC.04 Programme management and administration	\$ 14,698,774	16%	\$ 22,971,886	21%	\$ 8,273,112	56%
ASC.05 Incentives for Human resources	\$ 1,398,096	2%	\$ 2,049,941	2%	\$ 651,844	47%
ASC.06 Social protection and social services	\$ 969,324	1%	\$ 678,209	1%	-\$ 291,115	-30%
ASC.07 Enabling environment	\$ 1,554,830	2%	\$ 1,542,860	1%	-\$ 11,969	-1%
ASC.08 HIV and AIDS-related research	\$ 312,891	0%	\$ 116,396	0%	-\$ 196,495	-63%
<b>Total</b>	<b>\$ 90,294,971</b>	<b>100%</b>	<b>\$ 109,500,896</b>	<b>100%</b>	<b>\$ 19,205,925</b>	<b>21%</b>

Programme management and administration represents 16% and 21%. These three programmatic areas capture more than 90% of total HIV spending in both years. In relative terms, Incentives for human resources<sup>17</sup> was the area with the biggest growth, increasing by 47% between 2016 and 2017. In absolute terms, Programme management and administration<sup>18</sup> had the largest growth, increasing by US\$ 8.3 million in 2017, followed by Care and Treatment, which increased by US\$ 7.9 million.

Figure 12 HIV spending per programmatic area in 2016 and 2017

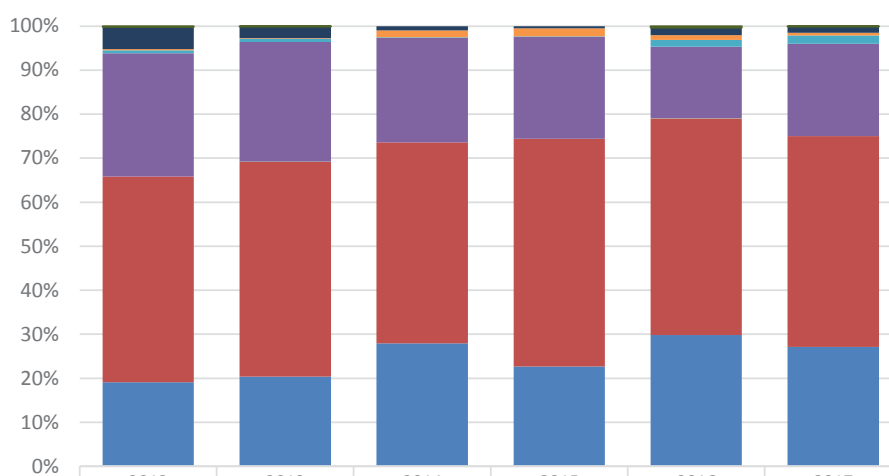


<sup>16</sup> Includes: Training, Monetary incentives and Formative education to build-up an HIV workforce. [http://files.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090916\\_nasa\\_classifications\\_edition\\_en.pdf](http://files.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090916_nasa_classifications_edition_en.pdf)

<sup>18</sup> Includes, among other programmes: Planning, coordination, and programme management, Administration and transaction costs associated with managing and disbursing funds, Monitoring and Evaluation and Upgrading and construction of infrastructure [http://files.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090916\\_nasa\\_classifications\\_edition\\_en.pdf](http://files.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090916_nasa_classifications_edition_en.pdf)

The share of Care and Treatment as a percentage of overall HIV spending has been approximately 50% of overall HIV spending in the period 2012 – 2017 (figure 13), with the lowest share of overall spending in 2014 (45%) and highest in 2015 (51%). The share of Prevention spending grew constantly in the period (both in absolute and relative terms), from 19% in 2012 to 27% in 2017, peaking in 2016, with 30% of HIV spending. Programme management and administration spending represented 28% of HIV spending in 2012, decreasing its share to 21% in 2017. This variation may reflect a refinement in the data reported, since some organizations have been improving the allocation of their programmes' indirect costs, which were in some cases reported as overheads before.

Figure 13 Trends of HIV spending on programmatic interventions 2012 – 2017 – chart.



	2012	2013	2014	2015	2016	2017
ASC.08 HIV-related research	\$ 69,566	\$ 62,200			\$ 312,891	\$ 116,396
ASC.07 Enabling environment	\$ 1,991,101	\$ 1,403,684	\$ 641,561	\$ 438,886	\$ 1,554,830	\$ 1,542,860
ASC.06 Social protection and Social services	\$ 109,842	\$ 45,914	\$ 1,062,948	\$ 1,525,628	\$ 969,324	\$ 678,209
ASC.05 Incentives for Human resources	\$ 261,392	\$ 420,824	\$ 106,156	\$ 89,327	\$ 1,398,096	\$ 2,049,941
ASC.04 Programme management and Administration	\$ 11,040,318	\$ 14,547,616	\$ 16,267,255	\$ 19,364,797	\$ 14,698,774	\$ 22,971,886
ASC.03 Orphans and Vulnerable Children		\$ 15,759			\$ 14,284	\$ -
ASC.02 Care and Treatment	\$ 18,410,465	\$ 26,099,641	\$ 31,245,671	\$ 43,236,905	\$ 44,438,518	\$ 52,427,739
ASC.01 Prevention	\$ 7,539,607	\$ 10,922,285	\$ 19,091,580	\$ 18,991,241	\$ 26,908,255	\$ 29,713,865

International funding is the main funding source of all programmatic areas, financing 67% of Care and Treatment, and more than 80% of all other areas.

Table 7 Funding Flows of the main funding sources in Myanmar in 2017

## USD Current dollars

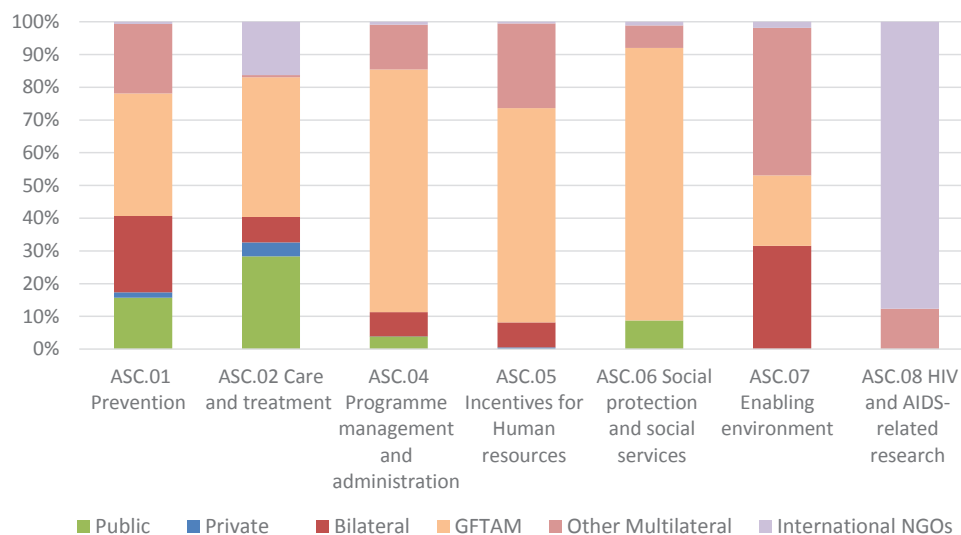
2017	FS.01 Public funds	FS.02 Private Funds	FS.03 International funds	Total
ASC.01 Prevention	4,666,893	493,506	24,553,466	29,713,865
ASC.02 Care and treatment	14,849,434	2,238,498	35,339,807	52,427,739
ASC.04 Programme management and administration	888,437	1,564	22,081,885	22,971,886
ASC.05 Incentives for Human resources	0	10,764	2,039,177	2,049,941
ASC.06 Social protection and social services	59,575	0	618,634	678,209
ASC.07 Enabling environment	0	0	1,542,860	1,542,860
ASC.08 HIV and AIDS-related research	0	0	116,396	116,396
<b>Total</b>	<b>20,464,340</b>	<b>2,744,331</b>	<b>86,292,225</b>	<b>109,500,896</b>

When analysing each specific international funding source and their funding towards each programmatic area of the HIV response (figure 14), the importance of GFATM contribution becomes clear.

The GFATM is the main funding source of most HIV programmatic areas, financing in 2017 37% of all Prevention programmes, 43% of Care and Treatment, 74% of Programme management and administration, 65% of Incentives for Human resources and 83% of all Social protection and social services.

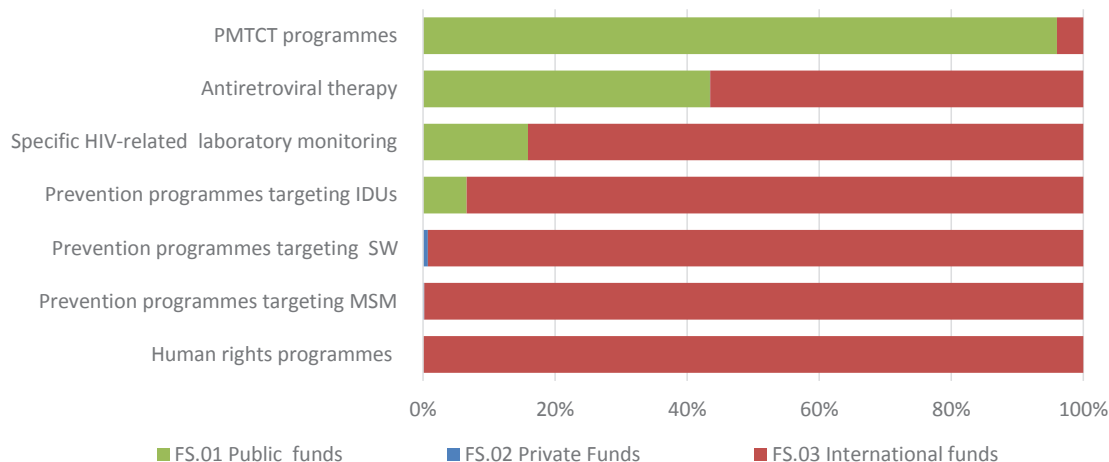
Other multilateral sources (3MDG and UN) are the main funding source for Enabling environment programmes (45%), and International NGOs are the main funding source for HIV and AIDS-related research (88%).

Figure 14 Funding source per Spending Category in 2017



While shifting from international to public funding, particular care needs to be considered in maintaining an adequate funding to activities that have the biggest impact on the epidemic, such as programmes targeting Key populations and ARV treatment, and to critical enablers of the response, such as Human Rights programmes, all of which are highly dependent on donor funding (figure 15).

Figure 15 Donor dependency on Selected Key programmes in 2017



The table below describes in detail spending in prevention programmes. Almost half of HIV prevention funds (47.1%) is allocated to Harm-reduction programmes for people who inject drugs (IDUs).

