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CAMBODIA
NATIONAL AIDS SPENDING ASSESSMENT VII
2020-2022

April, 2024

Supported by UNAIDS and LHSS/Abt

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AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ASC	AIDS Spending Classifications
BP	Beneficiary Populations
CENAT	National Center for Tuberculosis and Leprosy
CHE	Current Health Expenditure
CSO	Civil society Organization
DP	Development Partners
FA	Financing Agents
FAP	Financing Agent and Purchaser
FE	Financing Entities
FEW	Female Entertainment Workers
GDP	Gross Domestic Product
GF	Global Fund
GGE	General Government Health Expenditure
GGE-D	Domestic General Government Health Expenditure
HDI	Human Development Index
HEF	Health Equity Fund
HEQIP	Health Equity and Quality Improvement Program
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IDPoor	Identification of Poor Households Program
IDU	Injecting drug users
ILO	International Labor Organization
KHANA	Khmer HIV/AIDS NGO Alliance

KP	Key Populations
MoEF	Ministry of Economy and Finance
MoH	Ministry of Health
MPI	Multidimensional Poverty Index
MSM	Men who have Sex with Men
NAA	National AIDS Authority
NASA	National AIDS Spending Assessment
NCHADS	National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases
NGOs	Non-governmental organisation
NHA	National Health Accounts
NMCHC	National Maternal and Child Health Center
OOP	Out-of-Pocket Spending
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PF	Production Factors
PLHIV	People Living with HIV
PPP	Purchasing Power Parity
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
SHA	System of Health Accounts
SP	Service Providers
TG	Transgender
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

ACKNOWLEDGEMENTS

The National AIDS Spending Assessment for the triennium of 2020-2022 in Cambodia, designated as NASA VII, was successfully conducted under the guidance of the National AIDS Authority (NAA), with valuable technical and financial support from the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Our gratitude goes out to the members of the NASA VII Steering Committee, including representatives from the NAA, MoH, NCHADS, NMCHC, CENAT, MoEF, UNAIDS, WHO, PEPFAR, civil society, and private healthcare providers. Their expert advice, careful review of preliminary results, and insightful contributions were crucial to the development of this report.

We extend our heartfelt thanks to UNAIDS for their invaluable technical assistance throughout the development of this report. Special appreciation goes to Patricia Ongpin and Dr Khin Cho Win Htin, whose efforts in supporting coordination were essential. We further wish to express our profound gratitude to Pia Roddewig for her exceptional contributions to this report. Her analytical expertise and leadership in report writing have been fundamental in shaping the outcomes of this work. Additionally, her adept communication with the team and our partners has played a crucial role in ensuring the success of our collaborative efforts.

Additionally, we would like to express our deep appreciation to Katerina Sharapka, the international consultant, for her exceptional support and outstanding expertise throughout this project.

We further extend our heartfelt gratitude to all contributors—including national and international partners, NGOs, and communities—for their professionalism and dedication in sharing valuable data for NASA VII.

EXECUTIVE SUMMARY

Cambodia has seen an extensive economic upswing after three decades of civil conflict and is classified as a lower-middle income country since 2015 yet remains within the category of countries with medium human development. After experiencing one of the fastest growing HIV epidemics in Asia, with new infections reaching an all-time high of 15,000 in 1996, Cambodia's strong AIDS response led to a considerable containment of the epidemic. As of 2022, an estimated 76,000 people were living with HIV in Cambodia, and the country is on the right track towards reaching 95-95-95 targets by 2025. However, challenges persist, particularly in closing the gaps in the HIV testing and treatment cascade. Since 2006, Cambodia has tracked its expenditures on HIV/AIDS programs through NASA, with a noticeable shift in funding priorities from prevention to care and treatment in recent years.

This document reports how money is spent on HIV/AIDS programs between 2020 and 2022 using a methodology called NASA (National AIDS Spending Assessment), developed by UNAIDS, which aims to track both government and private funding for HIV/AIDS, including out-of-pocket expenses by patients. NASA VII offers a comprehensive analysis of HIV/AIDS program expenditures across three fiscal years (2020-2022), categorized by nine classifications, such as financing entities, revenue, financing scheme, financing agents and purchasers, providers of services, AIDS spending categories, service delivery modality, beneficiary population, and production factors.

Cambodia is taking a coordinated approach to tackling HIV/AIDS. Led by the National AIDS Authority (NAA) and supported by UNAIDS, a steering committee was established for NASA VII. This committee guided stakeholders, supported data collection, and incorporated valuable input and feedback. Through NASA VII, Cambodia aims to (1) strengthen data collection and analysis of HIV/AIDS spending, (2) identify funding priorities for future strategies and programs, (3) guide resource allocation to ensure program sustainability, and (4) make data-driven decisions to optimize the fight against HIV/AIDS.

Key Findings

Cambodia's HIV/AIDS funding landscape is evolving. The total funding for HIV/AIDS declined slightly, dropping from 34.3 million United States dollars in 2020 to 30.8 million United States dollars in 2021 and to 31.6 million United States dollars in 2022. Global Fund was the primary contributor, even though it showed a steady decrease in its contributions, falling by 27% from 15.5 million United States dollars in 2020 to 11.3 million United States dollars in 2022 (36% of total contributions in 2022). Conversely, the Government of Cambodia's contribution increased, rising from 8.1 million United States dollars in 2020 to 9.7 million United States dollars in 2022 (around 7 % increase withing the 3-year period). US Government support (PEPFAR) also decreased, dropping from 6 million United States dollars in 2020 to 4.8 million United States dollars in 2022 (15% of total contributions in 2022). Other bilateral funding (excluding PEPFAR) increased from 0.4 million United States dollars in 2020 to 2.7 million United States dollars in 2022.

There's a growing reliance on internal resources and a slight decrease in dependence on multilateral funding. Bilateral aid remains important, and households continue to shoulder a significant financial burden. While international support remains the primary driver (64%), Cambodia's government is taking on a larger role (31%) in financing the fight against HIV/AIDS. Households' out-of-pocket

expenditure reaches 6% but is limited to travel expenses by PLWHIV due to data constraints and thus likely to be underestimated.

The primary financing agent and purchaser is the government, responsible for managing 61% of the programs in 2020, increasing to 65% in 2021, before dipping slightly to 62% in 2022. Whilst Non-profit organizations saw a slight decrease in their spending, managing 13% in 2020, but dropping to 10% in 2021 and 2022. With regard to the providers of services, Government organizations remain the main service providers, though their share decreased slightly from 65% (22.3 million United States dollars) in 2020 to 63% (19.9 million United States dollars) in 2022. From 32% to 45% in the same period, public hospitals were the service providers. The Non-profit providers (CSOs) increased their share from 9% to 12% (around $3.9 million) between 2020 and 2022, reflecting a growing role in service delivery.

The NASA findings further suggest that HIV Care and Treatment has the highest expenditure across the years followed by Programme enablers and systems strengthening and HIV testing and counseling (HTC). The percentage share of HIV Care and Treatment Care has also decreased the most significantly from 52.5% in 2020 to 39.2% in 2022. Even there is a trend of decreasing public funding for PLHIV treatment and increasing funding for prevention programs, particularly for general populations while services for key populations remain donor funded. Programme enablers and systems strengthening has consistently remained around 34% to 36% while HIV testing and counseling (HTC) has increased slightly from 6.7% in 2021 to 11.2% in 2022.

PLHIV remain the primary beneficiaries of total HIV/AIDS spending, which consumed around 53.6% in 2020, 52.5% in 2021 and 40.4% in 2022 of the total expenditure. This likely reflects an increase in treatment coverage rates. The country is allocating more resources to non-targeted interventions, and less on key populations, and vulnerable groups. The spending targeting key populations such as female entertainment workers, men who have sex with men, and people who inject drugs, has slightly grown. The total expenditure on key population was 4.7% in 2020, 3.9% in 2021 and 7% in 2022 of the total spending.

Based on the information provided in report, key recommendations are presented below:

Improve HIV program planning and implementation circle:

- Increased joint planning cooperation to determine where to direct public and donor funds could minimize duplication of funding and parallel planning processes, with consideration of improving the sustainability of key interventions. This will guarantee good intersectoral coordination for achieving the country's strategic goals and will allow avoiding possible duplication or underspending of the funding in the future.

Optimize, re-prioritize spending allocation:

- The report highlights that a significant portion of the expenditure goes towards service provision activities like care and treatment (40% in 2022), prevention (12% in 2022) and HTC (11% in 2022). However, it is important to analyze deeper efficiency of programs implementation and find potential ways for optimization and re-prioritization of program areas. Consider a more balanced approach, ensuring sufficient resources for all the country priorities based on strategic plans.

- The current public funding is concentrated on treatment, laboratory monitoring and care programs. The steady increase in donors spending on key populations across various programs is positive. However, although the funding for HIV prevention is being scaled up, the results of the assessment showed that public funding expansion is directed more towards the general population, rather than the key populations. The same trends are observed for HIV testing, public sector is limited and consists of testing at the level of the confirmation of the HIV status.
- It is strongly recommended to analyze the impact of these programs to ensure they are effectively reaching and supporting target groups. This could involve expanding outreach programs, particularly for high-risk groups, and investing in public awareness campaigns.
- As Program management and above service provision activities take over 35% per year, it is recommended to analyze these expenses in more details to ensure funds are used efficiently.

Sustainability of funding:

- Cambodia's growing reliance on domestic resources is positive but country still has a significant dependence on the external sources of funding around 67% of the total budget. The increase in foreign aid is welcome, but there is some concern about fluctuations in contributions to HIV programs and about a significant dependence on donor aid, which makes priority programs highly unstable and unsustainable. This could mean that the country's government should be prepared for filling potential funding gaps in the event of a decrease in foreign aid. The government can explore innovative financing mechanisms to further reduce dependence on external aid. This could involve public-private partnerships and cooperation with business. The government may need technical support from international organizations to properly prepare and manage the transition in funding landscape.
- It is important for the government to ensure that these donor-funded services are seamlessly integrated into national planning and state funding, which will ensure the sustainability of activities in the event that donors decide to cut or withdraw their funding.

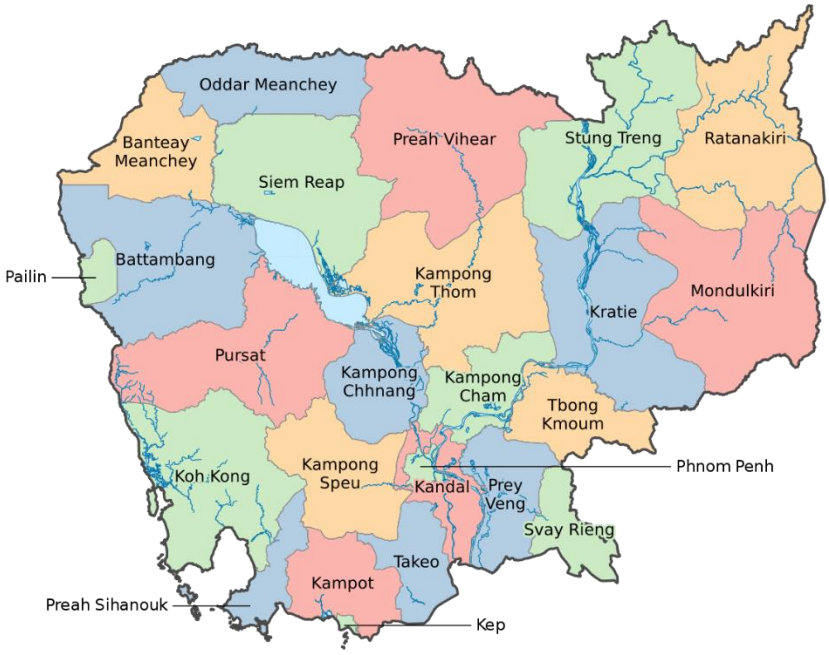
Institutionalization and development of country capacities in resource tracking, and improvement of data granularity:

- In the future, it is necessary to envisage the possibility of institutionalizing the NASA in the country in order to regularly and effectively track the costs of HIV, which will allow responding more quickly to problems and making logical decisions connected with the budget allocation, reducing duplication of services by several sources of funding.
- It is also necessary to strengthen the capacity of ministries and state agencies connected with tracking expenditures, including the provincial level.
- It is recommended to improve the inclusion of the private sector contributions.
- It is important to ensure development of local human resource and involvement of local experts with knowledge of finance, resource tracking in next NASA rounds with potential minimization of external TA assistance in future.