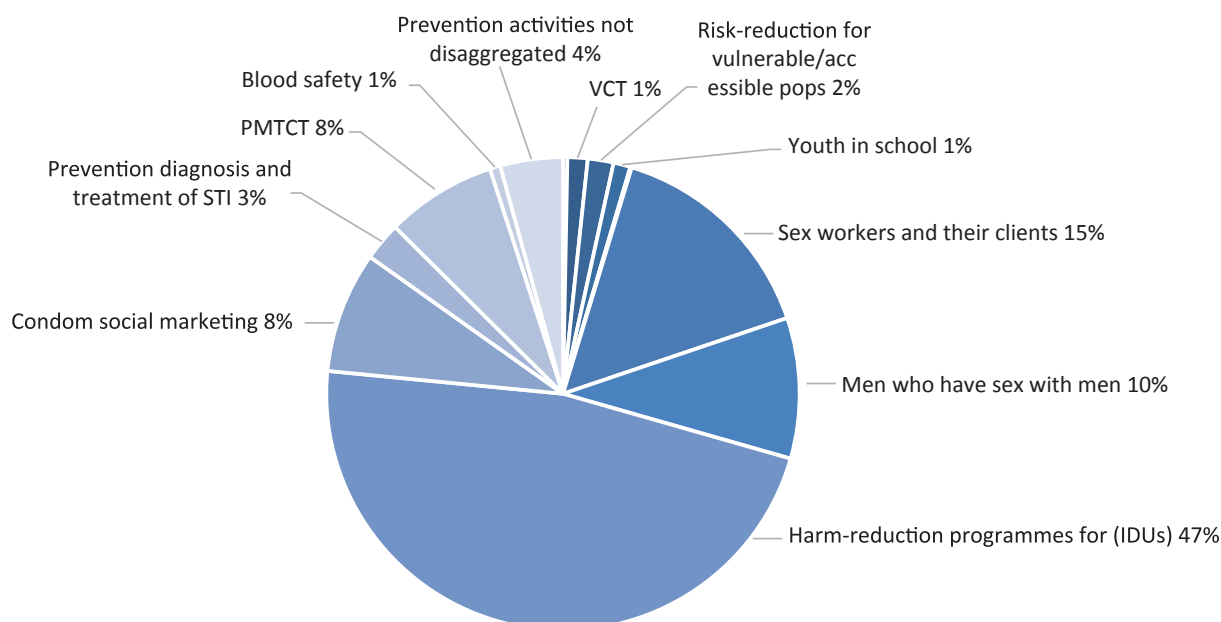
Table 8 HIV prevention spending in 2017

Prevention - 2017	Total	% over Prevention	% over total HIV spending
ASC.01.01 Communication for social and behavioural change	\$ 87,741	0.3%	0.1%
ASC.01.03 Voluntary counselling and testing (VCT)	\$ 410,517	1.4%	0.4%
ASC.01.04 Risk-reduction for vulnerable and accessible populations	\$ 523,363	1.8%	0.5%
ASC.01.05 Prevention – youth in school	\$ 344,031	1.2%	0.3%
ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)	\$ 28,379	0.1%	0.0%
ASC.01.08 Prevention programmes for sex workers and their clients	\$ 4,492,080	15.1%	4.1%
ASC.01.09 Programmes for men who have sex with men (MSM)	\$ 2,856,177	9.6%	2.6%
ASC.01.10 Harm-reduction programmes for people who inject drugs (IDUs)	\$14,000,727	47.1%	12.8%
ASC.01.12 Condom social marketing	\$ 2,459,802	8.3%	2.2%
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	\$ 780,285	2.6%	0.7%
ASC.01.17 Prevention of mother-to-child transmission (PMTCT)	\$ 2,246,218	7.6%	2.1%
ASC.01.19 Blood safety	\$ 213,667	0.7%	0.2%
ASC.01.98 Prevention activities not disaggregated by intervention	\$ 1,270,879	4.3%	1.2%
<b>ASC.01 Prevention Total</b>	<b>\$29,713,865</b>	<b>100.0%</b>	<b>27.1%</b>



Prevention programmes for sex workers and their clients is the second most funded prevention programme, with 15.1% of overall prevention funding in 2017, followed by Programmes for men who have sex with men (MSM) (9.6%) and Prevention of mother-to-child transmission (PMTCT) (7.6%). Some prevention activities were reported in a way that made it impossible to classify to a specific prevention program, since it referred to a mix of prevention activities. These were accounted under Prevention activities not disaggregated by intervention (ASC.01.98) and represented 4.3% of the prevention spending.

Figure 16 HIV prevention spending in 2017 –chart



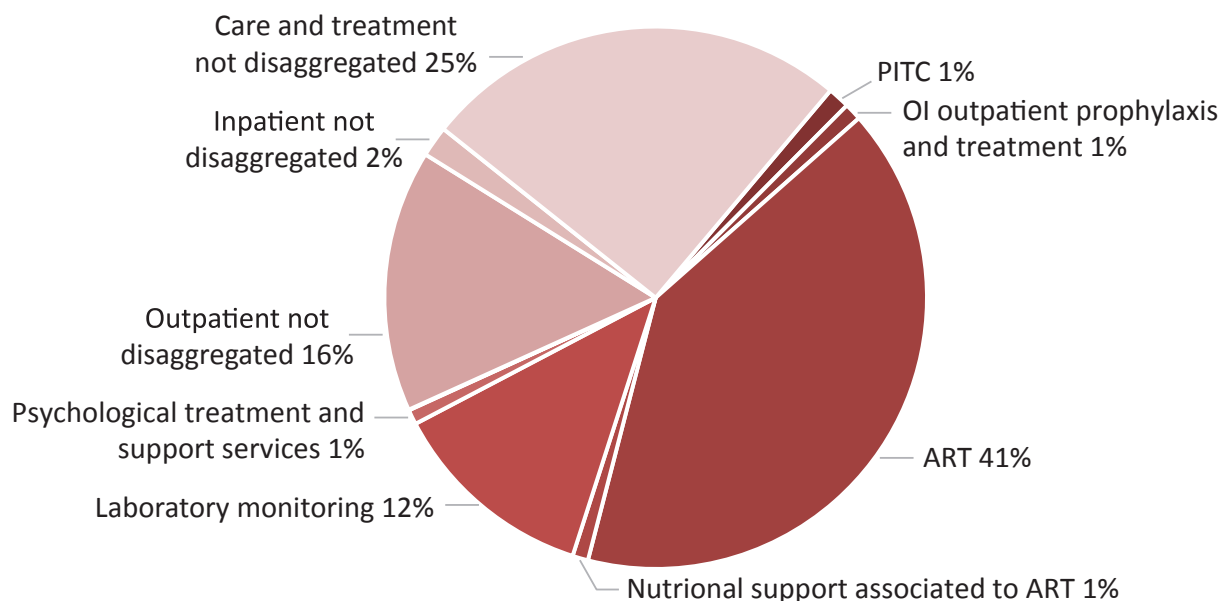
In 2017, the most funded program in Care and treatment was ART, accounting for 40.5% of the Care and treatment spending. Two “not disaggregated by intervention” categories are the following most funded spending categories, Care and treatment services not disaggregated by intervention and Outpatient care services not disaggregated by intervention with 25.5% and 15.6% respectively. These “.98”<sup>19</sup> categories include funding for Specific HIV-related laboratory monitoring and Provider- initiated testing and counselling (PITC), but it was impossible to further disaggregate into a specific ASC with the information available.

<sup>19</sup> Whenever it is not possible to break down a specific expenditure into its appropriate subcategory, the expenditure should be reported as “.98” (not broken down by type). For example, when the available information on expenditures for ASC.01 Communication for social and behavioural change is not detailed enough to report as Health-related (ASC.01.01.01) or Non-health-related (ASC.01.01.02), it should be classified as ASC.01.01.98 Communication for social and behavioural change not broken down by type. However, it is essential to provide all efforts to report the data as broken down as possible. The inclusion of Categories “.98” does not violate the principle of mutual exclusiveness; each datum obtained when tracking goods and services consumed will be entered once, either broken down, or not broken down by type (“.98”).

Table 9 Care and treatment spending in 2017

Care & Treatment - 2017	Total	% over C&T	% over total HIV spending
ASC.02.01.01 Provider- initiated testing and counselling (PITC)	\$ 682,797	1.3%	0.6%
ASC.02.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	\$ 539,277	1.0%	0.5%
ASC.02.01.03 Antiretroviral therapy	\$ 21,256,195	40.5%	19.4%
ASC.02.01.04 Nutritional support associated to ARV therapy	\$ 488,342	0.9%	0.4%
ASC.02.01.05 Specific HIV-related laboratory monitoring	\$ 6,475,696	12.4%	5.9%
ASC.02.01.07 Psychological treatment and support services	\$ 462,772	0.9%	0.4%
ASC.02.01.09 Home-based care	\$ 19,454	0.0%	0.0%
ASC.02.01.98 Outpatient care services not disaggregated by intervention	\$ 8,199,438	15.6%	7.5%
ASC.02.02.98 Inpatient care services not disaggregated by intervention	\$ 960,795	1.8%	0.9%
ASC.02.98 Care and treatment services not disaggregated by intervention	\$ 13,342,973	25.5%	12.2%
<b>ASC.02 Care &amp; Treatment Total</b>	<b>\$ 52,427,739</b>	<b>100.0%</b>	<b>47.9%</b>

Figure 17 Care and treatment spending in 2017 –chart



Planning, coordination and programme management is the most funded programme inside ASC.04, Programme management and administration. These activities, mainly carried out by the NAP, represented 27.6% of its spending in 2017.

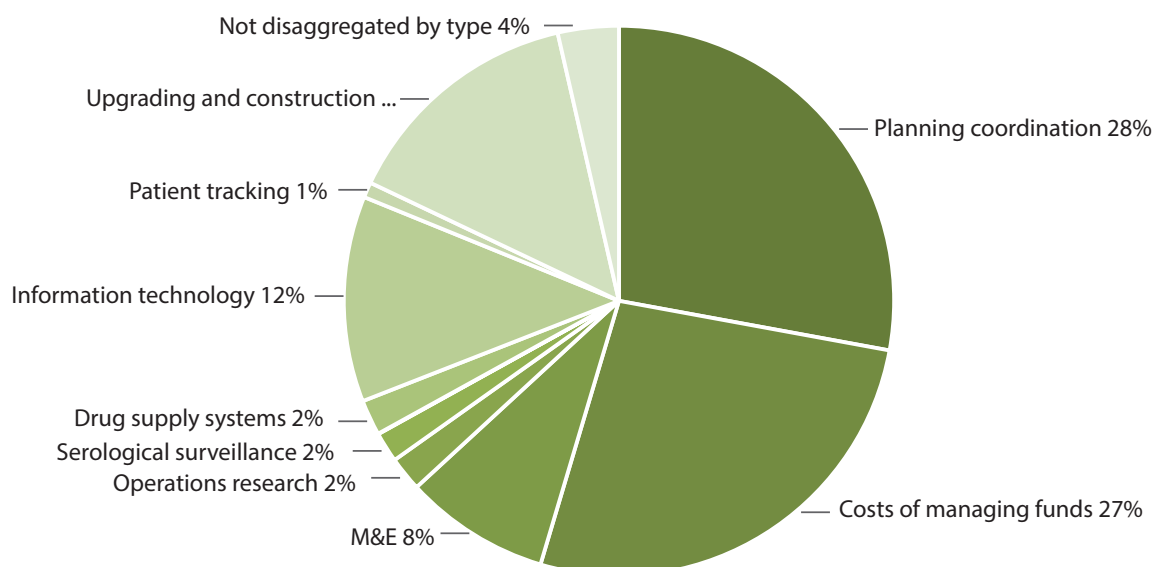
Administration and transaction costs associated with managing and disbursing funds represented 26.7%. These activities are associated to overhead costs of the PRs and other organizations for the administration of grants.

In 2017 the country had a significant investment in Upgrading and construction of infrastructure and Information technology, which represented 14.4% and 12.1% of Programme management and administration in 2017.

Table 10 Programme management and administration in 2017

Programme management and administration - 2017	Total	% over C&T	% over total HIV spending
ASC.04.01 Planning, coordination and programme management	\$ 6,406,207	27.9%	5.9%
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	\$ 6,137,176	26.7%	5.6%
ASC.04.03 Monitoring and evaluation	\$ 1,964,220	8.6%	1.8%
ASC.04.04 Operations research	\$ 464,600	2.0%	0.4%
ASC.04.05 Serological-surveillance (sousveillance)	\$ 407,218	1.8%	0.4%
ASC.04.06 HIV drug-resistance surveillance	\$ 5,981	0.0%	0.0%
ASC.04.07 Drug supply systems	\$ 478,944	2.1%	0.4%
ASC.04.08 Information technology	\$ 2,779,039	12.1%	2.5%
ASC.04.09 Patient tracking	\$ 207,898	0.9%	0.2%
ASC.04.10 Upgrading and construction of infrastructure	\$ 3,298,601	14.4%	3.0%
ASC.04.98 Programme management and administration not disaggregated by type	\$ 822,003	3.6%	0.8%
<b>ASC.04 Programme management and administration Total</b>	<b>\$ 22,971,886</b>	<b>100.0%</b>	<b>21.0%</b>

Figure 18 Programme management and administration in 2017—chart



The table below shows in detail the spending in other programmatic areas. It is worth mentioning that Training represented 1.5% of overall HIV spending in 2017.

*Table 11 Human resources, Social protection, Enabling environment and HIV Research in 2017*

Incentives for Human resources - 2017	Total	% over ASC.05	% over total HIV spending
ASC.05.01.03.03 Monetary incentives for other staff for programme management and administration	\$ 426,246	20.8%	0.4%
ASC.05.03 Training	\$ 1,623,694	79.2%	1.5%
<b>ASC.05 Incentives for Human resources Total</b>	<b>\$ 2,049,941</b>	<b>100.0%</b>	<b>1.9%</b>

Social protection and social services -2017	Total	% over ASC.06	% over total HIV spending
ASC.06.01 Social protection through monetary benefits	\$ 126,687	18.7%	0.1%
ASC.06.02 Social protection through in-kind benefits	\$ 154,811	22.8%	0.1%
ASC.06.03 Social protection through provision of social services	\$ 332,049	49.0%	0.3%
ASC.06.04 HIV-specific income generation projects	\$ 1,203	0.2%	0.0%
ASC.06.98 Social protection services and social services not disaggregated by type	\$ 63,458	9.4%	0.1%
<b>ASC.06 Social protection and social services Total</b>	<b>\$ 678,209</b>	<b>100.0%</b>	<b>0.6%</b>

Enabling environment	Total	% over ASC.07	% over total HIV spending
ASC.07.01 Advocacy	\$ 387,949	25.1%	0.4%
ASC.07.02 Human rights programmes	\$ 310,632	20.1%	0.3%
ASC.07.03 AIDS-specific institutional development	\$ 3,373	0.2%	0.0%
ASC.07.98 Enabling environment not disaggregated by type	\$ 840,907	54.5%	0.8%
<b>ASC.07 Enabling environment Total</b>	<b>\$ 1,542,860</b>	<b>100.0%</b>	<b>1.4%</b>

HIV and AIDS-related research - 2017	Total	% over ASC.08	% over total HIV spending
ASC.08.04 Social science research	\$ 14,386	12.4%	0.0%
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	\$ 15,004	12.9%	0.0%
ASC.08.99 HIV and AIDS-related research activities n.e.c.	\$ 87,006	74.8%	0.1%
<b>ASC.08 HIV and AIDS-related research Total</b>	<b>\$ 116,396</b>	<b>100.0%</b>	<b>0.1%</b>

### 3.5. PREVENTION SPENDING TARGETING KEY POPULATIONS

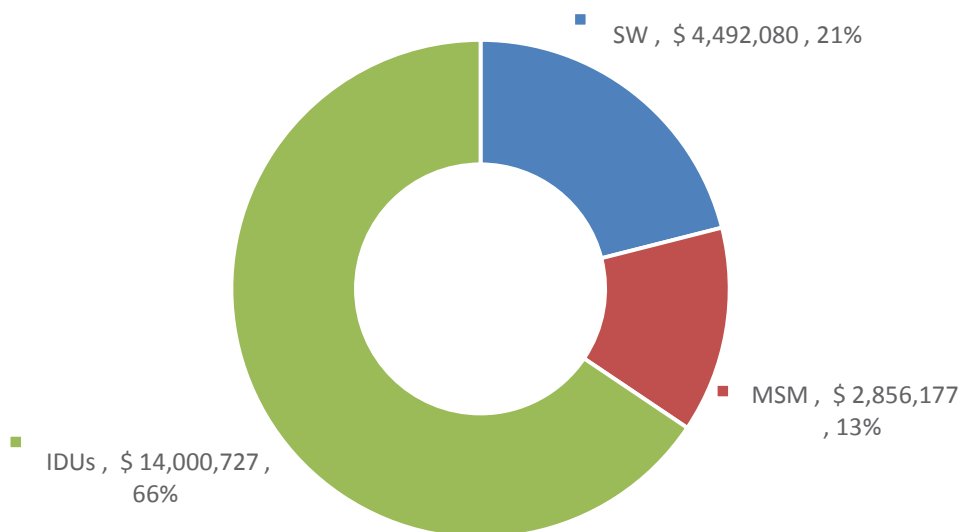
Prevention spending targeting key populations is a key component of the response for a concentrated epidemic. Spending on the Key populations has increased significantly from US\$ 6 million in 2012 to over US\$ 21 million in 2017.

People who inject drugs receive the largest portion of prevention spending among Key populations. In 2017, 66% (US\$ 14 million) of the prevention spending targeting Key populations was captured by programmes targeting People who inject drugs<sup>20</sup>.

Prevention spending targeting Sex workers and their clients in 2017 presents a 15% increase from the figures of 2014 (US\$ 3.9 million), reaching US\$ 4.5 million.

Prevention spending targeting Men who have sex with Men had similar values in 2014 (US\$ 2.8 million) and in 2017 (US\$ 2.9 million).

Figure 19 Prevention Programmes targeting Key populations at higher risk in 2017 – chart



The accounting framework of NASA allows recording spending in detailed activities inside a programme. This means that there are specific third digit level codes to record activities such as; Behavioural change and communication (BCC), Voluntary counselling and testing (VCT), condom promotion and provision or Sterile syringe and needle exchange activities targeting a specific Key population. But even if the NASA categories allow such detail, this level of detail is not always available in the data collected, or it would require a longer period of data collection and analysis to get it. For this reason, most of the prevention spending targeting Key populations is coded

<sup>20</sup> It should be noted that some of the organizations reported PWID spending that includes non-injecting drug users. This may have pumped up the overall spending for PWID. However, since the previous NASA round has encountered the same issue in the organizations' data collection forms and reports, the overall results are compatible across all NASA rounds in Myanmar.

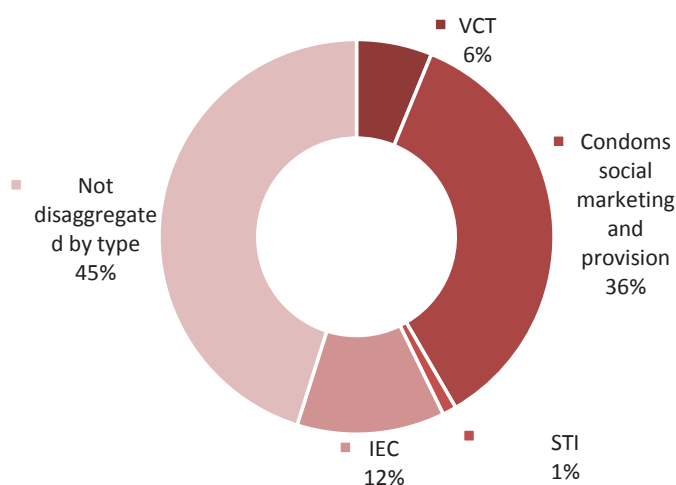
under “.98 not disaggregated by type” interventions. For example, an organization reporting a figure for condom distribution and VCT targeting sex workers. Each of these activities has a specific ASC code, but because data is aggregated the NASA team has two options, either get back to the organization asking for further clarification dividing this figure into two or more specific categories, or classify it under a “.98” category inside its corresponding second level digit ASC. The NASA team tried to get as much clarification as possible, in particular with the bigger reported figures, but still, as we can see in the following tables (tables 12 to 14) and charts (figures 20 to 22) the not disaggregated categories account for half or more of the spending.

In the case of prevention programmes targeting sex workers and their clients, 45.1% of the spending is accounted as not disaggregated, followed by condom social provision and promotion, with 35.4% of the prevention spending targeting this key population.

*Table 12 Prevention programmes for sex workers and their clients*

ASC.01.08 Prevention programmes for sex workers and their clients	Total	%
ASC.01.08.01 VCT as part of programmes for sex workers and their clients	\$ 278,305	6.2%
ASC.01.08.02 Condom social marketing and male and female condom provision as part of programmes for FSW and their clients	\$ 1,591,576	35.4%
ASC.01.08.03 STI prevention and treatment as part of programmes for FSW and their clients	\$ 51,108	1.1%
ASC.01.08.04 Behaviour change communication (BCC) as part of programmes for FSW and their clients	\$ 543,663	12.1%
ASC.01.08.98 Programmatic interventions for FSW and their clients not disaggregated by type	\$ 2,027,428	45.1%
<b>Total</b>	<b>\$ 4,492,080</b>	<b>100%</b>

*Figure 20 Prevention programmes for sex workers and their clients - chart*



In the case of prevention programmes for men who have sex with men and harm reduction programmes for people who inject drugs, more than 70% of the spending has been recorded under non disaggregated categories.

Table 13 Prevention programmes for men who have sex with men

ASC.01.09 Programmes for men who have sex with men (MSM)	Total	%
ASC.01.09.01 VCT as part of programmes for MSM	\$ 138,206	4.8%
ASC.01.09.02 Condom social marketing and male and female condom provision as part of programmes for MSM	\$ 145,192	5.1%
ASC.01.09.03 STI prevention and treatment as part of programmes for MSM	\$ 29,907	1.0%
ASC.01.09.04 Behaviour change communication (BCC) as part of programmes for MSM	\$ 538,740	18.9%
ASC.01.09.98 Programmatic interventions for MSM not disaggregated by type	\$ 2,004,131	70.2%
<b>Total</b>	<b>\$ 2,856,177</b>	<b>100%</b>

Figure 21 Prevention programmes for men who have sex with men - chart

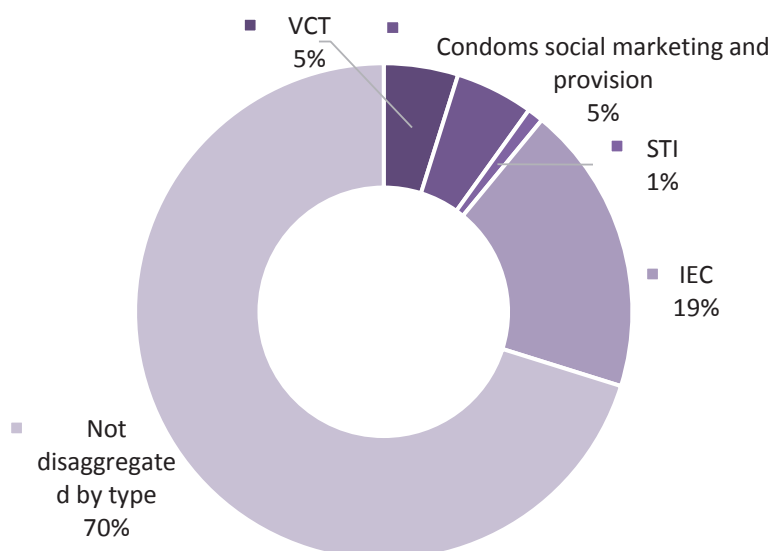
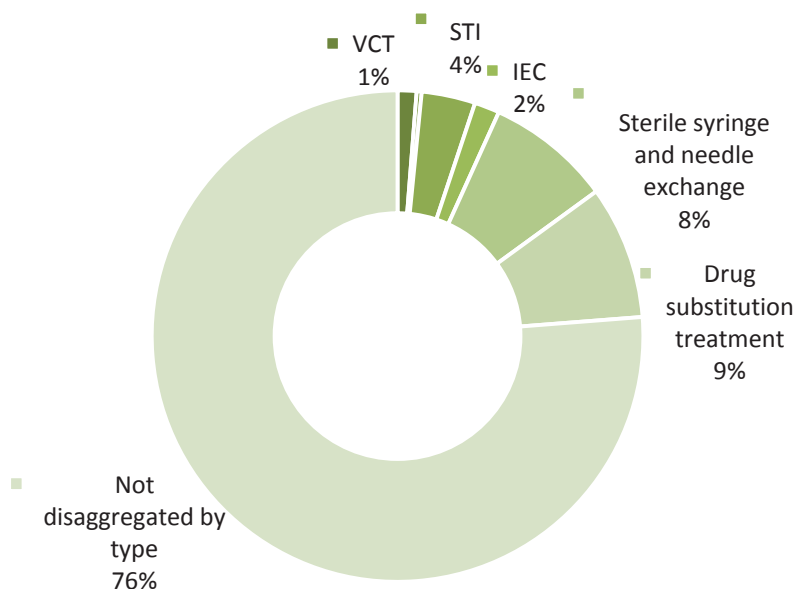


Table 14 Harm-reduction programmes for people who inject drugs

ASC.01.10 Harm-reduction programmes for people who inject drugs (IDUs)	Total	%
ASC.01.10.01 VCT as part of programmes for IDUs	\$ 174,550	1.2%
ASC.01.10.02 Condom social marketing and male and female condom provision as part of programmes for IDUs	\$ 45,948	0.3%
ASC.01.10.03 STI prevention and treatment as part of programmes for IDUs	\$ 495,171	3.5%
ASC.01.10.04 Behaviour change communication (BCC) as part of programmes for IDUs	\$ 231,360	1.7%
ASC.01.10.05 Sterile syringe and needle exchange as part of programmes for IDUs	\$ 1,150,147	8.2%
ASC.01.10.06 Drug substitution treatment as part of programmes for IDUs	\$ 1,229,033	8.8%
ASC.01.10.98 Programmatic interventions for IDUs not disaggregated by type	\$ 10,674,518	76.2%
<b>Total</b>	<b>\$ 14,000,727</b>	<b>100%</b>

Figure 22 Harm-reduction programmes for people who inject drugs



### 3.6. BENEFICIARIES

NASA operates with six main types of the beneficiaries of the HIV programmes (BP): BP.01 People living with HIV, BP.02 Key populations, BP.03 Other key populations, BP.04 Specific “accessible” populations, BP.05 General population and BP.06 Non-targeted interventions. This latter encompasses programmes that are considered cross-cutting in the HIV response or that have an indirect impact on populations (e.g. policy development, management, M&E etc). Beneficiaries coded under BP.01 People living with HIV and BP.05 General population can have a further disaggregation by age and gender. However, there was not enough data to capture such level of detail.