1. INTRODUCTION & BACKGROUND

1.1 Cambodia's geographic and socio-demographic context

Cambodia is located in Southeast Asia and shares its borders with Viet Nam, Lao PDR, and Thailand. The official language is Khmer. The country is divided into 25 provinces including Phnom Penh, which is considered an autonomous municipality. Provinces are subdivided into 162 districts as of 2023. The country's population reached 16.8 million in 2022, with 75% residing in rural areas.[1] The median age is 27. 29% are under the age of 14, 65% between 15 and 64, and 6% aged 65 and above, representing a relatively young population that enables the promotion of socioeconomic transformation. [2,1]



Cambodia is classified as a country with medium human development. Partly due to the relatively low prioritization of the social sector in the allocation of the national budget through fiscal policy measures, human development declined since 2019 as measured by the Human Development Index (HDI).[3] The country's HDI of 0.593 in 2021 (rank 146/191) represents an improvement from its rank in 2020 (rank 148/191) but a decrease of the index in absolute terms from 0.589 in 2019 and 0.596 in 2020[4].

Over the years, the country has seen improvements in basic population health measures. Life expectancy at birth increased from 59 years in 2000 to 70 years in 2021. The under-five mortality rate dropped from 106 per 1,000 live births in 2000 to 25 per 1,000 live births in 2021. The neonatal mortality rate followed the same trend but stands with 13 per 1,000 live births in 2021 second highest among the neighboring countries. Challenges persist, notably in the maternal mortality

[1] World Bank. World Development Indicators. (2023).

[2] National Institute of Statistics (NIS). (2020). General Population Census 2019.

[3] United Nations. (2023). Cambodia Common Country Analysis.

[4] United Nations Development Programme (UNDP). (2022). Human Development Report 2021/2022.

ratio, which is 218 per 100,00 live births in 2020 substantially higher than in all neighboring countries (Lao PDR has with 126 the second highest ratio). As of 2021, Cambodia's Universal Health Coverage index was at 58 out of 100.[1] Within the course of developing a universal healthcare system, the Royal Government directs the focus on social solidarity in terms of physical and financial access to quality healthcare. Obstacles to overcome in this regard include access for the poor population, as well as population groups characterized by stigma, as they currently face barriers that prevent utilizing healthcare services and seeking treatment.[3]

Universal access to primary education has been achieved and the gross primary school enrollment rate reached 110% in 2022. Yet a considerable share of human capital is currently not formally educated. Gross secondary school enrollment rate was at 58% in 2021 and expected years of schooling are 11.5 years as of 2021.[1,5,6] Constraints of the education sector include low quality of education, high dropout rates and low retention rates regarding secondary education and above.[3] Inequality remains an issue: the Gini coefficient was at 54.6 in 2019.[4] Despite improving living standards for the majority of the population, the advantages of Cambodia's strong economic growth were not equally shared among different segments of the population. The lower percentiles of society experienced minimal gains from the cascading effects of economic growth, exposing inequalities.[6]

1.2 Cambodia's economic context

Cambodia experienced an extensive economic upswing after three decades of civil conflict and is classified as a lower-middle income country since 2015, a result of more than 20 years of substantial economic growth. GDP growth rates averaged 7.7% between 1998 and 2019, driven by open borders attracting foreign direct investment. Globally, the country was considered to be one of the fastest-growing economies.[7] The COVID-19 pandemic caused the country to fall into recession in 2020, resulting in a 3.1% contraction in the economy - one of the highest contractions in the Asia-Pacific region. This led to increased unemployment, particularly affecting women, and people in or threatened to plunge into poverty. The poverty rate at national poverty line fell from 47.8% in 2007 to 13.5% in 2014 due to increases in employment and wages caused by the long period of strong economic growth.[6,8] Yet part of the progress was reversed by the COVID-19 pandemic and let poverty to increase to 17.8% in 2019. Social assistance programs were launched in 2020 to alleviate the financial burden of worst-affected Cambodian households, but projections suggest that poverty levels continue to be higher post-pandemic.[3] Cambodia's Multidimensional Poverty Index (MPI) stands at 16.6% as of 2022.[9]

The country's economy continues to recover from the pandemic as GDP per capita sharply increased again, reaching 5,350 PPP (current international US$) in 2022. While this level still represents the lowest among neighboring countries, GDP per capita growth rate is with 4% in 2022 second highest after Viet Nam.[1] Rising consumer demand promoted the recovery of the service sector, subsequently fostering economic growth, which nevertheless remains limited by inadequate

[5] Expected years of schooling is the number of years a child of school entrance age can expect to receive if the current age-specific enrollment rates persist throughout the child's years of schooling.

[6] United Nations. (2023). United Nations Sustainable Development Cooperation Framework for Cambodia 2024-2028.

[7] World Bank, "The World Bank in Cambodia: Overview", 12 April 2023. https://www..worldbank.org/en/country/cambodia/overview

[8] World Bank, "Cambodia: Reducing Poverty and Sharing Prosperity", 29 October 2019. https://www.worldbank.org/en/results/2019/10/30/cambodia-reducing-poverty-and-sharing-prosperity

[9] UNDP. (2023). 2023 Global Multidimensional Poverty Index (MPI) – Unstacking global poverty: Data for high impact action.

infrastructure, superficial integration within the production sector, diversification and innovation constraints, which leads to lacking resilience.[3] While the unemployment is relatively low post-pandemic as only 0.4% of the total labor force was unemployed in 2022 (modeled ILO estimate)[1], Cambodia is characterized by a significant informal economy as 88% is considered to be informally employed. The majority of this share is female.[10] This has significant implications for social protection coverage and tax revenue as part of national budget.

Cambodia's Current Health Expenditure (CHE) was 8% of GDP in 2021, which is equivalent to 122 US$ per capita. The allocation of national budget towards the health sector as part of GDP is highest relative to its neighbors, which all stay at or below 5% of GDP. However, Domestic General Government Health Expenditure (GGHE-D) is 2% of GDP and 7% of General Government Expenditure (GGE) – less than half of the 15% of GGE that is advised to be allocated towards the health sector. Key sources financing Cambodia's health system include government funding, external donors, and OOP by the population. The latter represents the primary source of funding as more than half (55%) of CHE was financed out-of-pocket, which poses a tremendous financial burden to Cambodian households. Although OOP decreased from 64% in 2019, it was still considerably higher than in neighboring countries in 2021 with a 22-percentage points difference to the second highest share in Viet Nam (40%).[11] The majority of Cambodia's OOP is spent within the private health sector. As an effort to mitigate the financial burden of user fees in the public health sector, which were implemented following the health sector reforms in 1996, the Health Equity Fund (HEF) was established, aiming to financially support households when seeking care in public facilities. The HEF covers the part of the population considered to be poor as determined by the Identification of Poor Households Program (IDPoor) and either fully or partially reimburses costs of medical care in public sector facilities.[12] Following a new policy initiated in 2019, PLHIV were considered eligible for being covered by the HEF. Coverage also includes some KPs, including female entertainment workers. Moving forward, the 2024-2028 National Strategic Plan for a Comprehensive, Multi-sectoral Response to HIV/AIDS aims to include the majority of PLHIV and KPs in any kind of social protection system in the future.[13] High expenditures still represent a considerable constraint for households accessing healthcare and leads to severe consequences in many cases: 18% of the population had household expenditures on health greater than 10% of total household expenditure in 2019 – an amount considered to be catastrophic. In 10 years, catastrophic health expenditure on average decreased by merely 1 percentage point (19% in 2009).[14] Representing the second largest funding source of Cambodia's health system, domestic general government health expenditure has been increasing in recent years, yet still makes up only 27% of CHE in 2021 – the second lowest share in the region.[11] Government funds largely flow to the Ministry of Health and other health institutions in the form of regular annual budget for health activities, and partly as a support to the countries Health Equity and Quality Improvement Program (OOP-EQIP).[12] The country's health system continues to be largely dependent on external financing as funding from external donors accounted for 14% of CHE in 2021. Although this share has been significantly declining in recent years from 23% of CHE in 2014 down to 6% of CHE in 2020, external health expenditure more than doubled in 2021.[11] Donor funding is primarily allocated towards disease

[10] Kingdom of Cambodia, NIS Ministry of Planning. (2019). Report on the Cambodia Labour Force Survey 2019.

[11] World Health Organization (WHO). Global Health Expenditure Database. (2023).

[12] Asante, A.D., Ir, P., Jacobs, B., et al. 2019. Who benefits from healthcare spending in Cambodia? Evidence for a universal health coverage policy. *Health policy and planning*; 34: i4-i13.

[13] 2024-2028 National Strategic Plan for a Comprehensive, Multi-sectoral Response to HIV/AIDS

[14] World Health Organization (WHO). Global Health Observatory data repository. (2023). Catastrophic out-of-pocket health spending.

specific national programs such as HIV/AIDS, yet it also accounts for approximately 40% of HEF funding, while the government funds the rest.[12]

According to previous NASA reports, HIV Expenditure equaled 34.5 million US$ in 2017, which translated into HIV spending per PLHIV of 487 US$. Since 2010, when overall HIV expenditure reached 58.1 million US$, Cambodia experienced a consistent decline in the amount spent. Funding of HIV/AIDS heavily depends on external donors as international HIV spending accounted for 76% of overall HIV spending in 2017. Public HIV spending made up 24%, and private HIV spending 0.2%. By programmatic area, almost half of overall expenditure (46%) was channeled into HIV care and treatment, followed by 33% that was allocated towards programme management and administration, and 15% into HIV prevention. By beneficiary, PHLIV received with 47% most of the overall HIV expenditure, whereas 37% was flowing into non-targeted interventions. Key populations and other key populations received 7%, respectively.[15]

Table 1: Key Economic indicators for Cambodia

Key Economic Indicators	
GDP per capita (PPP (current international US$), 2022)[1]	5,350 PPP
GDP per capita growth rate (%, 2022) [1]	4%
World Bank per capita income group[7]	Lower-middle
Multidimensional Poverty Index (%, 2022)[9]	16.6%
Health Financing	
CHE as % of GDP (2021)[11]	8%
CHE per capita (current US$, 2021) [11]	122United States dollars
GGHE-D as % of GDP (2021) [11]	2%
GGHE-D as % of GGE (2021) [11]	7%
OOP as % of CHE (2021) [11]	55%
GGHE-D as % of CHE (2021) [11]	27%
EXT as % of CHE (2021) [11]	14%
HIV Financing	
HIV spending (US$, 2017) [15]	34.5 million United States dollars
HIV spending per PLHIV (US$, 2017) [15]	487 United States dollars
HIV spending as % of overall health expenditure (2016) [15]	0.03%

[15] National AIDS spending assessment for period 2016-2017 in Cambodia. (2018).

Public HIV spending as % of total HIV spending (2017) [15]	24%
Private HIV spending as % of total HIV spending (2017) [15]	0.20%
Int. HIV spending as % of total HIV spending (2017) [15]	76%
HIV spending (US$, 2017) [15]	34.5 million United States dollars

1.3 Cambodia's HIV situation

After experiencing one of the fastest growing HIV epidemics in Asia, with new infections reaching an all-time high of 15,000 in 1996, Cambodia's strong AIDS response led to a considerable containment of the epidemic. New infections decreased by 91% since 1996, and the country became one of the seven countries worldwide to achieve the 90-90-90 targets in 2017. As of 2022, an estimated 76,000 people were living with HIV in Cambodia, of which 2,000 are below the age of 15. Estimated 1,400 people have been newly infected in 2022. 83% of new infections are estimated to have happened among key populations and their sexual partners. Men who have sex with men make up the largest share with 40% of all new HIV infections among key populations and their partners, followed by female entertainment workers with 15%, clients and sex partners of key populations with 14%, transgender with 12%, and people who inject drugs with 3%. An estimated 17% of overall new infections were among the remaining population. The vast majority of newly infected people are male (79%).[16] 1100 people died from AIDS-related illnesses in 2022, representing a 78% decrease since the peak of 5100 deaths in 2003 (and a 30% decline since 2010).[17]

Cambodia is on the right track towards reaching 95-95-95 targets by 2025, yet gaps in the HIV testing and treatment cascade remain. As of 2022, among adults aged 15+, 87% of estimated PLHIV know their status, 100% of PLHIV who know their status are on treatment, and 98% of those who are on treatment are virally suppressed. Among children aged 0-14 who are living with HIV, 59% know their status, 100% of those are on treatment, and 89% of those on treatment have a suppressed viral load. This implies that out of all PLHIV, 86% know their status, 86% are on treatment, and 84% are virally suppressed. Hence, HIV diagnosis and optimal viral load suppression for children on treatment represent the crucial challenges for Cambodia.[16] The goal of reducing new infections by 90% between 2010 and 2025 is far from being reached. New infections decreased by 33% between 2010 and 2022 and are projected to increase again should future funding not be ensured. One particular concern is the increase in new infections among MSM, as their share of total new HIV infections was rapidly growing from 8% in 2010 to 40% in 2022. Moreover, the young population is moving into focus as 43% of total new infections are in the age group 15-24 years.[17]

[16] Cambodia HIV Estimates 2023 based on AEM-spectrum modelling estimates.