As expected, the majority of funding is benefiting people living with HIV (the recipients of all treatment and care services of the HIV Response), followed Non-targeted interventions (expenditure not belonging to explicitly selected targeted population, programmes that improve coordination and service delivery in general and are not population-specific by nature).



Table 15 Beneficiary Populations in 2016 and 2017

Beneficiary Population	2016	%	2017	%
BP.01 People living with HIV	\$ 47,087,831	52%	\$ 53,532,494	49%
BP.02.01 Injecting drug users (IDU) and their sexual partners	\$ 13,660,640	15%	\$ 14,087,267	13%
BP.02 Sex workers and their clients	\$ 2,498,727	3%	\$ 4,518,841	4%
BP.02.03 Men who have sex with men (MSM)	\$ 2,254,928	2%	\$ 2,919,905	3%
BP.02.98 "Key populations" not disaggregated by type	\$ 46,155	0%	\$ 173,133	0%
BP.03.01 Orphans and vulnerable children (OVC)	\$ 14,284	0%	\$ -	0%
BP.03.02 Children born or to be born of women living with HIV	\$ 2,213,802	2%	\$ 2,292,721	2%
BP.03.07 Prisoners and other institutionalized persons	\$ 965	0%	\$ 634	0%
BP.03.13 Partners of people living with HIV	\$ 77,618	0%	\$ 47,370	0%
BP.03.14 Recipients of blood or blood products	\$ 174,848	0%	\$ 213,667	0%
BP.03.98 Other key populations not disaggregated by type	\$ -	0%	\$ 139,691	0%
BP.04.01 People attending STI clinics	\$ 791,478	1%	\$ 780,285	1%
BP.04.02 Elementary school students	\$ 138,097	0%	\$ 125,102	0%
BP.04.03 Junior high/high school students	\$ 241,670	0%	\$ 218,929	0%
BP.04.05 Health care workers	\$ -	0%	\$ -	0%
BP.04.98 Specific "accessible" populations not disaggregated by type	\$ -	0%	\$ 334,747	0%
BP.05.98 General population not disaggregated by age or gender	\$ 5,711,990	6%	\$ 5,122,199	5%
BP.06 Non-targeted interventions	\$ 15,381,940	17%	\$ 24,993,911	23%
<b>Total</b>	<b>\$ 90,294,971</b>	<b>100%</b>	<b>\$ 109,500,896</b>	<b>100%</b>

People living with HIV benefit from 52% and 49% of total HIV spending in 2016 and 2017 respectively. Non targeted interventions represented 17% of the HIV spending in 2016 and 23% in 2017. Key populations, together, represented 20% of total HIV spending in 2016 and in 2017.

Figure 23 Beneficiary Populations in 2017 - chart

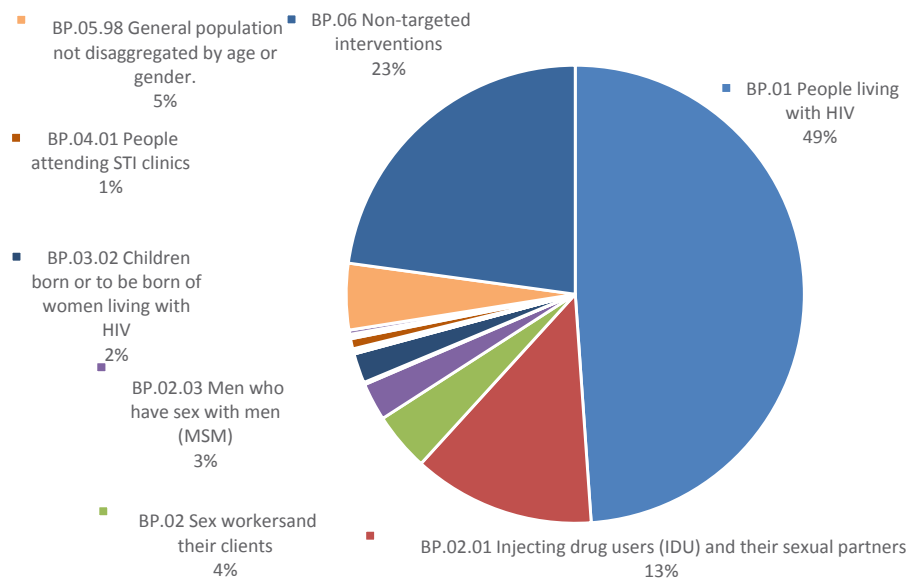


Table 16 shows the allocation of spending from the different funding sources into beneficiary populations in 2017.

Table 16 Beneficiary Populations per Funding Source in 2017

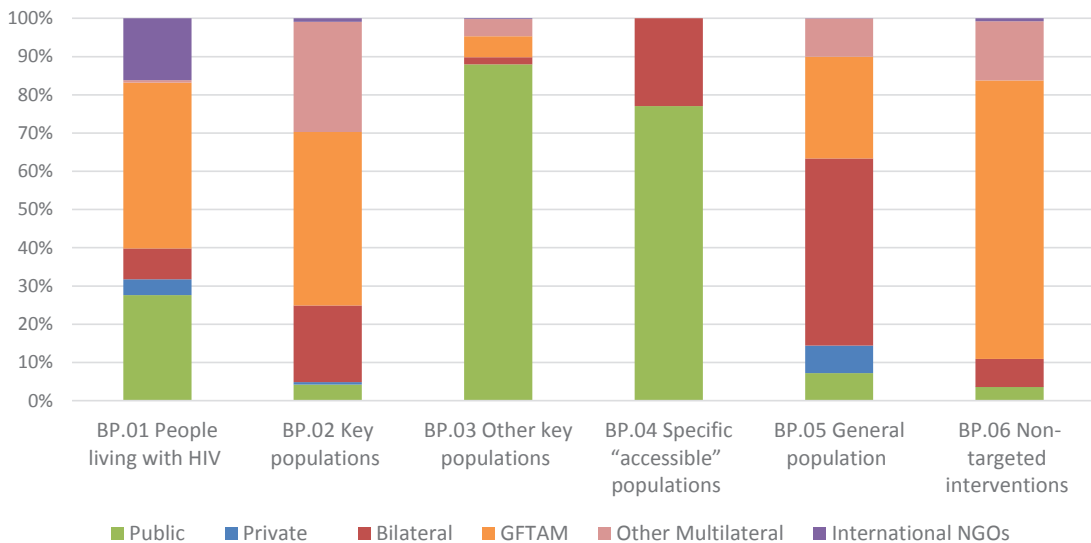
2017	Public	Private	Bilateral	GFATM	Other Multilateral	International NGOs	Total
BP.01 People living with HIV	14,799,543	2,240,062	4,300,156	23,255,294	364,239	8,659,750	53,619,044
BP.02 Key populations	921,400	131,232	4,362,193	9,851,305	6,255,639	189,195	21,710,963
BP.03 Other key populations	2,369,767	-	50,959	147,932	120,887	4,538	2,694,083
BP.04 Specific "accessible" populations	1,124,315	-	334,747	-	-	-	1,459,062
BP.05 General population	360,878	362,274	2,459,642	1,336,916	503,668	455	5,023,833
BP.06 Non-targeted interventions	888,437	10,764	1,832,347	18,206,934	3,861,039	194,391	24,993,911
<b>Total</b>	<b>20,464,340</b>	<b>2,744,331</b>	<b>13,340,044</b>	<b>52,798,381</b>	<b>11,105,473</b>	<b>9,048,328</b>	<b>109,500,896</b>

Public funding is the main source for programmes targeting accessible populations (People attending STI clinics, Elementary, Junior and High school students and Health care workers) and also targeting Other Key populations (Children born or to be born of women living with HIV for PMTCT activities, Partners of people living with HIV, Prisoners and other institutionalized persons and Recipients of blood or blood products).

The Global Fund is the Main funding source for Non-Targeted interventions (mainly for the overhead costs of both PRs), for People living with HIV (mainly ARV drugs) and for the programmes targeting Key populations, mainly through condom social marketing and other prevention activities.

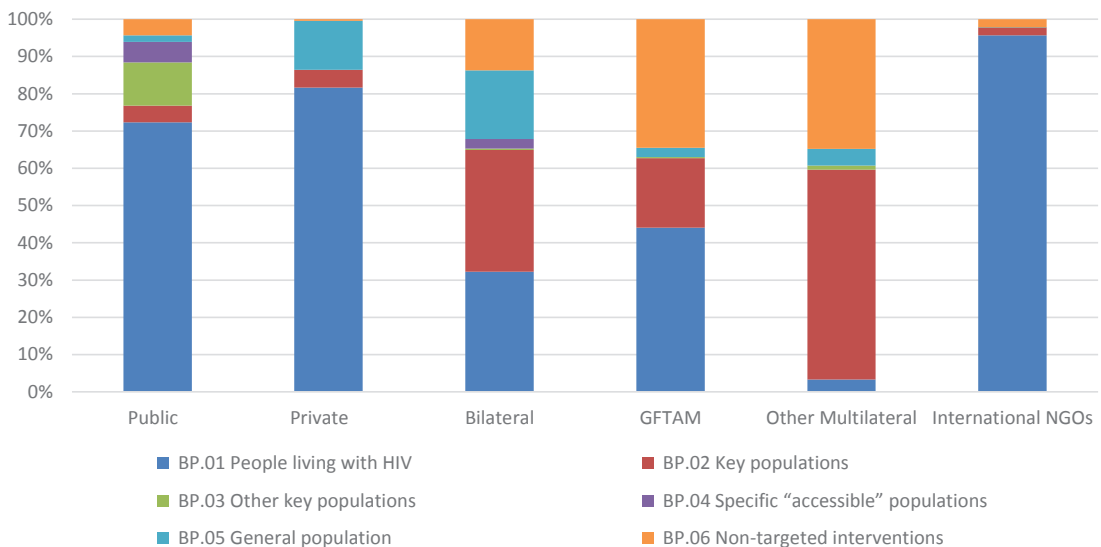
Bilateral sources are the main funding source for activities targeting the general population.

Figure 24 Beneficiary Populations per Funding Source in 2017 – chart



This data can also be analysed by funding source of programmes for different beneficiaries. In the case of public and private sources, the GFATM and international NGOs, PLHIV is the most funded beneficiary population. For bilateral and other multilateral sources such as the UN and the 3MDG funds, the key populations are the most funded beneficiary populations (figure 25).

Figure 25 Funding Source allocation of resources by Beneficiary Population in 2017 - chart



### 3.7. PROVIDERS

As well as in previous years, the majority of HIV services and programmes are still being implemented by the private sector non for-profit providers, however the public sector service provision is continuously expanding. The share of services provided in the public sector have increased both in absolute values and as a proportion of the total spending, from US\$ 5.3 million in 2012 (which represented 13% of the total service provision) to over US\$ 38 million in 2017 (representing 35% of the overall service provision expenditure). Civil society organizations or NGOs implemented more than half of the HIV response in 2017 (55%<sup>21</sup>).

Table 17 Providers of services in 2017

Providers	2016	%	2017	%
PS.01.01.01 Hospitals (Governmental)	\$ 11,060,628	12%	\$ 18,650,360	17%
PS.01.01.02 Ambulatory care (Governmental)	\$ 9,108,881	10%	\$ 10,338,358	9%
PS.01.01.05 Laboratory and imaging facilities (Governmental)	\$ 17,285	0%	\$ 14,218	0%
PS.01.01.06 Blood banks (Governmental)	\$ 174,848	0%	\$ 213,667	0%
PS.01.01.10.01 Primary education (Governmental)	\$ 138,097	0%	\$ 125,102	0%
PS.01.01.10.02 Secondary education (Governmental)	\$ 241,670	0%	\$ 218,929	0%
PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	\$ 6,092,104	7%	\$ 8,835,762	8%
PS.01.01.14.04 Departments inside the Ministry of Social Development or equivalent	\$ 62,137	0%	\$ 59,575	0%
PS.02.01.01.13 Research institutions (Non-profit non faith-based)	\$ 599,564	1%	\$ 851,627	1%
PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	\$ 54,288,748	60%	\$ 60,355,675	55%
PS.02.02.01 Hospitals (For profit)	\$ 1,332,835	1%	\$ 1,219,489	1%
PS.02.02.14 Consultancy firms (For profit)	\$ 335,070	0%	\$ 219,214	0%
PS.03.01 Bilateral agencies	\$ 151,550	0%	\$ 117,470	0%
PS.03.02 Multilateral agencies	\$ 6,691,555	7%	\$ 8,281,449	8%
<b>Total</b>	<b>\$ 90,294,971</b>	<b>100%</b>	<b>\$ 109,500,896</b>	<b>100%</b>

<sup>21</sup> NGOs working inside public hospitals and clinics were considered as providers of services during this and previous NASA studies. We maintained this classification in order to keep consistency with the way they were classified on previous NASAs. Nevertheless, it is important to mention that following National Accounting principles, NGOs providing services inside public care setting would not necessarily be considered Provider of Services. The provider would be the public clinic or hospital since it is the main responsible for the provision of services (the NGO would in this case be a Production Factor, providing services for the public hospitals and clinics).

The table below (Table 18) shows the main two service providers of each programmatic area -marked in a red cell. NGOs are the main service provider for most of the programmatic areas of the response, implementing 80% of Enabling environment activities, 77% of the Prevention, 76% Social protection and social services and 53% of Care and Treatment.

It is worth mentioning that NGOs implement 87% of the prevention programmes targeting Key populations.

*Table 18 AIDS Spending Category by Service Provider in 2017*

Providers	ASC.01 Prevention	ASC.02 Care and treatment	ASC.04 Programme management and administration	ASC.05 Incentives for Human resources	ASC.06 Social protection and social services	ASC.07 Enabling environment	ASC.08 HIV and AIDS-related research	Total
PS.01.01.01 Hospitals (Governmental)	6%	32%	0%	0%	0%	0%	0%	17%
PS.01.01.02 Ambulatory care (Governmental)	14%	12%	0%	1%	0%	0%	0%	9%
PS.01.01.05 Laboratory and imaging facilities (Governmental)	0%	0%	0%	0%	0%	0%	0%	0%
PS.01.01.06 Blood banks (Governmental)	1%	0%	0%	0%	0%	0%	0%	0%
PS.01.01.10.01 Primary education (Governmental)	0%	0%	0%	0%	0%	0%	0%	0%
PS.01.01.10.02 Secondary education (Governmental)	1%	0%	0%	0%	0%	0%	0%	0%
PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	0%	0%	35%	34%	15%	1%	0%	8%
PS.01.01.14.04 Departments inside the Ministry of Social Development or equivalent	0%	0%	0%	0%	9%	0%	0%	0%
PS.02.01.01.13 Research institutions (Non-profit non faith-based)	0%	0%	3%	0%	0%	5%	0%	1%
PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	77%	53%	30%	44%	76%	80%	100%	55%
PS.02.02.01 Hospitals (For profit)	0%	2%	0%	0%	0%	0%	0%	1%
PS.02.02.14 Consultancy firms (For profit)	0%	0%	1%	0%	0%	0%	0%	0%
PS.03.01 Bilateral agencies	0%	0%	1%	0%	0%	0%	0%	0%
PS.03.02 Multilateral agencies	0%	1%	30%	21%	0%	14%	0%	8%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

### 3.8. PRODUCTION FACTORS

In NASA, expenditures can be categorized in terms of resources used for the production, production factors or budgetary items, such as: wages, salaries, new buildings, renovations, etc. Production factors are categorized under two main categories, PF.01. Current expenditures and PF.02. Capital expenditures. This third NASA in Myanmar incorporates for the first time the analysis of HIV spending adding the Production Factors dimension.

Table 19 shows the national HIV spending for 2016 and 2017 according to its production factors. Almost 40% of HIV spending in 2017 was classified as “not disaggregated by type” category (PF.01.98 Current expenditures not disaggregated by type, PF.02.98 Capital expenditure not disaggregated by type or PF.98 Production factors not disaggregated by type). This refers to data for which not enough information was available to further classify it into a more specific PF category.

*Table 19 AIDS Spending Production Factors in 2016 and 2017*

Production Factors	2016	%	2017	%	Var. 2017-2016	Var. %
PF.01.01.01 Wages	11,595,061	13%	18,106,197	17%	6,511,136	56%
PF.01.01.03 Non-wage labour income	50,823	0%	-	0%	- 50,823	-100%
PF.01.01.98 Labour income not disaggregated by type	4,630,581	5%	26,195	0%	- 4,604,386	-99%
PF.01.02.01.01 Antiretrovirals	19,278,107	21%	16,286,034	15%	- 2,992,073	-16%
PF.01.02.01.02 Other drugs and pharmaceuticals (excluding ARVs)	5,150,440	6%	8,886,935	8%	3,736,495	73%
PF.01.02.01.03 Medical and surgical supplies	192,745	0%	474,722	0%	281,977	146%
PF.01.02.01.04 Condoms	129,174	0%	1,189,736	1%	1,060,563	821%
PF.01.02.01.05 Reagents and materials	3,544,462	4%	4,343,125	4%	798,662	23%
PF.01.02.01.06 Food and nutrients	890,098	1%	569,702	1%	- 320,396	-36%
PF.01.02.01.98 Material supplies not disaggregated by type	1,032,966	1%	464,320	0%	- 568,646	-55%
PF.01.02.01.99 Other material supplies n.e.c.	145,682	0%	94,053	0%	- 51,629	-35%
PF.01.02.02.01 Administrative services	2,178,569	2%	1,275,032	1%	- 903,536	-41%
PF.01.02.02.02 Maintenance and repair services	117,419	0%	215,940	0%	98,521	84%
PF.01.02.02.03 Publisher, broadcasting and programming services	188,980	0%	227,121	0%	38,141	20%
PF.01.02.02.04 Consulting services	1,662,697	2%	1,382,589	1%	- 280,108	-17%
PF.01.02.02.05 Transportation and travel services	1,635,460	2%	1,225,407	1%	- 410,053	-25%

Production Factors	2016	%	2017	%	Var. 2017-2016	Var. %
PF.01.02.02.08 Financial intermediation services	1,647	0%	308	0%	- 1,339	-81%
PF.01.02.02.98 Services not disaggregated by type	3,031,717	3%	4,469,529	4%	1,437,812	47%
PF.01.02.02.99 Services n.e.c.	-	0%	5,972	0%	5,972	N/A
PF.01.98 Current expenditures not disaggregated by type	15,219,679	17%	19,700,191	18%	4,480,512	29%
PF.02.01.01 Laboratory and other infrastructure upgrading	8,124	0%	950,173	1%	942,049	11596%
PF.02.01.02 Construction of new health centres	-	0%	945,728	1%	945,728	N/A
PF.02.01.98 Buildings not disaggregated by type	26,014	0%	9,973	0%	-16,041	-62%
PF.02.02.01 Vehicles	40,337	0%	124,327	0%	83,990	208%
PF.02.02.02 Information technology (hardware and software)	717,681	1%	3,576,621	3%	2,858,940	398%
PF.02.02.03 Laboratory and other medical equipment	1,240,891	1%	1,773,029	2%	532,138	43%
PF.02.02.98 Equipment not disaggregated by type	146,799	0%	230,991	0%	84,192	57%
PF.02.98 Capital expenditure not disaggregated by type	399,379	0%	316,209	0%	- 83,170	-21%
PF.02.99 Capital expenditure n.e.c.	-	0%	229,218	0%	229,218	N/A
PF.98 Production factors not disaggregated by type	17,039,440	19%	22,401,519	20%	5,362,079	31%
<b>Grand Total</b>	<b>90,294,971</b>	<b>100%</b>	<b>109,500,896</b>	<b>100%</b>	<b>19,205,925</b>	<b>21%</b>

Wages and Antiretrovirals were the biggest production factor categories in 2017, capturing 17% and 15% of total HIV spending, followed by Other drugs and pharmaceuticals (8%).

### 3.9. DATA COLLECTED DETAILS

The data collected and processed has different characteristics for each NASA assessment. The following tables show an overview of how data was collected and summarized in this third NASA implementation in Myanmar.

Table 20 Data Collection for 2017

Data Collection	2016	%	2017	%	Var. 2017-2016	Var. %
↑ Bottom up	\$ 22,016,070	24%	\$ 25,312,082	23%	\$ 3,296,012	15%
↓ Top down	\$ 27,344,373	30%	\$ 38,681,024	35%	\$ 11,336,651	41%
↕ Bottom up & Top down	\$ 40,934,529	45%	\$ 45,507,791	42%	\$ 4,573,262	11%
<b>Total</b>	<b>\$ 90,294,971</b>	<b>100%</b>	<b>\$ 109,500,896</b>	<b>100%</b>	<b>\$ 19,205,925</b>	<b>21%</b>

Table 21 Type of data for 2017

Type of Data	2016	%	2017	%	Var. 2017-2016	Var. %
Budget figures	\$ 30,303,264	34%	\$ 23,397,183	21%	-\$ 6,906,080	-23%
Estimated (PxQ)	\$ 4,506,516	5%	\$ 5,856,020	5%	\$ 1,349,503	30%
Reported expenditures	\$ 55,485,192	61%	\$ 80,247,693	73%	\$ 24,762,502	45%
<b>Total</b>	<b>\$ 90,294,971</b>	<b>100%</b>	<b>\$ 109,500,896</b>	<b>100%</b>	<b>\$ 19,205,925</b>	<b>21%</b>

Table 22 Source of Data for 2017

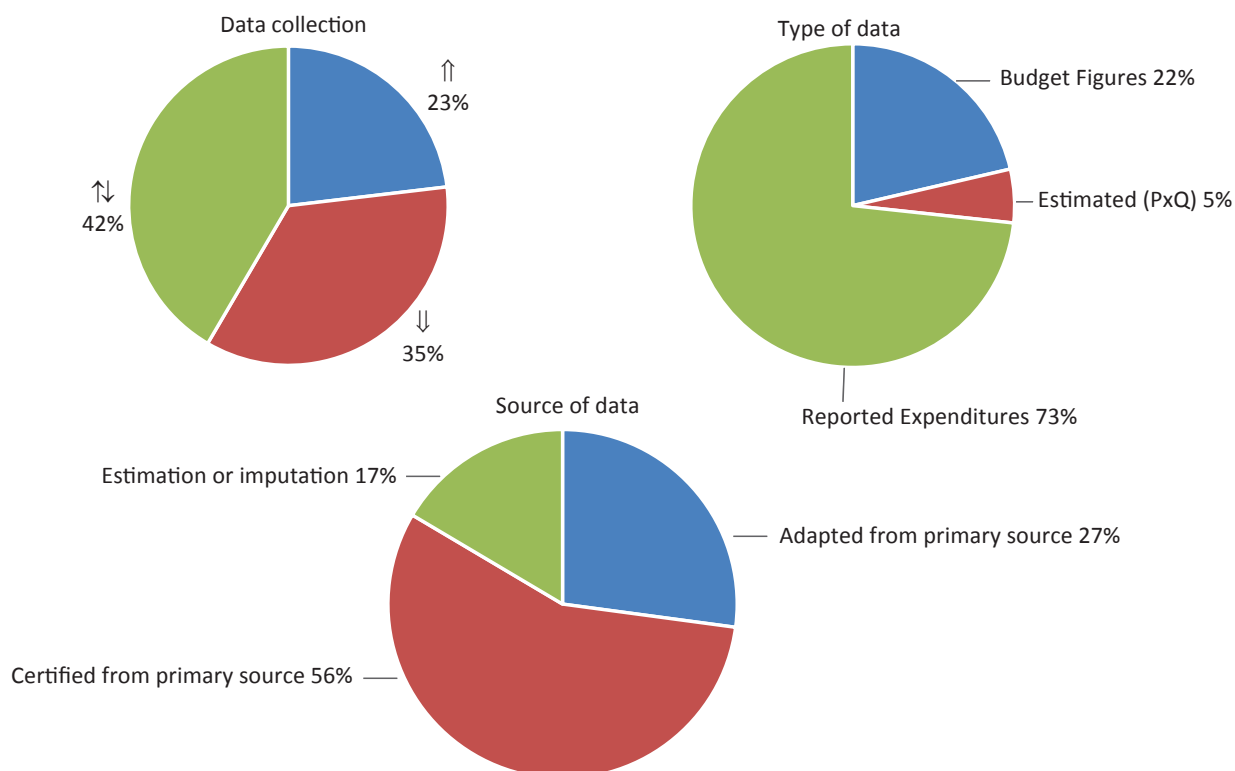
Source of Data	2016	%	2017	%	Var. 2017-2016	Var. %
Adapted from primary source	\$ 31,266,977	35%	\$ 29,705,164	27%	-\$ 1,561,814	-5%
Certified from primary source	\$ 47,241,327	52%	\$ 61,746,988	56%	\$ 14,505,661	31%
Estimation or imputation	\$ 11,786,667	13%	\$ 18,048,745	16%	\$ 6,262,077	53%
<b>Total</b>	<b>\$ 90,294,971</b>	<b>100%</b>	<b>\$ 109,500,896</b>	<b>100%</b>	<b>\$ 19,205,925</b>	<b>21%</b>

Most of the expenditures collected were collected “top down”, meaning that the information was received by the source (FS) or the agent (FA) without being able to validate the actual expense of spending to the provider level, due to, mainly, time constraint.