[17] HIV/AIDS Estimate and Projection 2022 Cambodia: Using AEM and Spectrum. 2022: UNAIDS

2. THE NATIONAL AIDS SPENDING ASSESSMENT (NASA) IN CAMBODIA

2.1 Objectives and scopes of NASA in Cambodia

The primary objective for this assessment was to collect and analyze data on HIV expenditure in Cambodia from 2020 to 2022 using the NASA methodology, developed by UNAIDS.

Specific objectives:

- To implement a methodology for systematic monitoring of HIV and HIV/TB coinfection financial flows at national and regional level using the NASA methodology in Cambodia;
- Build national level capacity for systematic monitoring of HIV/AIDS financing flows using the NASA methodology, with a view to a yearly, fully-institutionalized NASA.
- To conduct an HIV and HIV/TB coinfection spending assessment focusing on public and development partner (external) resources, and including private (both for-profit and not-for-profit) entities known to be contributing to HIV activities.
- To collect (or estimate) the household/ individual out-of-pocket expenditure (OOP) for HIV-related health services.
- To identify and measure the flow of resources for HIV applying the latest NASA 2020 vectors and classifications, including:
    a. Financing entity (FE),
    b. revenue (REV),
    c. financing scheme (SCH),
    d. financing agent-purchaser (FAP),
    e. service provider (PS),
    f. service delivery modality (SDM), function/ intervention (ASC),
    g. cost components (factors of production) and,
    h. beneficiary populations (BP).

- To measure HIV/AIDS expenditures in the country during a given year and comparing them over time (period covered by NASAs).
- To quantify the contributions from foreign and domestic financing entities (sources) to HIV/AIDS financing schemes.
- To reconstruct the flows from financing entities to purchasing agents and service providers, and then reaching beneficiaries through different service modalities.

2.2 NASA methodology and classifications

The NASA methodology has been developed to measure resources mobilized, pooled and invested in containing, mitigating and reducing the impact of HIV and AIDS. The resource flows between institutional units, from sources through schemes, from purchasing agents to providers, from service provision to end-users (beneficiaries), are reconstructed transaction by transaction and after steps are taken to validate and reconcile the figures in each step of the estimation process. So, this NASA round fully applied the new NASA framework with the updated vectors and classifications.

The methodology was aligned with the NASA Guide, and therefore based on standardized methods, principles, definitions and accounting rules. The nine vectors are defined as follows:

FINANCING:

1. Financing entity (FE) is the economic unit providing the resources to the schemes;
2. Financing schemes (SCH) are the modalities through which the population access the HIV services;
3. Financing revenues (REV) are mechanisms to provide resources to financing schemes;
4. Financing agents-purchasers (FAP) are economic units that operate the schemes. They collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities).

PROVISION OF HIV SERVICES:

1. Providers of services (PS) are entities that engage in the production, provision, and delivery of HIV services.
2. Production factors (PF) are inputs/resources (labor, capital, natural resources, "know-how," and entrepreneurial resources) used for the production of ASC.

USE/ CONSUMPTION:

1. AIDS spending categories (ASC) are HIV-related interventions and activities.
2. Beneficiary segments of the population (BP) are populations intended to benefit from specific activities (eg. key population groups such as men who have sex with men, injecting drug users, etc.)
3. Service delivery modality (SDM) is a new variable in NASA which indicates the modality of the service provided.

2.3 NASA Coordination and Leadership

To ensure quality, inclusive processes and timely completion of the NASA VII exercise with optimal coordination support and oversight mechanisms, NASA VII Steering Committee was established with the leadership from the National AIDS Authority (NAA).

NAA, with the support of UNAIDS and USAID, has taken the lead on previous, as well as the current NASA, by securing the buy-in of all partners and ensuring the process meets the country's needs.

The overall responsibility of the Steering Committee was to provide strategic guidance and oversee the NASA exercise including progress tracking while ensuring the needed coordination support for the data collection, quality assurance, and data validation in consultation with key stakeholders. The primary responsibilities of the Steering Committee were as follow:

1. Identify priorities for NASA analysis (in addition to NASA framework) such as detailed analysis on HIV prevention; detailed analysis on key populations; detailed analysis on community-led responses, analysis on STI etc. Though the focus of NASA exercise is a retrospective data collection, identification of priorities should take into consideration of future advocacy and response needs based on the current epidemic and response trajectory.
2. In consultation with the international consultant – assess the feasibility, define and agree on the scope of work.
3. Support meaningful participation of relevant focal points for the NASA training.
4. Provide coordination support for smooth and timely data collection from relevant entities, institutions and line ministries.

5. Engage in quality assurance mechanisms and provide strategic guidance to the consultants particularly when the data is insufficient and secondary data, proxy measures and estimations need to be used to inform the analysis.
6. Review and provide timely and constructive feedbacks on the key results and the NASA report; advise on policy and programme recommendations
7. Develop dissemination plan and mobilize resources if there is a resource gap in dissemination
8. Promote use of NASA results and reports to inform resource mobilization, sustainability dialogues and evidence-based advocacy
9. The NASA VII Steering Committee has been established to guide the NASA, with representation that includes key ministries/ public institutions and development partners and public private providers:
    - National AIDS Authority (NAA)
    - National Center for HIV/AIDS, Dermatology and STD (NCHADS)
    - National Maternal and Child Health Center (NMCHC)
    - National Center for Tuberculosis and Leprosy Control (CENAT)
    - Ministry of Health (Budget and Finance Office, MoH-LIT and DPHI, Dept of mental health and substance abuse)
    - Ministry of Economy and Finance
    - UNAIDS
    - WHO
    - PEPFAR (USAID, EpiC, CDC, LHSS)
    - KHANA
    - RHAC
    - HACC
    - AHF
    - Private health providers represented by RHAC clinic, Marie Stopes Cambodia, and Pasteur Institute of Cambodia.

2.4 History of NASA Implementation in Cambodia

Since 2007, Cambodia has conducted seven rounds of the National AIDS Spending Assessment (NASA) with technical assistance from UNAIDS and various development partners as show in Table 2.

Table 2: HIV financing sources in all seven rounds 2006-2022, US dollars

Financing sources	Roun 1	Round 2		Round 3		Round 4		Round 5		Round 6		Round 7		
	2006	2007	2008	2009	2010	2011	2012	2014	2015	2016	2017	2020	2021	2022
National budget	6,055,310	6,045,435	5,261,582	1,703,403	2,436,832	5,644,947	5,671,862	6,438,230	8,188,161	7,913,080	8,257,614	8,071,179	9,195,749	9,730,098
Private sources	-	-	-	36,955	51,540	963,952	956,837	24,723	262,750	13,631,573	15,904,335	1,647,871	1,631,283	1,734,420
International NGOs	2,040,156	-	-	9,119,295	7,516,331	3,736,224	2,855,882	2,409,038	2,274,751	152,277	173,851	245,734	126,211	161,237
Bilateral agencies	18,788,575	24,405,983	20,677,015	15,565,137	15,662,527	15,713,795	15,872,474	12,376,155	12,047,855	10,596,276	11,493,171	6,148,796	5,454,695	5,641,663
UN agencies	8,551,586	5,579,291	4,695,757	7,547,437	8,382,652	7,128,857	4,320,352	2,300,222	2,357,121	664,013	960,853	725,194	611,567	962,650
Global fund	9,479,207	16,589,956	19,087,509	19,023,277	22,711,245	18,030,595	20,027,132	25,202,527	19,435,027	276,345	255,068	15,451,876	11,856,854	11,248,214
Multilateral agencies	-	-	-	612,307	1,043,168	1,745,621	1,165,243	367,761	200,998	107,435	372,799	9,777	-	-
Others	1,392,754	638,100	2,125,134	127,286	255,174	254,654	57,619	3,149	97,745	28,422	189,351	1,998,669	1,927,029	2,087,412
Total (USD)	46,307,588	53,258,765	51,846,997	53,735,097	58,059,469	53,218,645	50,927,401	49,121,805	44,864,408	33,369,421	37,607,042	34,299,097	30,803,388	31,565,694

I. The first round of NASA was collected for 1 year of expenditure - 2006. The public source spent 6.1 million United States dollars accounting for 13.08% of the total funds while the international source spent more than 40.25 million United States dollars which is accounting for 86.92% of the total funds.

II. For the biennium of 2007-2008, NASA II revealed total expenditure of $53.3 million United States dollars in 2007 and $51.8 million United States dollars in 2008. On average, bilateral sources (mainly, PEPFAR) emerged as the principal contributors with 43.5%, whilst the Global Fund provided substantial support at 34%. The Government of Cambodia contributed 10.5%, UN Agencies 9%, and Other International sources accounted for 3%.

III. For the biennium of 2009-2010, NASA III reported Cambodia's spending on HIV/AIDS as $53.7 million in 2009, and US$ 58.1 million United States dollars in 2010. Out of those expenditure, the expenditure from public source was 1.7 million United States dollars in 2009 and 2.4 million United States dollars in 2010. The international source was 52.0 million United States dollars in 2009 and 55.6 million United States dollars in 2010. The private source was less than 0.1 million United States dollars in 2009 and 2010 respectively.

IV. NASA IV, covering the biennium 2011-2012, reports a total expenditure of $53.2 million in 2011 and a slight decrease to $50.9 million in 2012. Out of the total expenditure, the public source was 5.6 million United States dollars in 2011 and 5.7 million United States dollars in 2012. At the same time, international source was 46.6 million United States dollars and 44.3 million United States dollars respectively. The private source was 1 million United States dollars in 2011 and kept the same level in 2012.

V. NASA V, encompassing 2014 and 2015, documented Cambodia’s HIV/AIDS expenditures as $49.1 million for 2014 and a slight reduction to $46.9 million for 2015. Out of the total expenditure, the public source was 6.4 million United States dollars in 2014 and 8.2 million United States dollars in 2015. At the same time, international source was 42.7 million United States dollars and 38.4 million United States dollars respectively. The private source was 0.02 million United States dollars in 2014 and 0.3 02 million United States dollars in 2015.

VI. The NASA VI for the years 2016 and 2017 revealed an upward trajectory in funding from $31.5 million to $34.4 million, respectively. Out of the total expenditure, the public source was 7.9 million United States dollars in 2016 and 8.3 million United States dollars in 2017. At the same time, international source was 23.6 million United States dollars and 26.2 million United States dollars respectively. The private source was 3,9 million United States dollars in 2016 and 2,7 million United States dollars in 2017.

VII. The current round of NASA captures the expenditure for 3 years (2020 -2022). The total expenditure for HIV/AIDS response in Cambodia was 34.3 million United States dollars in 2020, more than 30.8 million United States dollars in 2021 and 31.6 million United States dollars in 2022. Out of those expenditure, the public source contributed 8.1 million United States dollars in 2020, around 9.2 million United States dollars in 2021 and more than 9.7 million United States dollars in 2022. The international sources was around 24.6 million United States dollars in 2020, around 20 million United States dollars in 2021, and 20.1 million United States dollars in 2022. As opposed to previous 6 rounds on NASA, this round partly captures OOP for the first time, amounting to around 1.6 million United States dollars in 2020, around 1.6 million United States dollars in 2021 and 1.7 million United States dollars in 2022.

2.5 Overview of the data included in NASA

With the help of the steering committee a list of respondents has been developed that included implementors of HIV/AIDS program in Cambodia. They included the MoEF, MOSAVY, MOP, MoWA, MoLVT, MoYES, MOI, MoH, NCHADS, NAA, NIPH, Blood bank, NMCHC, PCA, CENAT, 4FTC, DMH, MOH-LIT and Kuthabopha Hospital, Non-Profit Organizations (NGO) such as KHANA, RHAC, FHI360, AHF, LHSS, CHAI, AUA, FI, CRS, CRC, HACC, CPN+, CWPD, and MHC were included as well. The international partners were WHO, UNAIDS, UNDP, ILO, UNPA, UNWOMEN, Global Fund, USC-CDC, USAID.

Additionally, private for-profit organizations, such as RHAC clinic, Pasteur Institute, and Marie Stopes were advised for inclusion (although, the private sector was limited with only several organizations and excluded pharmacies).

The Table 3 summarizes the number of respondents provided the information on expenditure between 2020 and 2022. The response rate of information received from all relevant ministries, departments, provinces, development partners and stakeholders was 93% (with different quality of the data). More than four fifths (87%) of the government ministries and departments reported their expenditure. This includes responses from ART sites where the rate was very poor (11%) and only 18 of 72 provided some information of which only 8 reports were included in the analysis due to the low quality of the data (ART sites' data included running costs and salaries, drugs, tests and other commodities data has been collected directly from central level - MOH). The data from these 8 sites was used in assumptions applied which are described in chapter 2.6 Limitations, challenges and assumptions.