In relation to the type of data collected, in 2017 most of the expenditures (73%) were reported expenditures (as opposed to budget figures or estimates). It is also worth mentioning that more than half of the spending data (56%) was Certified from the primary source.



Figure 26 Data collection, type and source for 2017



### 3.10. SUB NATIONAL ALLOCATION OF HIV SPENDING (PILOT STUDY)

During this assessment the NASA team did the first attempt to reconstruct the geographical allocation of HIV spending in Myanmar. The pilot exercise showed that it is possible to do a NASA with geographical allocation of Spending in the country. Nonetheless, it would require a larger NASA team, a longer data collection period, and an extra effort by all organizations involved in the HIV response to report data on a more detailed level.

Table 23 HIV spending by region 2016 and 2017

Location	2016	%	2017	%
Bago	N/A		\$ 2,030	0%
Eastern Shan State and Special Regions	\$ 717,764	1%	\$ 441,545	0%
Kachin	\$ 648,425	1%	\$ 608,941	1%
Mandalay	N/A		\$ 2,030	0%
National spending	\$ 3,140,925	3%	\$ 4,352,925	4%
Tanintharyi	\$ 2,096,186	2%	\$ 1,228,589	1%
Yangon	\$ 1,750,032	2%	\$ 2,562,624	2%
Not disaggregated by region	\$ 81,941,639	91%	\$ 100,302,212	92%
<b>Total</b>	<b>\$ 90,294,971</b>	<b>100%</b>	<b>\$ 109,500,896</b>	<b>100%</b>

Table 24 HIV spending by region and Financing Source 2016 and 2017

Location	FS.01 Public funds	FS.02 Private Funds	FS.03 International funds	Total
Bago			\$ 2,030	\$ 2,030
Eastern Shan State and Special Regions			\$ 441,545	\$ 441,545
Kachin			\$ 608,941	\$ 608,941
Mandalay			\$ 2,030	\$ 2,030
National spending	\$ 888,437		\$ 3,464,489	\$ 4,352,925
Not disaggregated by region	\$ 18,615,314	\$ 1,253,734	\$ 80,433,164	\$ 100,302,212
Tanintharyi			\$ 1,228,589	\$ 1,228,589
Yangon	\$ 960,589	\$ 1,490,597	\$ 111,438	\$ 2,562,624
<b>Total</b>	<b>\$ 20,464,340</b>	<b>\$ 2,744,331</b>	<b>\$ 86,292,225</b>	<b>\$ 109,500,896</b>

Table 25 HIV spending by region and AIDS Spending Category 2016 and 2017

Location	ASC.01 Prevention	ASC.02 Care and treatment	ASC.04 Programme management and administration	ASC.07 Enabling environment	Other	Total
Bago	2,030	-	-	-	-	2,030
Eastern Shan State and Special Regions	42,159	378,059	1,613	2,536	17,179	441,545
Kachin	596,082	11,538	-	1,321	-	608,941
Mandalay	2,030	-	-	-	-	2,030
National spending	-	-	3,875,243	280,283	197,399	4,352,925
Not disaggregated by region	28,358,063	49,341,207	18,821,219	1,252,534	2,529,189	100,302,212
Tanintharyi	195,849	697,607	248,127	-	87,006	1,228,589
Yangon	517,653	1,999,329	25,685	6,186	13,772	2,562,624
<b>Total</b>	<b>29,713,865</b>	<b>52,427,739</b>	<b>22,971,886</b>	<b>1,542,860</b>	<b>2,844,546</b>	<b>109,500,896</b>

A complete regional analysis of spending would provide detailed information on all NASA variables on each region (Sources, ACS, Beneficiaries, Providers, Agents and Production Factors).

## 4. CONCLUSIONS AND RECOMMENDATIONS

### CONCLUSIONS

The spending assessment revealed that there has been a continued increase in HIV spending in Myanmar between 2012 and 2017, from US\$ 39.4 million in 2012 to US\$ 109.5 million in 2017. This increase is explained by the interest of foreign donors to support the national response, as well as to the greater participation of the Government in its financing.

Public spending increased 29 times between 2012 and 2017, from US\$ 0.7 million to US\$ 20.5 million, with the share of public increasing from 2% in 2012 to 19% in 2017. It is also worth mentioning that Public spending reached in 2017 the goal of 1 US\$ million on Methadone maintenance treatment.

Despite this significant increase in public funding, the country depends to a large extent on international funding to maintain the growing pace of its national HIV response, with international funds covering 80% of the national HIV spending in 2017.

Care and Treatment represents 49% in 2016 and 48% in 2017 of total HIV spending. Followed by Prevention (30% and 27%) and Programme management and administration (16% and 21%). The HIV response in Myanmar has, over the years, improved the allocation of its resources into programmes that have the higher impact in the national Epidemic. An example of this is the fact that prevention programmes targeting Key populations (IDU, MSM, FSW) reached in 2017 20% of overall HIV spending as well as Antiretroviral therapy, which also represented 20% of total HIV spending in 2017.

The main beneficiaries of the HIV response are people living with HIV, receiving 52% and 49% of total HIV spending in 2016 and 2017 respectively.

Civil society organizations and NGOs implemented in 2017 more than half of the HIV response in Myanmar (55%).

The third NASA incorporated the analysis of the HIV spending production factors. This analysis shows that almost 40% of HIV spending in 2017 had to be classified as a “not disaggregated by type” category (PF.01.98 Current expenditures not disaggregated by type, PF.02.98 Capital expenditure not disaggregated by type or PF.98 Production factors not disaggregated by type) due to lack of enough information to further classify it into a more specific PF category. Wages and Antiretrovirals were the biggest production factor categories in 2017, capturing 17% and 15% of total HIV spending, followed by Other drugs and pharmaceuticals (8%).

## RECOMMENDATIONS

In order to reach the Fast Track targets and a Universal Health Coverage, continued adequate funding of the HIV response is needed. The increase in domestic public funding should be accelerated, in particular as the current international funding environment is expected to decline or stagnate.

While shifting from international to public funding, particular care needs to be considered in maintaining an adequate funding to activities that have the largest impact on the epidemic, but are currently highly dependent from donor funding, such as programmes targeting Key populations and ARV treatment, and to critical enablers of the response, such as Human Rights programmes. A transition financial plan to ensure the progressive shift from international to public funding is needed.

It is recommended to implement a subnational monitoring of HIV spending in the near future to analyse whether resources are being allocated where the epidemic is concentrated.

To produce more detailed information at the production factors level and subnational data, there is a need to strengthen the NASA process, with more human resources and organizations involved in the process, and with a larger data collection and data analysis period of time.

Furthermore, in future NASA rounds, an additional effort will be needed to access and collect data from the private corporate sector.

Institutionalisation of the NASA exercise will require efforts to build the national capacity ensuring a cheaper data collection system that can be sustained over time.

## APPENDIX 1: LIST OF INSTITUTIONS WHICH REPORTED DATA

#	Name	Main Role in NASA transaction	Type
1	Asian Harm Reduction Network	Provider	International NGO
2	Alliance	Provider	International NGO
3	Aye Myanmar Association	Provider	Local NGO
4	Burnet	Provider	International NGO
5	Clinton Health Access Initiative	Source	International NGO
6	Cipla	-	Pharmaceutical comp
7	Community Partners International	Provider	International NGO
8	Drug Dependence Treatment and Research Unit	Provider	Government institution
9	Future Light	Provider	National NGO
10	Hetero	Provider	Pharmaceutical comp
11	Health Poverty Action	Provider	International NGO
12	ICAP Columbia University	Agent	International NGO
13	IOM	Agent	UN
14	Japan Fund for Poverty Reduction / Asian Development Bank	Provider	Multilateral
15	Japan International Cooperation Agency	Source	Bilateral
16	Malteser	Provider	International NGO
17	Medical Action Myanmar	Provider	International NGO
18	Myanmar Anti Narcotic Association	Provider	International NGO
19	Médecins du Monde	Provider	International NGO
20	Myanmar Interfaith Network on AIDS	Provider	National NGO
21	Myanmar MSM Network	Provider	National NGO
22	Ministry of Education	Source	Ministry
23	Ministry of Health and Sports	Source	Ministry
24	Moon Shade Karuna Association	Provider	National NGO
25	Ministry of Social Welfare, Relief and Resettlement MOSW	Source	Ministry
26	Myanmar Positive Group	Provider	National NGO

#	Name	Main Role in NASA transaction	Type
27	Médecins Sans Frontières -CH	Source	International NGO
28	Médecins Sans Frontières -Holland	Source	International NGO
29	Marie Stopes International	Source	International NGO
30	Mylam	Provider	Pharmaceutical comp
31	National AIDS Program	Agent	Government institution
32	National AIDS Program -Ware house	Agent	Government institution
33	National Blood Center	Provider	Government institution
34	National Health Laboratory	Provider	Government institution
35	OKKA Thiri	-	Medical equipment comp
36	Pyi Gyi Khin	Provider	National NGO
37	Public Health Laboratory	Provider	Government institute
38	Project Management Unit, Capacity Building HIV/AIDS Project	-	Government institute
39	Population Services International	Source	International NGO
40	Première Urgence – Aide Médicale Internationale	Provider	International NGO
41	Red Cross	Provider	National NGO
42	Substance Abuse Research Association	Provider	International NGO
43	Save the Children (GFATM PR)	Agent	International NGO
44	Save the Children	Provider	International NGO
45	SCMS/Chemonics (GHSC-PSM)	Provider	For profit
46	UNAIDS	Source	UN
47	UNICEF	Source	UN
48	UNION	Provider	International NGO
49	UNODC	Source	UN
50	UNOPS (3MDG PR)	Agent	UN
51	UNOPS (GFATM PR)	Agent	UN
52	USAID	Source	Bilateral
53	WFP	Source	UN
54	WHO	Source	UN

## APPENDIX 2: METHODOLOGICAL NOTES

### EXCHANGE RATE USD TO MMR KYAT

The results of the assessment are presented in US Dollars. When the data was reported in the local currency, Myanmar Kyat (MMK), the following exchange rate has been applied to convert the amounts in to US Dollars: in 2016 1 US Dollar = 1,232.3 MMK and in 2017 1 US Dollar = 1,360.3 MMK.

Source: <https://forex.cbm.gov.mm/index.php/fxrate/history>

### ASSUMPTIONS AND CALCULATION STRATEGY

#### Government procurement of drugs and reagents

The cost for antiretroviral, OI drugs, Methadone and STI drugs were estimated from procurement data rather than consumption<sup>22</sup>.

Procurement of pharmaceutical products of government funds is carried out by UNOPS.

Procurement data was available in three categories such as: “Antiretrovirals”, “Methadone” and “Others”.

All antiretroviral spending was classified as “ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment.” (since it was not possible to disaggregate the procurement of ARV between first- and second-line treatments), BP.01.98 People living with HIV not disaggregated by age or gender and PF.01.02.01.01 Antiretrovirals.

The category “Others” was revised item by item and further classified by the NASA team into “STI” (for TPHA test for Syphilis detection) and “HIV testing” (detection test kits) and “Viral load and CD4” (for calibration kits, reagent kits, collection kits, etc), in order to properly classify it into a NASA ASC.

In order to classify the service provider of ART, laboratory monitoring and provider-initiated testing, we used the number of ART patients of clinics and hospitals to identify an attribution rate.

Site	No. ART Patients (Public)	% structure
Clinics	32,314	31%
Hospitals	70,608	69%

Based on this the transactions were classified as PS.01.01.01 Hospitals (Governmental) for 69% of the ART spending and PS.01.01.02 Ambulatory care (Governmental) for the remaining 31%.

PS.01.01.01 Hospitals (Governmental)	69%
PS.01.01.02 Ambulatory care (Governmental)	31%

<sup>22</sup> This is consistent with the way it was done on previous NASAs in MMR, but the NHA and NASA methodology recommends using consumption data in order to reflect the actual implementation of programmes, for this reason more efforts to cost the consumption of ARVs and other key drugs should be taken before or during the next NASA implementation.

### Government decentralized sites HR costs

There were 126 general hospitals (decentralized sites) in 2016 and 174 in 2017 providing ART across the country. Staffing costs in these hospitals were calculated based on the number of staffs per facility according to their capacity / number of beds: 20% of full-time equivalent staff for 25-50 bed hospitals; 30% for 100 bed hospitals and 30%-50% for  $\geq 200$  bed hospitals, depending on the case load).

The minimum health personnel considered to calculate human resources costs, by types of personnel, required to provide ART at these hospitals were the following:

Minimum staffing requirements of the hospitals		
Type of hospital – number of beds	Type of health personnel	Number of personnel
More than 200 beds	Physician	1
	Assistant Surgeon	1
	Paediatrician	1
	Assistant Surgeon	1
	Pathologist +1	2
	Laboratory Technician (grade 1)	1
	Laboratory Technician (grade 2)	1
	Medical Social Worker	2
	Pharmacist	1
	Nurse	2
100 beds	Physician	1
	Assistant Surgeon	1
	Paediatrician	1
	Assistant Surgeon	1
	Laboratory Technician (grade 1)	1
	Laboratory Technician (grade 2)	1
	Nurse	2
	Counsellor	1
	Compounder	1
25-50 beds	Township Medical Officer	1
	Assistant Surgeon	1
	Laboratory (grade 1)	1
	Compounder	1
	Nurse	1
	Counsellor	1

### ARV prophylaxis for HIV-infected pregnant women and new-borns

The cost of ARV prophylaxis for pregnant women was calculated based on the Guidelines for the Clinical Management of HIV Infection in Myanmar, 5th ed.<sup>23</sup> and the procurement cost of NVP syrup and of AZT.

<sup>23</sup> [https://aidsfree.usaid.gov/sites/default/files/mmr\\_hiv\\_guidelines\\_2017.pdf](https://aidsfree.usaid.gov/sites/default/files/mmr_hiv_guidelines_2017.pdf)



Dosing of NVP based on MMR ART guidelines	6 weeks ARV
NVP. 1d x 6 weeks 1.5 ml syrup daily	\$ 1.39
AZT 10 mg 2d x 6 w 1.5 ml twice daily	\$ 2.66
Total Prophylaxis	\$ 4.05

The estimated prophylaxis cost of ARVs was applied to the total number of HIV positive births (4,474 in 2016 and 4,553 in 2017). The estimated expenditure was therefore US\$ 18,120 and US\$ 18,440 in 2017. This expenditure was classified as ASC.01.17.02 Antiretroviral prophylaxis for HIV-infected pregnant women and new-borns, BP.03.02 Children born or to be born of women living with HIV and PF.01.02.01.01 Antiretrovirals.

### NAP central unit costs

Expenditure of the National AIDS Programme central unit (including salary, travel, infrastructure, and maintenance costs) was assigned under the category of programme management, ASC.04.01. Planning, coordination, and programme management.

### PMTCT safe delivery practices

There were no costs available of safe delivery practices in Myanmar. We used the Costs of vaginal delivery and Caesarean section at a tertiary level public hospital in Islamabad, Pakistan for 2010<sup>24</sup>. We excluded capital costs from the unit costs estimation, since this are not considered in NASA.

<b>Cost 1 C-Section - hospital side</b>		<b>\$ 162.0</b>
Cost 1 C-Section - Capital Cost (excluded in NASA)	16.8%	\$ 27.2
Cost 1 C-Section - exc. Capital Costs		\$ 134.8

ASC.01.17.04 Delivery practices as part of PMTCT programmes total cost = Total number of HIV positive pregnancies x C-Section unit cost:

Total Positive pregnancies 2017	C-Section Unit Cost	Total Cost
4,553	\$ 134.8	\$ 613,672

### PMTCT VCT staff costs

The cost of staff costs for HIV counselling and testing was estimated based on the number of pregnant women attending antenatal clinics and the ANC protocol.

The human resource costs of the counselling sessions were estimated based on the average Nurse salary, the number of pregnant women who tested positive in ANCs and the assumption that all these women attended two counselling 15 minutes sessions, pre and post testing. The estimated expenditures were classified as ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes, BP.03.02 Children born or to be born of women living with HIV and PF.01.01.01 Wages.

<sup>24</sup> <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-2>

ANCs counselling and testing HR	2016	2017
Nurse / Midwife Monthly Salary	\$ 121	\$ 121
Nurse / Midwife 15 minutes Salary	\$ 0.010	\$ 0.010
Time spent per counselling in minutes	15	15
No. of counselling per PW	\$ 2.00	\$ 2.00
Women attending ANCs who tested positive for HIV	885,632	995,262
Salaries for PMTCT counselling and testing Total Cost	\$ 258,223	\$ 290,188

### PMTCT counselling and testing reagents' costs

The cost of the reagents used in counselling and testing in PMTCT programmes was estimated based on the number of HIV tests carried out and the average cost of HIV test. The cost of confirmatory tests for positive tests was also considered. These costs were deducted from the procurement data on reagents kits in order to avoid double counting.

Item.	Category	Description	Unit	Pack Size	Quantity Contracted	Unit cost (USD)	Total cost (USD)
153	Others	HIV 1 + 2 Determine Test	Test	100 tests/kit	1,361,700	\$ 1.00	\$ 1,366,466
154	Others	HIV 1+2 Determine test kit for NAP-MOH (2017)	Test	100 tests/kit	473,400	\$ 1.00	\$ 471,682
155	Others	HIV 1+2 Unigold rapid test kit for NAP-MOH (2017)	Test	20 tests/kit	13,740	\$ 1.58	\$ 21,767
211	Others	Stat-Pak HIV 1/2 Kit, 30 Tests	Test	30 tests/kit	87,210	\$ 1.00	\$ 86,919
<b>Total</b>					<b>1,936,050</b>	<b>\$ 1.01</b>	<b>\$ 1,946,834</b>
					<b>Test Kit average Cost - 2017</b>	<b>\$ 1.01</b>	

Number of HIV tests x HIV test unit cost = Total Cost.

Total HIV tests 2016: 885,632 Total HIV tests 2017: 995,262

Total Positive tests 2016: 4,474 Total Positive tests 2017: 4,553

Total estimated cost: US\$ 1,009,963 Total estimated cost: US\$ 899,563

New-born are also tested. We estimated the cost of 2 tests for 80% of every HIV positive New-born. Kids are tested twice when they are breast fed, we assume 80% of all kids are breast fed in MMR<sup>25</sup>. The new-born testing cost includes the cost of an Abbott Sample Preparation System DNA (US\$ 4,6), Abbott Real Time HIV-1 Control Kit (US\$ 0,9) and 1 Abbott Real Time

<sup>25</sup> <https://www.unicef.org/breastfeeding/>

HIV-1 Qualitative Amplification Reagent Kit (US\$ 15). The estimated reagents cost adding up to US\$ 20,50. Applying this cost twice for 80% of New-borns and once for the remaining 20% who are only tested once, totalled up to US\$ \$168,038 in 2017 and US\$ 165,122 in 2016. This was classified as ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes, BP.03.02 Children born or to be born of women living with HIV and PF.01.02.01.05 Reagents and materials.

### **OOPE ART and specific HIV-related laboratory monitoring**

Out of pocket expenditures to purchase antiretroviral treatment in private clinics has been partially estimated in this third NASA implementation. It was very difficult to access to data from the private sector, and only two Pharmaceutical Suppliers based in Myanmar shared their data with the NASA team. The OOPE expenditure on ART was then estimated based on the data received of number of patients in first- and second-line treatment schemes and the average cost of each treatment in private clinics. This expenditure is therefore underestimated. Hopefully more efforts and a higher collaboration from the private sector will allow a more precise estimation in future NASA implementations in MMR. The type of data required for an estimation of OOPE on ART either can be total number of patients that the pharmaceutical company provided ARV drugs or number of patients treated in each and every private hospital across the country. The development of HIV/AIDS reporting system from private sector should be considered and would solve this current lack of comprehensive information.

### **Prevention spending targeting Key populations**

In a few cases some partners reported spending data for prevention activities targeting Key populations in an aggregated manner (for example, spending for implementing prevention programmes for PWID, FSW and MSM), rather than splitting the amount into each group. Whenever this amount was below US\$ 50,000, it was divided by thirds and attributed 1/3 of the spending into each KAPs. For amounts that were above US\$ 50,000 the NASA team reverted to the organisation to obtain a breakdown of the spending according to NASA requirements. This procedure was established in order to reach the agreed deadlines for data collection and process since the follow up with the organizations for further clarifications on the data received was highly time consuming.

### **AIDS/STD HIV Clinic Cost**

In 2017 STD HIV Clinics in Myanmar had 49 officer and 115 non-officer staff, with an annual cost of salaries of US\$ 378,420. In order to estimate non staff costs we considered the staff and non-staff cost of the AIDS/STD team Clinics in Yangon region and applied it to the national figures as per the table below.

Items	2016-2017	%	2017-2018	%
Staff salary	119,378,656 K	92%	112,762,249 K	91%
Others (travel cost, uniform, office equipment, etc.)	9,797,802 K	8%	11,508,624 K	9%
<b>Total</b>	<b>129,176,458 K</b>	<b>100%</b>	<b>124,270,873 K</b>	<b>100%</b>

In order to classify the AIDS/STD HIV Clinics national annual costs into specific AIDS Spending Categories, we used an attribution key based in the number of visits of the La Thar AIDS/STD Yangon Clinic (national figures were not available).

Number of Patients and Consultations	2016	2017	2016 % Structure	2017 Structure
Total number of STD Visits	82,103	76,849	75%	69%
HTS	2,467	3,287	2%	3%
Total number of ARV patients	24,571	32,043	23%	29%
<b>Total</b>	<b>109,141</b>	<b>112,179</b>	<b>100%</b>	<b>100%</b>

Using this attribution rate, the overall spending was assigned into the following ASCs:

- ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI) (75% and 69% in 2016 and 2017 respectively)
- ASC.01.03 HIV testing services (HTS) (2% and 3% in 2016 and 2017 respectively)
- ASC.02.01.98 Outpatient care services not disaggregated by intervention (23% and 29% in 2016 and 2017 respectively)

### VDRL Tests in ANCs

Pregnant women undergo a test for Syphilis detection. We estimated the cost of this activity multiplying the total number of tests realized by the average cost of the test. Based on procurement data we identified the average cost of TPHA test for Syphilis detection.

Number of Primigravida's who undergo for syphilis test (VDRL test): 116,459 in 2016 and 295,570 in 2017.

TPHA test for Syphilis detection average procurement cost: US\$ 1,67 in 2016 and 2017.



Total cost: US\$ 194,875 2016 and US\$ 494,587 in 2017.

The estimated expenditures were classified as ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI), BP.04.01 People attending STI clinics and PF.01.02.01.05 Reagents and materials.

## APPENDIX 3: DATA COLLECTION FORMS

The data collection form used for this Myanmar NASA was adapted from the standard form, which was developed by UNAIDS for use in different countries. This was the third time such a data collection tool was used to capture expenditure data in Myanmar.

It was sent to respondents by email. The form required respondents to provide the following information for each reported unit of spending: financing source; name of projects; project activity with a brief description; intended beneficiary; and amounts spent by the organisation itself and/or transferred to other organisations. The respondents could also include in-kind contributions such as condoms and medicines. For future NASA implementations it will be necessary to incorporate the PF and geographical information into the data collection template.