During the NASA VII, the mini online survey on the household's expenditure was conducted. The survey was hosted on ODK (open data kits) where the link was generated for the respondents to answer using the web browser on the mobile. The data collection was done by sending the link to key populations and PLHIV though the NGOs who were working with them. The NGOs who were helping the dissemination were (1) CWPD, (2) Friend International, (3) CRS, and (4) CPN+. The questionnaire included questions on types of the HIV associated services paid by clients (KPs and PLWHIV), frequency of visits to services providers and average annual expenditure (with the break down by cost category where possible). Unfortunately, the total number of responses was low, and quality was questionable. Due to this fact, only expenditure on travel from PLWHIV was used for this NASA round.

Table 3: Overview of NASA data collection in the assessment

Organization/department/ministries/ART sites	Contacted	Responded	Response rate
Government Ministries/Departments*	23	20	87%
Non-profit organizations (local and international NGOs)	14	13	93%
Development Partners (including bilateral and multilateral agencies)	9	9	100%
Private for-profit organizations	3	3	100%
ART sites	72	8	11%
Grand Total	121	54	44.63%

2.6 Limitations, challenges and assumptions

Despite the NASA team's efforts made to collect data from all organizations, a few organizations did not respond. These respondents were left out of the NASA, except where their information could be obtained from a secondary source or partly other respondents.

- Some of the donors which manage external funds provided financial data in aggregate form (for location, BP or PF). Thus, the desired level of accuracy of the data on the allocated funds could not be achieved in the NASA classification format. In some cases, the funds that were spent on various activities could not be broken down, for example, into specific production factors and were therefore labeled as "PF not disaggregated". However, this label was applied within the allowable value.
- Since the data were collected in 2023 retrospectively for 3 calendar years, it was difficult to ensure the necessary data detailing. It was necessary to resort to the use of archival data; in addition, the personnel who had the necessary information sometimes changed (or project was closed) and this negatively affected the data collection process and required significantly more time for data collection and verification than was originally expected.
- Significant efforts were made to collect the 'bottom up' data from the providers level where it was possible (ART sites and other health facilities, NGOs). Not all ART sites were able to report all their expenditure including salaries, office utilities and local procurement, so response rate from the ART sites providers was limited, only 18 of 72 ART sites were able to provide the data and only 8 of those who reported, provided data in the required quality and format. The data collected were limited to salaries and running facility costs to fulfil data gaps, while commodities including ARVs, HIV test kits and other commodity related spending was captured directly from NCHADS expenditure reports. As the result, the data from 8 ART sites was used for calculation of expenditure per 1 PLWHIV on ART and applied for the rest of the sites.
- A selected list of private sector providers was limited with largest private clinics/laboratories. The data collected was limited to spending on STI and OI screening and HIV testing. No STI and OI treatment services data was captured due to the limited access to information.
- Data from pharmacies (as a part of OOP) was not captured as there was no access to this data.
- Scope of this NASA included the expenditures of individuals (out-of-pocket payments) as based on the mini online survey (as described above) but was limited to expenditure on travel from PLWHIV. So, expenditure was significantly underestimated and didn't include the following data: expenditure for some STI and OI drugs and commodities, as well as other treatment related costs from PLWHIV and excluded information on expenses from KPs.
- Since, some expenditure data was received directly from providers level (i.e. NGOs) and from financing entities, there was a challenge to reconstruct transactions correctly, and to avoid both double-counting or potential data underestimation (no challenges met on PEPFAR and GF data as it was excluded from NGOs level and received directly from GF PR and PEPFAR ER data based in Panorama).
- It was not possible to disaggregate the consumption of ARV between first- and second-line treatment regimen. Data on ARV procurements (top-down) was used in the place of consumption (bottom-up), which means that there may have been ARVs paid for in 2021 (and captured as expenditure in 2021) but only consumed in 2022. It is assumed to be a small amount covering a buffer stock.
- Many organizations felt providing financial data with reasonable level of details to suit that NASA classification as an additional task and a burden, therefore there were significant delays in submitting the data from large number of organizations.

- Disaggregation of data by BP was limited for GF in 2021 and 2022 due to the changed reporting format of the donor where the GF intervention labels excluded breakdown by target population so it was almost not possible to split preventive and testing activities by KPs and general population.
- In some instances, there has been under-reporting from Governmental entities as some of the respondents failed to report activities implemented and focused more on salaries and administrative costs.
- Disaggregation of data by province could only be undertaken for separate donors (excluding PEPFAR and GF) and ART sites. PEPFAR and GF respondents were not able to label their expenditure to provinces as their internal reporting system excluded this information.
- Where expenditure collected was in in other currencies than US dollars, the average rate of exchange for the calendar year was used to convert the amounts to US dollars. The rates of exchange were obtained from: World Development Indicators.

Exchange rates applied to convert local currency Cambodian riel to United States dollars :

Row Labels	2020	2021	2022
Cambodian riel	4092.80	4098.70	4102.00

Source: World Development Indicators.

- TB expenditure included MDR-TB and Sensitive TB screening and treatment, as well as Tuberculosis Preventive Treatment (TPT). But was potentially underestimated and included only procurement of drugs, lab commodities, screenings, food and transportation cost (culture). But excluded salaries and shared running costs of the facilities.

3. KEY NASA FINDINGS

3.1. Trends in HIV spending in Cambodia, 2006-2022

In scrutinizing the progression of HIV-related expenditures in Cambodia from 2006 to 2022, delineated in Figure 1, we discern a financial trajectory segmented by the sectors of government, international donors, and household contributions. In 2010, expenditures on HIV reached a high of 58.1 million United States dollars, followed by a downward trend to 46.9 million United States dollars in 2015, marking a 19.3% decrease. The most pronounced decline was between 2015 and 2016, with a 32.8% drop to 31.5 million United States dollars. Thereafter, the financial trend displayed relative stability, with slight fluctuations, climbing to 34.4 million United States dollars in 2017 before decreasing again to 30.8 million United States dollars in 2021, and rising to 31.5 million United States dollars in 2022. These trends appear to have been primarily driven by international financing entities: overall financial shifts closely track with international funding patterns, which peaked in 2010 at 55.6 million United States dollars but then plunged by 57.7% to a low of 23.5 million United States dollars in 2016. Though there was a slight rebound in the following years, the international sources' levels dipped back to around 20 million United States dollars in 2021 and 2022. Government financing, on the other hand, presents a contrasting picture. After a sharp 79.0% reduction from 8.1 million United States dollars in 2006 to 1.7 million United States dollars in 2009, the trend then shifted towards gradual increases over the years, save for minor decreases in 2016 and 2020. Capturing household's OOP at least to a certain extent was possible for 2020 onwards. Available data show a stable figure of 1.6 million United States dollars in 2020 and 2021 from households, with a small increment to 1.7 million United States dollars in 2022. It is critical to acknowledge that these reported figures likely capture only a fraction of the true economic burden borne by households, due to limitations regarding the scope and quality of data collected. This data includes only transportation costs covered by PLWIH but excludes STI and OI diagnostics and treatment as well as some other laboratory services. Out-of-pocket expenditure also excludes information from KPs. As such, any interpretations of this data, especially in the context of policy decision-making, should be made with caution, with an understanding that the numbers may understate the actual financial challenges faced by affected households.

Figure 1: Trends in HIV spending in Cambodia, 2006-2022, US dollars (millions)

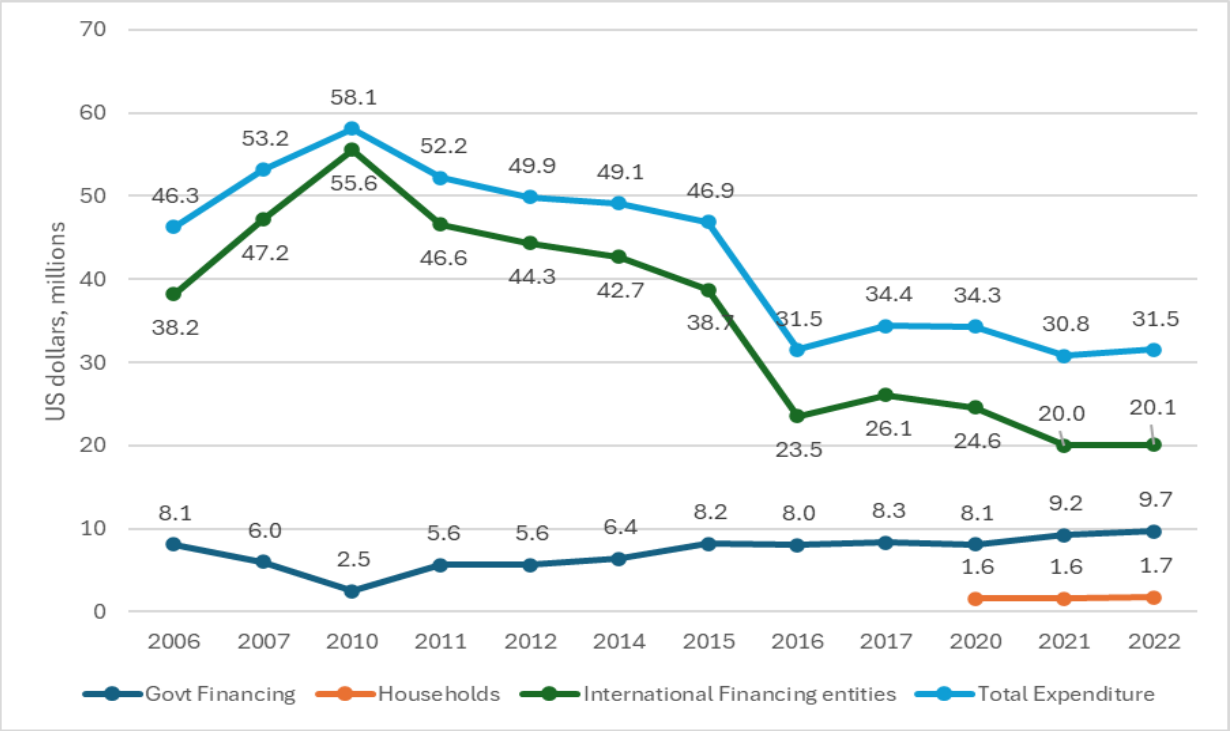
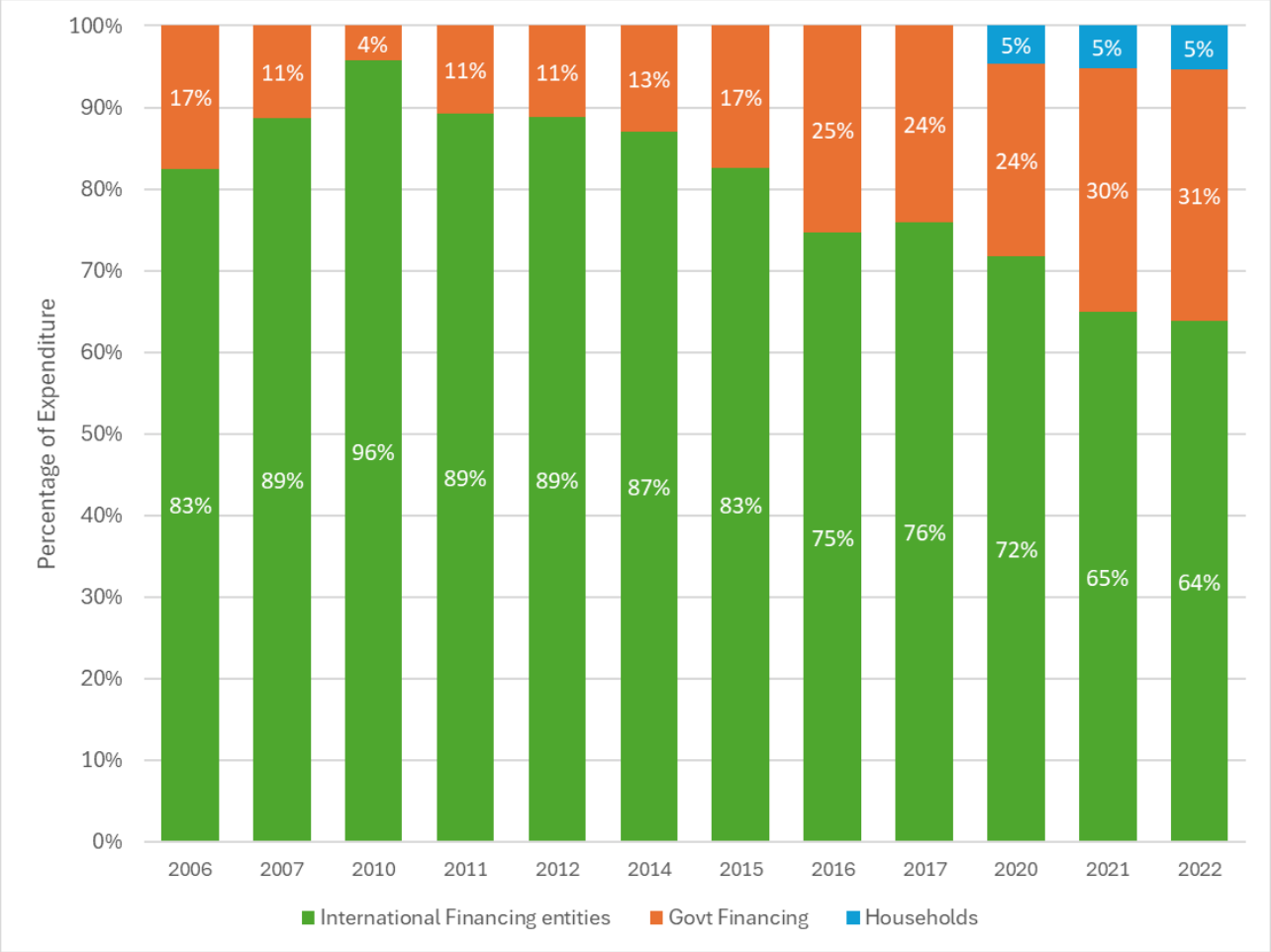


Figure 2 highlights the pivotal role played by international financial entities in the realm of HIV expenditure in Cambodia, a role that has seen a decline and stagnation over recent years. Notably, in 2010, international funds constituted 96% of total expenditure while the government's contribution was just 4%. However, by 2022, international contributions had receded to 64%, signaling a shift in the financial landscape. Concurrently, the government's role in funding HIV initiatives gained visibility from 2016 onwards, accounting for 25% of the total expenditure and further increasing to 30% in 2021 and 31% in 2022. Yet this shift, as inferred from Figure 3, is more reflective of a contraction in international funding than a significant escalation in government spending. Households have also been financing entities, contributing 5% to the total HIV expenditure from 2020 onwards. Again, it is critical to recognize the limitations of this data: our analysis is confined to 2020-2022, preventing a retrospective financial assessment. Moreover, the absence of OOP data for previous years should not be misconstrued as an absence of such expenses; literature indicates that OOP has been a longstanding burden for the population. Furthermore, the data that has been captured likely represents only a portion of the actual OOP, due to the constraints in data collection, suggesting that the real relative contribution of households to total HIV expenditure may be greater than what is reported. It is with these considerations that we interpret the current fiscal outline of HIV expenditure in Cambodia, acknowledging the likely underestimation of households' financial contributions.

Figure 2: Trends of HIV spending among international and government financing entities, and households in Cambodia, 2006-2022, %



3.2. Financing Vectors

3.2.1. HIV financing entities (FE)

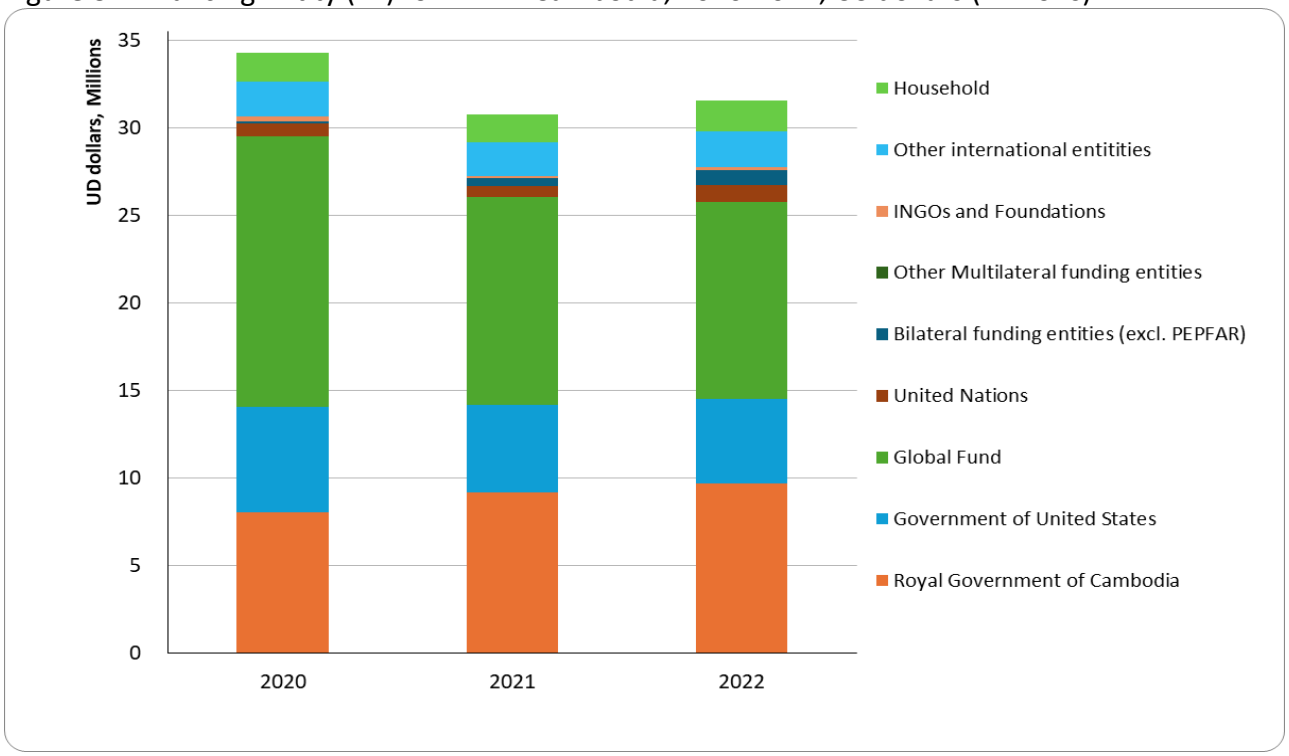
Focusing on the years of assessment of the current NASA: 2020-2022, detailed financing entities' contributions to HIV are presented in Table 4 and underscore the dynamic funding landscape in recent years highlighting the crucial role of both international support and domestic financing in sustaining HIV response efforts. Overall, funding allocations for HIV displayed a declining trend from 2020 to 2022, witnessing an initial decrease from around 34.3 million United States dollars in 2020 to 30.8 million United States dollars in 2021, marking a reduction of approximately 10%. This is followed by a modest rise to 31.6 million United States dollars in 2022, an increase of about 2%. Despite its status as the principal contributor, the Global Fund's contributions steadily decreased over this period, dropping by approximately 27% from 15.5 million United States dollars in 2020 to 11.3 million United States dollars in 2022, constituting 36% of all HIV contributions in 2022. Contrarily, the Royal Government's allocations consistently rose, starting from 8.1 million United States dollars in 2020, enhancing by about 14% to 9.2 million United States dollars in 2021, and further by approximately 6% to 9.7 million United States dollars in 2022. The Government of the United States accounted for 15% of the total HIV contributions in 2022, equating to 4.8 million

United States dollars, albeit their support decreased from 6.0 million United States dollars in 2020. Bilateral funding entities, excluding PEPFAR, although off a low base, significantly amplified their support from 0.1 million United States dollars in 2020 to 0.9 million United States dollars in 2022, contributing to 3% of the overall funds. In 2022, the United Nations accounted for 3% of total contributions, other international entities for 7%, and households maintained a consistent contribution of 5-6%, reaching 1.7 million United States dollars in 2022.

Table 4: HIV Financing Entity Contributions, 2020-2022, US dollars and %

HIV Financing Entities	2020	2021	2022	% 2020	% 2021	% 2022
Royal Government of Cambodia	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
Government of United States	6,006,408	5,002,895	4,786,621	17.5%	16.2%	15.2%
Global Fund	15,451,876	11,856,854	11,248,214	45.1%	38.5%	35.6%
United Nations	725,194	611,567	962,650	2.1%	2.0%	3.0%
Other Bilateral funding entities (excl. PEPFAR)	142,388	451,800	855,042	0.4%	1.5%	2.7%
Other Multilateral funding entities (excluding GF and UN)	9,777	-	-	0.0%	0.0%	0.0%
International NGOs and Foundations	2,244,403	2,053,240	2,248,649	6.50%	6.70%	7.10%
Households	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Figure 3: Financing Entity (FE) for HIV in Cambodia, 2020-2022, US dollars (millions)



3.2.2. Revenue for HIV (REV)

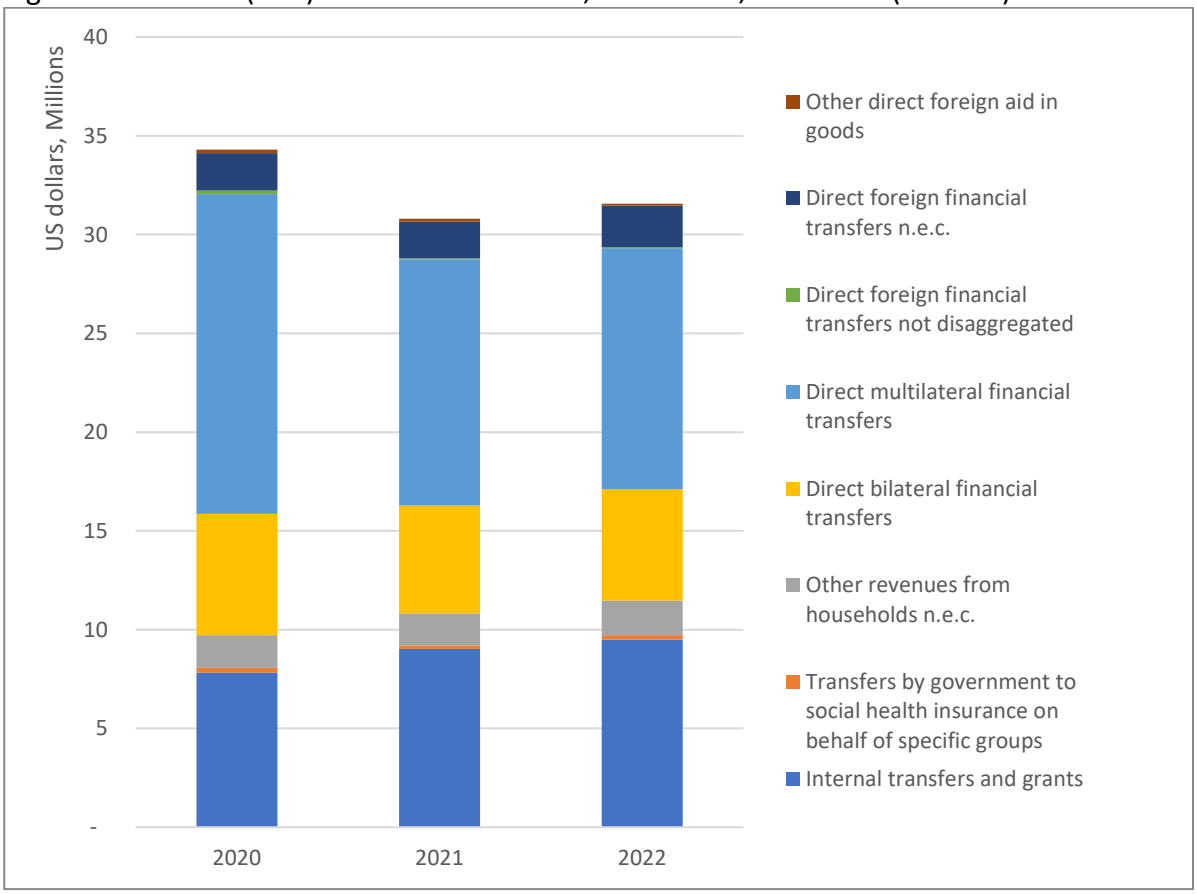
Figure 4 and Table 5 highlight the diverse revenue mechanisms that fund HIV financing schemes, revealing a nuanced landscape of financial support dynamics over recent years. In 2022, a significant 39% of resources came from direct multilateral financial transfers, though this marked a decline from 47% in 2020. Meanwhile, internal government transfers and grants saw an uptick, constituting 30% of the revenue in 2022, up from 23% in 2020, reflecting an increasing reliance on these mechanisms. Direct bilateral financial transfers remained a stable source of funding, consistently accounting for 18% of the revenues, which underscores the continued importance of bilateral relationships in the funding landscape. Additionally, 7% of the funds in 2022 were attributed to direct foreign financial transfers not elsewhere classified (n.e.c.). Other revenues from households n.e.c. contributed 6% in 2022, reflecting the payment by families affected by HIV in accessing HIV services. Overall, the distribution of financing revenues underscores the complex interplay of various financial mechanisms and the evolving nature of funding sources for HIV.