	A	B	C	D	E	F	G	H	I	J	K	
1												
2		<b>Myanmar - National AIDS Spending Assessment (NASA for 2016 and 2017)</b>										
3												
4		Full Name of Organisation	<input type="text"/>									
5												
6		Acronym of Organisation	<input type="text"/>									
7												
8		Address of Organisation:	<input type="text"/>									
9			<input type="text"/>									
10			<input type="text"/>									
11												
12												
13		<b>Contact person (Who fills in the form)</b>										
14		Full name:	.....									
15		Position:	.....									
16		Telephone (Office/ Mobile):	.....									
17		Email:	.....									
18		Address:	.....									
19												
20												
21		<b>The reported information is used in an aggregate manner only. The use of the reported information is strictly confidential and the ethic and administrative responsibility is ensured by the NASA Taskforce</b>										
22												
23												
24												
25		Year of report:										
26		Total HIV-related Funds received by your organisation	2016	2017								
27		Funds Transferred to other organisations										
28		Funds Spent by your organisation (excl. funds transferred)										
29		TOTAL	-	-								
30												
31		Currency reported:	US Dollar	US Dollar								
32			(Select the currency on which figures are reported on each year. Please specify the name of the currency in case it is not mentioned on the drop down menu)									

	A	B	C	D	E	F	G	H	I	
1										
2										
3		<b>Resources Used in 2017</b>								
4		In the survey below, we ask you to report on: <b>sources</b> of your 2015 HIV/AIDS funding as well as the <b>title</b> and <b>description</b> of each project or activity your organization implemented; names of other organizations to which you transferred project funding, if applicable; the <b>actual amount spent</b> on each project or activity; and the <b>beneficiary population(s)</b> reached, including the <b>number reached</b> , if possible. For the Total Activity Amount, only include direct project costs that are spent in the country (e.g. clinic support, condom distribution, or in-country project office costs). Exclude indirect costs that support functions performed outside of the country (e.g. administrative costs of a home office abroad).								
5		<b>Financial resources used for specific activities</b>								
6		<b>NOTE: (I) Use one line per Beneficiary Population for the same activity. (II) Use a different row to report on funds used and another row for funds transferred even if both refer to the same activity.</b>								
7										
8										
9										
10		*	Financing source (Origin of the funds)	Name of Project	Name of Activity	Description of Activity (Provide brief description of the scope of each activity in 1-2 sentences)	If funds are transferred to other organisation, please specify the name of the organization	Currency reported: US Dollar If funds were used implementing programmes/activities by your organization, please specify Total Activity Amount (Expenditures, not budgeted amounts)	Beneficiary Population (Please select one type of Beneficiary Population from the drop down list.)	Comments
11										
12										
13										
14										
15										
16										

# APPENDIX 4: 2017 SELECTED NASA MATRIXES

## Finances Sources x Financing Agents – 2017

FAO1.01.01.01 Ministry of Health (or equivalent sector entity)	20,043,700	FS.01.01 Central government revenue	FS.02.01 For-profit institutions and corporations	FS.02.02 Households' funds	FS.02.03 Not-for-profit institutions (other than social insurance)	FS.03.01.07 Government of France	FS.03.01.12 Government of Japan	FS.03.01.14 Government of Netherlands	FS.03.01.22 Government of United States	FS.03.02.06 Regional Development Banks (Africa, Latin America and the Caribbean, Islamic, Development Bank, etc.)	FS.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FS.03.02.08 UNAIDS Secretariat	FS.03.02.09 United Nations Children's Fund (UNICEF)	FS.03.02.19 World Food Programme (WFP)	FS.03.02.20 World Health Organization (WHO)	FS.03.02.99 Multilateral funds or development funds n.e.c.	FS.03.03.20 Médecins sans Frontières	FS.03.03.99 Other international not-for-profit organizations n.e.c.	Total (Current US\$)
FAO1.01.01.01 Ministry of Health (or equivalent sector entity)	20,043,700									1,942,955									21,986,655
FAO1.01.01.02 Ministry of Education (or equivalent sector entity)	344,031																		344,031
FAO1.01.02.03 Ministry of Social Development (or equivalent state sector entity)	59,575																		59,575
FAO1.01.03.01 Department of Health (or equivalent local sector entity)	17,034																		17,034
FAO2.04 Private households' (out-of-pocket payments)			1,219,489																1,219,489
FAO2.05 Not-for-profit institutions (other than social insurance)					1,501,361														1,501,361
FAO2.99 Other private financing agents n.e.c.			20,329	3,152															23,481
FAO3.01.12 Government of Japan							117,470												117,470
FAO3.01.14 Government of Netherlands								39,106											39,106
FAO3.01.22 Government of United States									11,990,363										11,990,363
FAO3.02.06 Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic, Development Bank, etc.)										311,178									311,178
FAO3.02.07 UNAIDS Secretariat									783,537							484,660			1,859,608
FAO3.02.08 United Nations Children's Fund (UNICEF)												591,411	971,820						971,820
FAO3.02.18 World Food Programme (WFP)													181,025						211,388
FAO3.02.19 World Health Organization (WHO)														24,297					24,297
FAO3.02.99 Other Multilateral entities n.e.c.																6,567,764			34,645,351
FAO3.03.01 International HIV/AIDS Alliance								217,029										18,293	235,321
FAO3.03.20 Médecins sans Frontières																8,772,170			8,772,170
FAO3.03.99 Other international not-for-profit organizations n.e.c.																		257,864	257,864
<b>Total (Current US\$)</b>	<b>20,464,340</b>	<b>20,329</b>	<b>1,223,641</b>	<b>1,501,361</b>	<b>192,539</b>	<b>192,539</b>	<b>117,470</b>	<b>256,135</b>	<b>12,775,900</b>	<b>2,254,132</b>	<b>52,798,881</b>	<b>621,774</b>	<b>971,820</b>	<b>181,025</b>	<b>24,297</b>	<b>7,052,424</b>	<b>8,772,170</b>	<b>276,240</b>	<b>109,500,896</b>

## Finances Agents x Providers – 2017

FA X PS 2017	FA.01.01.01 Ministry of Health (or equivalent sector entity)	FA.01.01.02 Ministry of Education (or equivalent sector entity)	FA.01.02.03 Ministry of Social Development (or equivalent state sector entity)	FA.01.03.01 Department of Health (or equivalent local sector entity)	FA.02.04 Private households' (out-of-pocket payments)	FA.02.05 Not-for-profit institutions (other than social insurance)	FA.02.99 Other private financing agents n.e.c.	FA.03.01.12 Government of Japan	FA.03.01.14 Government of Netherlands	FA.03.01.22 Government of United States	FA.03.02.06 Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.)	FA.03.02.07 UNAIDS Secretariat	FA.03.02.08 United Nations Children's Fund (UNICEF)	FA.03.02.18 World Food Programme (WFP)	FA.03.02.19 World Health Organization (WHO)	FA.03.02.99 Other Multilateral entities n.e.c.	FA.03.03.01 International HIV/AIDS Alliance	FA.03.03.20 Médecins sans Frontières	FA.03.03.99 Other International not-for-profit organizations n.e.c.	Total (Current US\$)
PS.01.01.01 Hospitals (Governmental)	12,767,704															5,882,656				18,650,360
PS.01.01.02 Ambulatory care (Governmental)	6,167,774															4,170,585				10,338,358
PS.01.01.05 Laboratory and imaging facilities (Governmental)	6,118												8,100							14,218
PS.01.01.06 Blood banks (Governmental)	213,667																			213,667
PS.01.01.10.01 Primary education (Governmental)		125,102																		125,102
PS.01.01.10.02 Secondary education (Governmental)		218,929																		218,929
PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including NAPS/NACPs)	1,982,335												92,424			6,761,003				8,835,762
PS.01.01.14.04 Departments inside the Ministry of Social Development or equivalent			59,575																	59,575
PS.02.01.13 Research institutions (Non-profit non faith-based)									851,627											851,627
PS.02.01.15 Civil society organizations (Non-profit non faith-based)				17,034		1,501,361	23,481		39,106	10,627,287		1,268,197	506,522	64,044		12,976,182	235,321	8,772,170	24,324,970	60,355,675
PS.02.02.01 Hospitals (For profit)					1,219,489															1,219,489
PS.02.02.14 Consultancy firms (For profit)										219,214										219,214
PS.03.01 Bilateral agencies								117,470												117,470
PS.03.02 Multilateral agencies	849,057									292,235	311,178	591,411	364,774	147,344	24,297	4,854,925			846,228	8,281,449
Total (Current US\$)	21,986,655	344,031	59,575	17,034	1,219,489	1,501,361	23,481	117,470	39,106	11,990,363	311,178	1,859,608	971,820	211,388	24,297	34,645,351	235,321	8,772,170	25,171,198	109,500,896

Production Factors x AIDS Spending Categories (1<sup>st</sup> digit level aggregation) – 2017

PF x ASC 1st Digit 2017	PF .01.01. Labour income	PF .01.02.01.01 Antiretrovirals	PF .01.02.01.02 Other drugs and pharmaceuticals (excluding antiretrovirals)	PF .01.02.01.03 Medical and surgical supplies	PF .01.02.01.04 Condoms	PF .01.02.01.05 Reagents and materials	PF .01.02.01.06 Food and nutrients	PF .01.02.01.98 Material supplies not disaggregated by type	PF .01.02.01.99 Other material supplies n.e.c.	PF .01.02.02. Services	PF .01.98 Current expenditures not disaggregated by type	PF .02.01. Buildings and infrastructure upgrading	PF .02.02. Equipment	PF .02.98 Capital expenditure not disaggregated by type	PF .02.99 Capital expenditure n.e.c.	PF .98 Production factors not disaggregated by type	Total (Current US\$)
ASC.01 Prevention	6,952,434	18,440	2,658,814	456,474	1,189,736	2,129,160	33,654	33,269	25,135	921,192	7,201,899	32,706	64,852	5,067		7,991,034	29,713,865
ASC.02 Care and treatment	5,996,819	16,267,594	6,228,121	18,249		2,213,965	496,027	425,311		4,627,287	6,258,388	295,644	551,711			9,048,624	52,427,739
ASC.04 Programme management and administration	4,482,039							5,739	68,918	3,046,472	4,591,509	1,577,524	5,081,965	311,142	229,218	3,577,360	22,871,886
ASC.05 Incentives for Human resources	426,246									59,980	915,987	-	-			647,727	2,049,941
ASC.06 Social protection and social services	-						39,351			1,08,353	470,930	-	-			59,575	678,209
ASC.07 Enabling environment	274,854						670			20,898	256,245	-	-			990,193	1,542,860
ASC.08 HIV and AIDS-related research	-									17,716	5,234	-	6,440			87,006	116,396
Total (Current US\$)	18,132,392	16,286,034	8,886,935	474,722	1,189,736	4,343,125	569,702	464,320	94,053	8,801,898	19,700,191	1,905,874	5,704,968	316,209	229,218	22,401,519	109,500,896



## Providers x AIDS Spending Categories (1st digit level aggregation) – 2017

PS x ASC 1st Digit 2017	PS.01.01.01 Hospitals (Governmental)	PS.01.01.02 Ambulatory care (Governmental)	PS.01.01.05 Laboratory and imaging facilities (Governmental)	PS.01.01.06 Blood banks (Governmental)	PS.01.01.10.01 Primary education (Governmental)	PS.01.01.10.02 Secondary education (Governmental)	PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including NAPs/NACPs)	PS.01.01.14.04 Departments inside the Ministry of Social Development or equivalent	PS.02.01.01.13 Research institutions (Non-profit non faith-based)	PS.02.01.01.15 NGOs / Civil society organizations (Non-profit non faith-based)	PS.02.02.01 Hospitals (For profit)	PS.02.02.14 Consultancy firms (For profit)	PS.03.01.01 Bilateral agencies	PS.03.02.02 Multilateral agencies	Total (Current US\$)
ASC.01 Prevention	1,916,810	4,269,155		213,667	125,102	218,929	28,676			22,906,358				35,167	29,713,865
ASC.02 Care and treatment	16,733,550	6,042,553	6,118							27,785,380	1,219,489			640,649	52,427,739
ASC.04 Programme management and administration		3,420					7,994,709		771,110	6,894,239		219,214	117,470	6,971,723	22,971,886
ASC.05 Incentives for Human resources		19,846	8,100				689,920			906,941				425,134	2,049,941
ASC.06 Social protection and social services							101,038	59,575		517,596					678,209
ASC.07 Enabling environment		3,385					21,419		80,517	1,228,765				208,775	1,542,860
ASC.08 HIV and AIDS-related research										116,396					116,396
Total (Current US\$)	18,650,360	10,338,358	14,218	213,667	125,102	218,929	8,835,762	59,575	851,627	60,355,675	1,219,489	219,214	117,470	8,281,449	109,500,896





UNAIDS