Table 5: Revenue (REV) for HIV in Cambodia, 2020-2022, US Dollars and %

HIV Revenue	2020	2021	2022	% 2020	% 2021	% 2022
Internal transfers and grants	7,830,299	9,032,638	9,498,049	22.8%	29.3%	30.1%

Transfers by government on behalf of specific groups	240,880	163,111	232,049	0.7%	0.5%	0.7%
Other revenues from households	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
Direct bilateral financial transfers	6,148,796	5,454,695	5,641,663	17.9%	17.7%	17.9%
Direct multilateral financial transfers	16,186,848	12,468,421	12,210,864	47.2%	40.5%	38.7%
Direct foreign financial transfers not disaggregated	170,194	50,000	39,623	0.5%	0.2%	0.1%
Direct foreign financial transfers n.e.c.	1,904,934	1,860,693	2,104,914	5.6%	6.0%	6.7%
Other direct foreign aid in goods	169,274	142,547	104,112	0.5%	0.5%	0.3%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Figure 4: Revenue (REV) for HIV in Cambodia, 2020-2022, US dollars (millions)



3.2.3. HIV Financing Schemes (SCH)

Figure 5 and Table 6 shed light on the financing schemes, illustrating the financing arrangements through which access to health services is enabled. Across all years, the bulk of financing schemes were central government schemes, reaching 61% in 2020, 65% in 2021, and 62% in 2022. This is followed by not-for-profit organization schemes, which slightly decreased from taking up 32% in 2020 to 28% in 2021 and 2022. OOP was at 5% in 2020 and 2021, and at 6% in 2022. Resident foreign agency schemes accounted for 2% in 2020 and 2021, and 5% in 2022.

Figure 5: HIV financing schemes (SCH) 2020-2022, US dollars (millions) and %

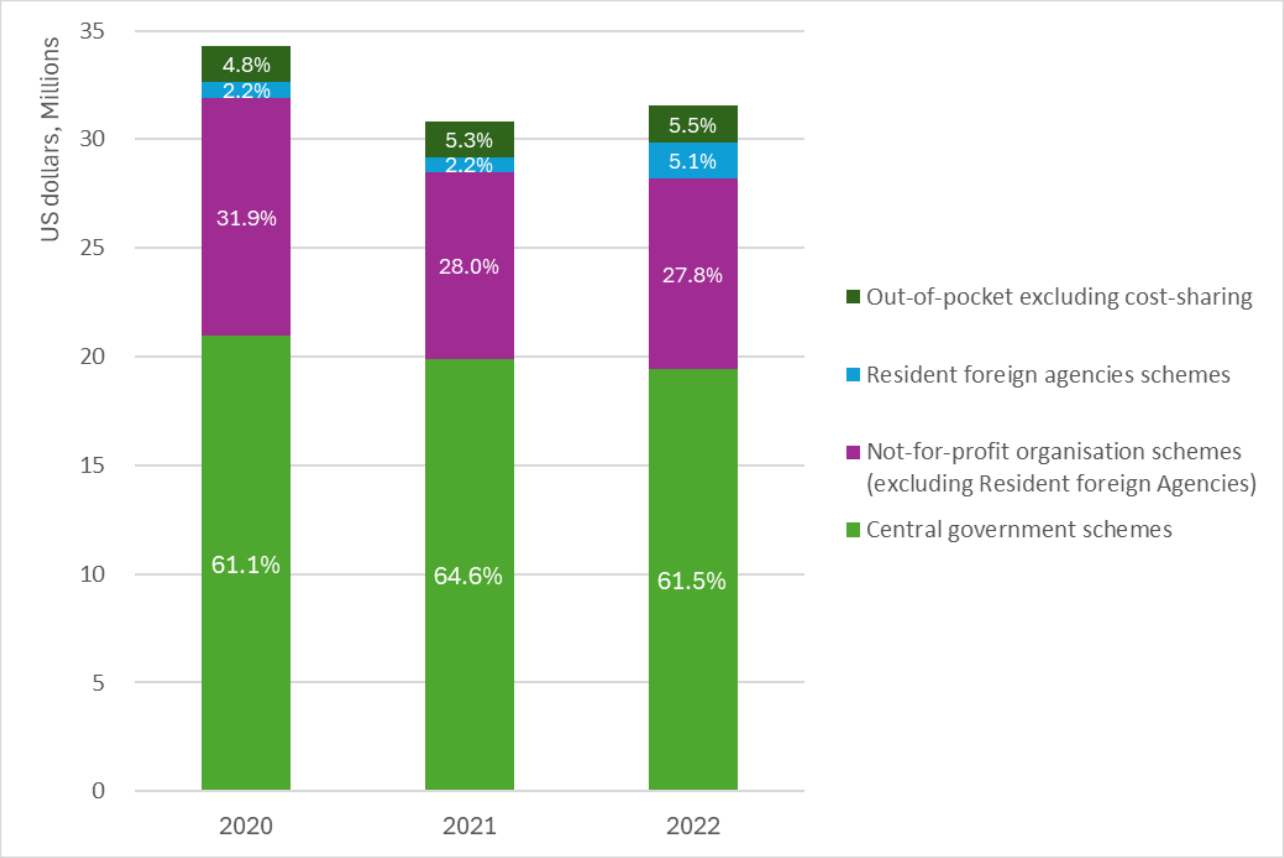


Table 6: Financing Entities (FE) by Financing Scheme (SCH), 2020-2022, US dollars and %

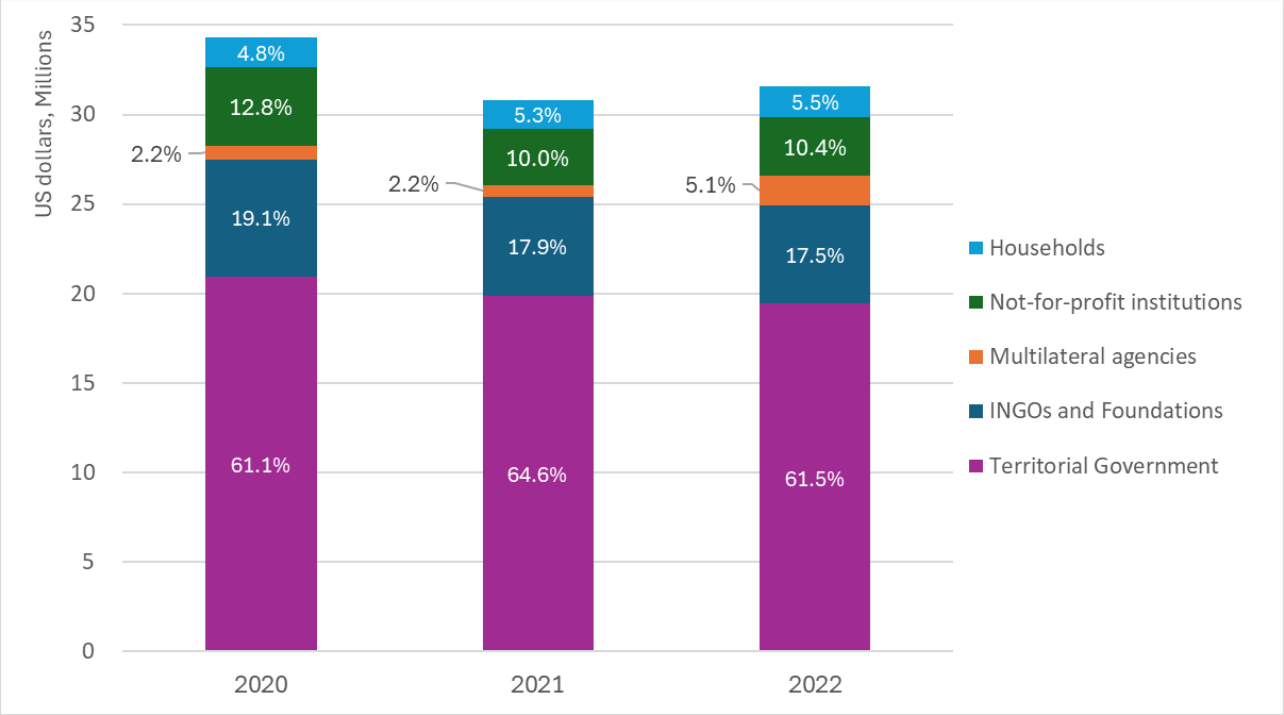
HIV Financing Entities and their schemes	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
SCH.1 Government schemes and compulsory contributory health care schemes	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
SCH.1.1.1 Central Government schemes	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
FE.02 Domestic Private Entities	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
SCH.3 Household out-of-pocket payment	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
SCH.3.1 Out-of-pocket excluding cost-sharing	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
FE.03 International Entities	24,580,047	19,976,356	20,101,176	71.7%	64.9%	63.7%

SCH.1 Government schemes and compulsory contributory health care schemes	12,881,205	10,701,405	9,697,447	37.6%	34.7%	30.7%
SCH.1.1.1 Central Government schemes	12,881,205	10,701,405	9,697,447	37.6%	34.7%	30.7%
SCH.2 Voluntary payment schemes	11,698,842	9,274,951	10,403,729	34.1%	30.1%	33.0%
SCH.2.2.1 Voluntary insurance schemes	6,535,469	5,024,417	5,670,581	19.1%	16.3%	18.0%
SCH.2.2.2 Resident foreign agencies schemes	768,717	664,141	1,625,251	2.2%	2.2%	5.1%
SCH.2.2.98 Not-for-profit organisation schemes not disaggregated	4,394,656	3,586,393	3,107,897	12.8%	11.6%	9.8%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.2.4. Financing Agent-Purchaser (FAP)

Figure 6 sheds light on the disaggregation by HIV financing agents and purchasers (FAPs), which are the economic units that operate the schemes. They collect revenue, pool financial resources, pay for the service provision, as well as pay for purchasing anti-retroviral drugs, allocation and purchase modalities in line with the policy and recommendation of the Global Fund. They are therefore important 'drivers' of the response. The primary FAP across 2020-2022 was the government, which made up 61% in 2020, increasing to 65% in 2021 and decreasing to 62% in 2022. INGOs and foundations represented the second largest FAP, ranging between 18-19% over the years. The share managed by not-for-profit institutions slightly diminished from 13% in 2020 to 10% in 2021 and 2022. Multilateral agencies experienced an increasing importance in their role as FAPs, with proportions increasing from 2% in 2020 and 2021 to 5% in 2022.

Figure 6: HIV Financing Agent-Purchasers (FAP), 2020-2022, US dollars (millions) and %



A breakdown by FE and FAP for HIV services is presented in Table 7. International entities represent the major FE for HIV services across all three years, while their relative contributions have been constantly declining from 72% in 2020 to 64% in 2022. Associated FAPs are governments in the public sector (31% in 2022), not-for-profit institutions in the private sector (10% in 2022), and multilateral agencies managing external resources, as well as international not-for-profit organizations and foundations, as international purchasing organizations (23% in 2022). Public entities, being the second largest FE, saw an elevation in absolute, as well as relative expenditure, reaching 31% in 2022, which amounts to 9.73 million United States dollars. This is entirely channeled through government FAPs. Lastly, domestic private entities as a FE in the form of private household's OOP as FAP contributed 5-6% across the years.

Table 7: Financing entity (FE) by Financing Agent-Purchaser (FAP) for HIV services, 2020-2022, US dollars and %

FE and FAP	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
FAP.01 Public sector	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
FAP.01.01 Territorial governments	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
FE.02 Domestic Private Entities	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
FAP.02 Private sector	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
FAP.02.04 Private households' out of pocket payments	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
FE.03 International Entities	24,580,047	19,976,356	20,101,176	71.7%	64.9%	63.7%
FAP.01 Public sector	12,881,205	10,701,405	9,697,447	37.6%	34.7%	30.7%
FAP.01.01 Territorial governments	12,881,205	10,701,405	9,697,447	37.6%	34.7%	30.7%
FAP.02 Private sector	4,391,241	3,093,151	3,267,507	12.8%	10.0%	10.4%
FAP.02.05 Not-for-profit institutions (other than social insurance)	4,391,241	3,093,151	3,267,507	12.8%	10.0%	10.4%
FAP.03 International purchasing organizations	7,307,601	6,181,800	7,136,221	21.3%	20.1%	22.6%
FAP.03.02 Multilateral agencies managing external resources	768,717	664,141	1,625,251	2.2%	2.2%	5.1%
FAP.03.03 International not-for-profit organizations and foundations	6,538,884	5,517,659	5,510,970	19.1%	17.9%	17.5%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.3. Provision vectors

3.3.1. Provider of services (PS)

Examining the HIV service providers in Cambodia, Figure 7 and Table 8 indicate that governmental organizations remained the cornerstone of service delivery, albeit with a slight decline in their

contribution from 65% (22.3 million United States dollars) in 2020 to 63% (19.9 million United States dollars) in 2022. Among governmental organizations, public hospitals reduced their share from 45% in 2020 to 32% in 2022. In contrast, non-profit providers, referring to civil society organizations, increased their share from 9% to 12%, corresponding to an absolute increase in funding to 3.9 million United States dollars in 2022. The role of bilateral and multilateral entities in service delivery themselves remained around 10% over the period, while service delivery by international NGOs and foundations increased slightly from 9% to 12%, and multilateral agencies only spent 4% themselves. Private providers n.e.c. consistently contributed 4-5% of the total HIV expenditure without significant fluctuation during this time frame – this category represents the service providers paid for by households (OOPP), their details being unknown.

Figure 7: Provider of services (PS), 2020-2022, US dollars (millions) and %

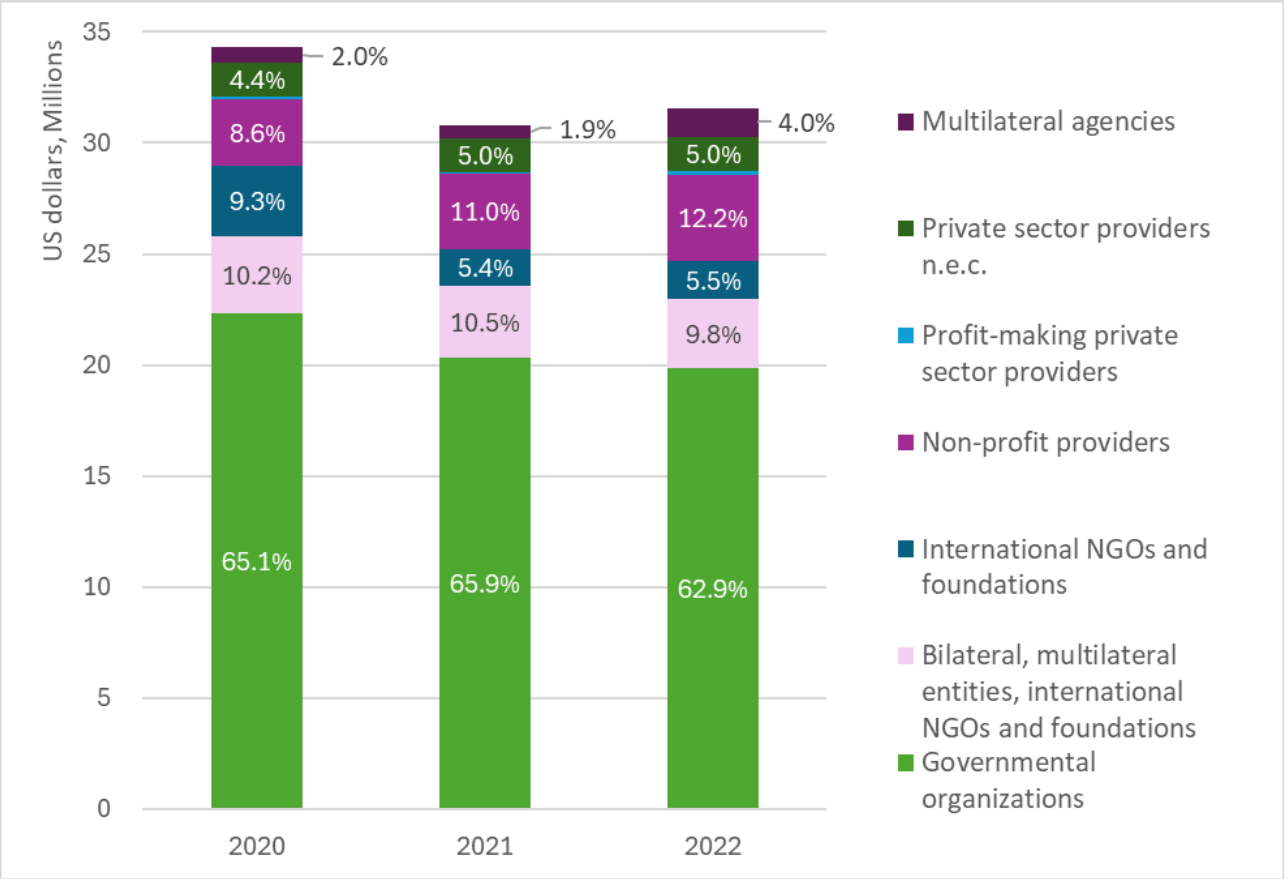


Table 8: Types of Provider of services (PS), 2020-2022, US dollars and %

Provider of services	2020	2021	2022	% 2020	% 2021	% 2022
PS.01.01 Governmental organizations	22,314,922	20,313,867	19,852,488	65.1%	65.9%	62.9%
Ambulatory care (public)	49,584	-	-	0.1%	0.0%	0.0%
Blood banks (public)	1,338,274	1,314,898	1,553,912	3.9%	4.3%	4.9%
Government entities (public)	2,813,696	2,545,250	2,69,848	8.2%	8.3%	8.5%
Governmental organizations not disaggregated	1,671,629	1,616,031	4,324,549	4.9%	5.2%	13.7%
Hospitals (public)	15,422,078	13,911,663	10,148,212	45.0%	45.2%	32.1%
National AIDS Coordinating Authority (NACs)	1,019,660	926,025	1,155,968	3.0%	3.0%	3.7%
PS.02.01 Non-profit providers	2,955,282	3,387,158	3,863,985	8.6%	11.0%	12.2%
Civil society organizations	2,955,282	3,387,158	3,863,985	8.6%	11.0%	12.2%
PS.02.02 Profit-making private sector providers	132,196	104,283	148,120	0.4%	0.3%	0.5%
Profit-making private sector providers not disaggregated	132,196	104,283	148,120	0.4%	0.3%	0.5%
PS.02.99 Private sector providers n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
Private sector providers n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
PS.03.02 Multilateral agencies	698,026	571,425	1,272,713	2.0%	1.9%	4.0%
Multilateral agencies	698,026	571,425	1,272,713	2.0%	1.9%	4.0%
PS.03.03 International NGOs and foundations	3,190,487	1,669,977	1,734,191	9.3%	5.4%	5.5%
International NGOs and foundations	3,190,487	1,669,977	1,734,191	9.3%	5.4%	5.5%
PS.03.99 Bilateral, multilateral entities, international NGOs and foundations - in country offices n.e.c.	3,492,508	3,229,678	3,107,897	10.2%	10.5%	9.8%
Bilateral, multilateral entities, international NGOs and foundations – in country offices n.e.c.	3,492,508	3,229,678	3,107,897	10.2%	10.5%	9.8%
Total HIV (United States dollars)	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.3.1.1 Activity implementation at national and province levels

This is the first national assessment (NASA VII) to capture HIV spending across Cambodia, both nationally and in individual provinces. Previously, such data wasn't collected at the provincial level. However, a large portion of total expenditure (around three-quarters in each year) could not be disaggregated by province, primarily due to Global Fund and PEPFAR expenditure data not being split by geographic location. While there are 72 HIV treatment centers (ART sites) nationwide, only

18 provided data but only 8 accessible for analysis. The remaining sites kept their data confidential for patients receiving services or had limited capacities to provide requested data. To estimate spending for provinces with missing data, the NASA team, with approval, used a weighted proportional approach**.** The calculated average spending per person on ART from the 8 reporting sites was multiplied by the number of patients receiving treatment (ART patients) at each non-reporting site. This estimated data is presented in Table 9.

Table 9 shows a slight decrease in national spending on HIV services as a proportion of the total spending. Phnom Penh has the highest overall spending and the largest share of spending (10%). Spending varied across provinces, with some increasing their share (Banteay Meanchey, Battambang) and others decreasing (Kampong Thom). As explained, a significant portion of the budget (around 74%) remains unallocated to specific provinces.

Table 9: HIV spending on provincial and national levels, 2020-2022, US dollars

Provincial & National levels	2020	2021	2022	% 2020	% 2021	% 2022
National Spending	654,696	466,552	438,809	1.9%	1.5%	1.4%
Banteay Meanchey	321,086	350,904	345,387	0.9%	1.1%	1.1%
Battambang	522,237	529,308	599,503	1.5%	1.7%	1.9%
Kampong Cham	286,782	305,913	306,979	0.8%	1.0%	1.0%
Kampong Chhnang	77,123	87,308	84,140	0.2%	0.3%	0.3%
Kampong Speu	181,939	194,587	214,601	0.5%	0.6%	0.7%
Kampong Thom	113,181	144,400	115,560	0.3%	0.5%	0.4%
Kampot	219,605	263,350	224,365	0.6%	0.9%	0.7%
Kandal	251,162	254,541	248,796	0.7%	0.8%	0.8%
Koh Kong	105,068	127,322	104,173	0.3%	0.4%	0.3%
Kratié	52,390	57,723	58,840	0.2%	0.2%	0.2%
Mondulkiri	4,282	4,813	5,064	0.0%	0.0%	0.0%
Phnom Penh	3,080,561	3,256,407	3,346,052	9.0%	10.6%	10.6%
Preah Vihear	26,075	31,019	29,998	0.1%	0.1%	0.1%
Prey Veng	232,238	252,215	244,200	0.7%	0.8%	0.8%
Pursat	119,249	129,576	124,916	0.3%	0.4%	0.4%
Ratanakiri	14,475	17,696	18,927	0.0%	0.1%	0.1%
Siem Reap	551,311	563,447	603,612	1.6%	1.8%	1.9%
Preah Sihanouk	204,200	203,570	210,928	0.6%	0.7%	0.7%
Stung Treng	11,004	11,312	12,363	0.0%	0.0%	0.0%
Svay Rieng	153,269	170,354	175,613	0.4%	0.6%	0.6%
Takéo	288,703	333,643	323,139	0.8%	1.1%	1.0%
Oddar Meanchey	42,370	45,785	45,833	0.1%	0.1%	0.1%
Kep	6,618	7,617	7,745	0.0%	0.0%	0.0%
Pailin	31,135	32,560	30,744	0.1%	0.1%	0.1%
Tboung Khmum	139,202	148,081	146,104	0.4%	0.5%	0.5%
Not disaggregated by part of the country	26,609,138	22,813,384	23,499,300	77.6%	74.1%	74.4%
Grand Total	34,299,097	30,803,388	31,565,694	100%	100%	100%

3.3.1.2 Provider of Services (PS) and Financing Agent-Purchaser (FAP)

Table 10 provides a detailed stratification of service providers, offering insight into the distribution of funds by financing agents and purchasers within the HIV sector. In 2021 and 2022, non-profit providers received 3% of the total funds from public FAPs, who directed the rest of their funds to public service providers, at 61.1% in 2020, 61.6% in 2021, and 58.1% in 2022. Private FAPs (managing 17.6% in 2020, 15.3% in 2021, and 15.8% in 2022) provided their funding primarily towards non-profit providers, less than 1% to profit providers and around 2% for INGO providers. The households' purchase of services was labelled to private not elsewhere classified (around 5%). Additionally, international purchasers allocated 20% to 23% of their funds to various entities—including multi-sectoral agencies, non-profit institutions, government and bilateral agencies, as well as non-governmental organizations—for the expenditure on HIV-related activities during the same period.

Table 10: HIV Financing Agent-Purchaser (FAP) by Provider of Services (PS), 2020-2022, US dollars and %

FAP and PS	2020	2021	2022	% 2020	% 2021	% 2022
FAP.01 Public sector	20,952,384	19,897,154	19,427,545	61.1%	64.6%	61.5%
FAP.01.01 Territorial governments	20,952,384	19,897,154	19,427,545	61.1%	64.6%	61.5%
PS.01.01 Governmental organizations	20,952,384	18,968,492	18,345,247	61.1%	61.6%	58.1%
PS.02.01 Non-profit providers	-	928,662	1,082,298	0.0%	3.0%	3.4%
FAP.02 Private sector	6,039,112	4,724,434	5,001,928	17.6%	15.3%	15.8%
FAP.02.04 Private households' (out-of-pocket payments)	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
PS.02.02 Profit-making private sector providers	132,196	104,283	148,120	0.4%	0.3%	0.5%
PS.02.99 Private sector providers n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
FAP.02.05 Not-for-profit institutions (other than social insurance)	4,391,241	3,093,151	3,267,507	12.8%	10.0%	10.4%
PS.02.01 Non-profit providers	2,494,884	2,430,733	2,561,379	7.3%	7.9%	8.1%
PS.03.03 International NGOs and foundations	1,896,357	662,418	706,129	5.5%	2.2%	2.2%
FAP.03 International purchasing organizations	7,307,601	6,181,800	7,136,221	21.3%	20.1%	22.6%
FAP.03.02 Multilateral agencies managing external resources	768,717	664,141	1,625,251	2.2%	2.2%	5.1%
PS.01.01 Governmental organizations	60,913	64,953	132,230	0.2%	0.2%	0.4%
PS.02.01 Non-profit providers	9,777	27,763	220,309	0.0%	0.1%	0.7%
PS.03.02 Multilateral agencies	698,026	571,425	1,272,713	2.0%	1.9%	4.0%
FAP.03.03 International not-for-profit organizations and foundations	6,538,884	5,517,659	5,510,970	19.1%	17.9%	17.5%

PS.01.01 Governmental organizations	1,301,625	1,280,422	1,375,011	3.8%	4.2%	4.4%
PS.02.01 Non-profit providers	450,621	-	-	1.3%	0.0%	0.0%
PS.03.03 International NGOs and foundations	1,294,130	1,007,559	1,028,062	3.8%	3.3%	3.3%
PS.03.99 Bilateral, multilateral entities, international NGOs and foundations – in country offices n.e.c.	3,492,508	3,229,678	3,107,897	10.2%	10.5%	9.8%
Grand Total	34,299,097	30,803,388	31,565,694	100%	100%	100%

3.3.2. Production Factors (PF) contributing to HIV/AIDS interventions.

Table 11 offers a comprehensive view of HIV expenditures categorized by production factors from 2020 to 2022, identifying three key areas: current direct and indirect expenditures, capital expenditures, and unclassified production factors. In the realm of current direct and indirect expenditures, personnel costs were the most significant, comprising 38% of the budget in 2021 and 37% in 2022. Medical products and supplies were also a major expense, accounting for 36% in 2021 and diminishing slightly to 30% in 2022, although in 2020, they took precedence at 34%, slightly ahead of personnel costs at 33%. "Other operational and program management current expenses" consistently ranked third, making up around 1% of total spending across the years.

Capital expenditures, which include spending on buildings, vehicles, and other capital items, remained a minor fraction of the overall budget, not surpassing 2% in any given year. Expenditure on building renovations or construction saw some fluctuation, from 30,000 United States dollars in 2020 to 56,000 United States dollars in 2021, then dropping to 51,000 United States dollars in 2022. Vehicle spending showed a decrease from 120,000 United States dollars in 2020 to 67,000 United States dollars in 2021, and further down to 38,000 United States dollars in 2022. Investments in other capital assets remained relatively stable, ranging from 0.9% to 1.2% of the total budget across the three years, illustrating a focused yet modest investment in capital assets within the broader context of HIV expenditure.

Table 11: Overall spending by Production Factors (PF), 2020-2022, US Dollars and %

PF	2020	2021	2022	% 2020	% 2021	% 2022
PF.01 Current direct and indirect expenditures	32,667,326	29,886,166	30,871,731	95.2%	97.0%	97.8%
PF.01.01 Personnel costs	11,455,644	11,543,605	11,532,878	33.4%	37.5%	36.5%
PF.01.02 Other operational and programme management current expenditures	4,357,125	3,496,978	3,524,752	12.7%	11.4%	11.2%
PF.01.03 Medical products and supplies	11,679,886	11,221,837	9,567,739	34.1%	36.4%	30.3%
PF.01.04 Contracted external services	1,330,195	890,223	999,983	3.9%	2.9%	3.2%

PF.01.05 Transportation related to beneficiaries	7,111	19,153	14,017	0.0%	0.1%	0.0%
PF.01.07 Financial support for beneficiaries	700,975	434,751	594,279	2.0%	1.4%	1.9%
PF.01.08 Training- Training related per diems/transport/ other costs	1,346,857	770,362	1,307,043	3.9%	2.5%	4.1%
PF.01.09 Logistics of events, including catering services	611,138	348,584	1,055,121	1.8%	1.1%	3.3%
PF.01.10 Indirect costs	907,430	1,040,871	1,182,912	2.6%	3.4%	3.7%
PF.01.98 Current direct and indirect expenditures not disaggregated	270,963	119,801	1,093,004	0.8%	0.4%	3.5%
PF.02 Capital expenditures	550,733	444,312	537,928	1.6%	1.4%	1.7%
PF.02.01 Building	30,102	55,922	51,328	0.1%	0.2%	0.2%
PF.02.02 Vehicles	120,480	66,528	38,118	0.4%	0.2%	0.1%
PF.02.03 Other capital investment	379,699	290,874	381,306	1.1%	0.9%	1.2%
PF.02.98 Capital expenditure not disaggregated	20,451	30,987	67,176	0.1%	0.1%	0.2%
PF.98 Production factors not disaggregated	1,081,038	472,910	156,035	3.2%	1.5%	0.5%
PF.98 Production factors not disaggregated	1,081,038	472,910	156,035	3.2%	1.5%	0.5%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.3.2.1. Production Factors (PF) and Financing Entity (FE)

Table 12 delves into the nuances of HIV expenditure patterns among various financing entities, highlighting distinct priorities and allocations. Domestic private entities channel a vast majority of their HIV-related funds, nearly 92%, towards operational and program management expenses. This significant allocation suggests an intense focus on building administrative capacities and programmatic infrastructure, underlining their commitment to enhancing the efficacy and reach of their initiatives.

In contrast, international entities allocate their budgets differently, with a notable 36% directed towards personnel costs. This investment likely reflects the necessity for specialized expertise in managing and implementing HIV programs across diverse international landscapes. Moreover, 24% of their funding goes towards medical products and supplies, emphasizing their role in providing direct health services and interventions.

Public entities, on the other hand, demonstrate a substantial commitment to both personnel costs and medical products and supplies, dedicating 45% and 48% of their expenditures to these areas, respectively. The focus on personnel costs underscores the importance of staffing in public health initiatives, while the significant investment in medical products and supplies signals a strong emphasis on ensuring accessible and effective direct service delivery to those affected by HIV.

Table 12: Financing Entity (FE) by Production Factors (PF), 2020-2022, US dollars and %

FE by PF	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
PF.01.01 Personnel costs	4,281,754	4,657,592	4,397,998	12.5%	15.1%	13.9%
PF.01.02 Other operational and programme management current expenditures	269,044	153,178	308,095	0.8%	0.5%	1.0%
PF.01.03 Medical products and supplies	3,204,756	4,181,289	4,659,842	9.3%	13.6%	14.8%
PF.01.07 Financial support for beneficiaries	240,880	163,111	232,049	0.7%	0.5%	0.7%
PF.01.09 Logistics of events, including catering services	66,505	34,832	127,855	0.2%	0.1%	0.4%
PF.01.98 Current direct and indirect expenditures not disaggregated	686	685	685	0.0%	0.0%	0.0%
PF.98 Production factors not disaggregated	7,555	5,062	3,574	0.0%	0.0%	0.0%
FE.02 Domestic Private Entities	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
PF.01.02 Other operational and programme management current expenditures	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
PF.98 Production factors not disaggregated	132,196	104,283	148,120	0.4%	0.3%	0.5%
FE.03 International Entities	24,580,047	19,976,356	20,101,176	71.7%	64.9%	63.7%
PF.01.01 Personnel costs	7,173,890	6,886,013	7,134,880	20.9%	22.4%	22.6%
PF.01.02 Other operational and programme management current expenditures	2,572,407	1,816,801	1,630,357	7.5%	5.9%	5.2%
PF.01.03 Medical products and supplies	8,475,130	7,040,548	4,907,898	24.7%	22.9%	15.5%
PF.01.04 Contracted external services	1,330,195	890,223	999,983	3.9%	2.9%	3.2%
PF.01.05 Transportation related to beneficiaries	7,111	19,153	14,017	0.0%	0.1%	0.0%
PF.01.07 Financial support for beneficiaries	460,096	271,639	362,231	1.3%	0.9%	1.1%
PF.01.08 Training- Training related per diems/transport/other costs	1,346,857	770,362	1,307,043	3.9%	2.5%	4.1%
PF.01.09 Logistics of events, including catering services	544,633	313,752	927,266	1.6%	1.0%	2.9%
PF.01.10 Indirect costs	907,430	1,040,871	1,182,912	2.6%	3.4%	3.7%
PF.01.98 Current direct and indirect expenditures not disaggregated	270,277	119,116	1,092,320	0.8%	0.4%	3.5%
PF.02.01 Building	30,102	55,922	51,328	0.1%	0.2%	0.2%
PF.02.02 Vehicles	120,480	66,528	38,118	0.4%	0.2%	0.1%
PF.02.03 Other capital investment	379,699	290,874	381,306	1.1%	0.9%	1.2%
PF.02.98 Capital expenditure not disaggregated	20,451	30,987	67,176	0.1%	0.1%	0.2%
PF.98 Production factors not disaggregated	941,287	363,565	4,340	2.7%	1.2%	0.0%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.4. Consumption vectors

3.4.1. AIDS Spending Categories (ASC)

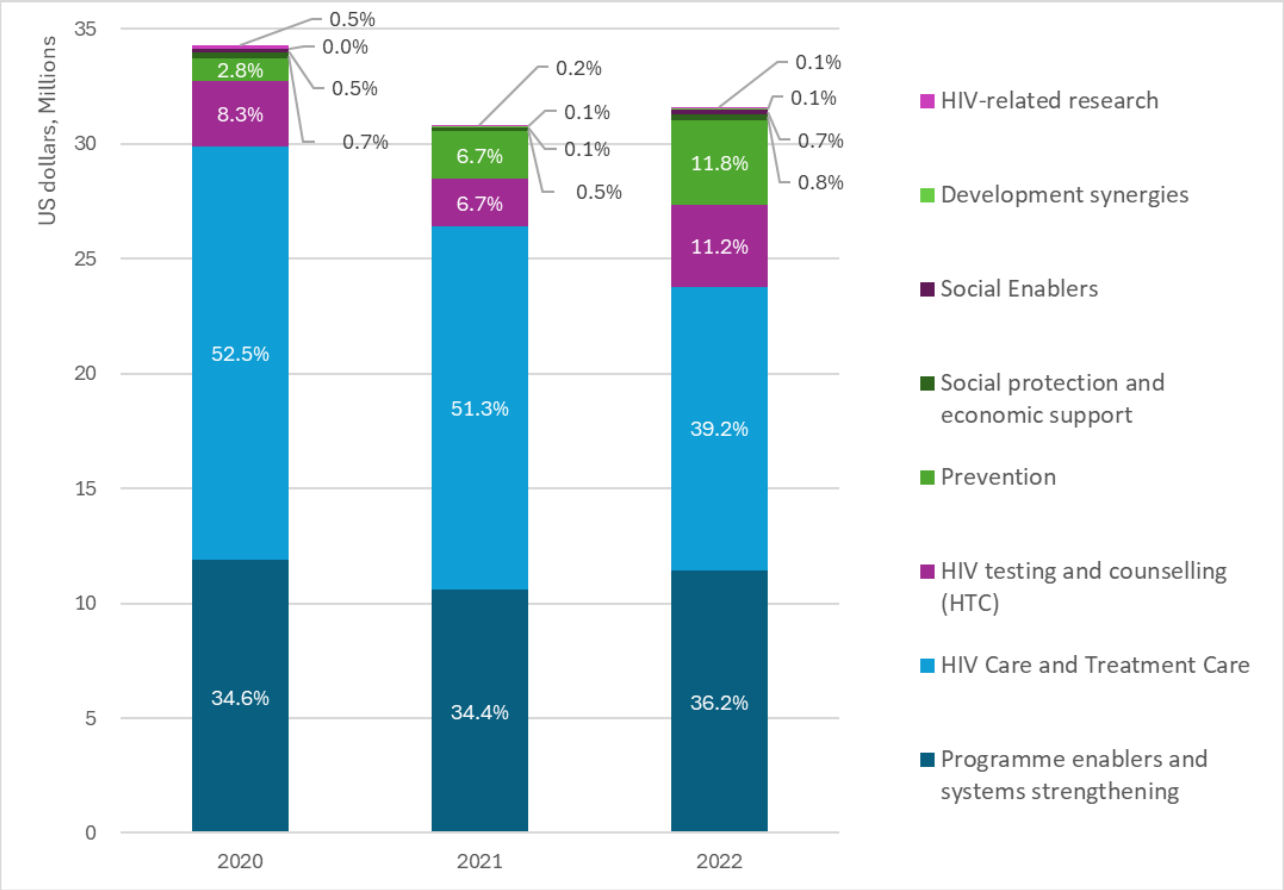
Table 13 and Figure 8 detail the distribution of total HIV spending by programme area over the years 2020 to 2022. Throughout this period, the bulk of funding was allocated to HIV care and treatment, despite a downward trend, with the absolute funding decreasing from 18.0 million United States dollars (53%) in 2020 to 12.4 million United States dollars in 2022, representing 39% of the total HIV expenditure in the latter year. Programme enablers and systems strengthening (including programme administration and management) remained a key focus, with its funding staying relatively consistent, amounting to 11.4 million United States dollars in 2022, or 36% of the total budget. Notably, prevention efforts saw a significant uptick in investment, experiencing a 3.8-fold increase from a low base of less than 1 million United States dollars in 2020 to 2022, culminating in 3.7 million United States dollars and capturing almost 12% of total HIV funding, a rise of 9 percentage points since 2020. HTC experienced a slight drop in funding between 2020 and 2021 but rebounded to 3.5 million United States dollars in 2022, accounting for 11% of the overall expenditure. Other programme areas each accounted for less than 1% of the total expenditure in 2022. Funding for social protection and economic support remained fairly constant, whereas social enablers witnessed a significant decrease in 2021. Meanwhile, spending on development synergies surged increased three-fold from a low base between 2020 and 2022. Conversely, investment in HIV-related research consistently diminished, with 2022 spending only 22% of what was allocated in 2020, reflecting shifting priorities within the HIV funding landscape.

It is important to note that above service provision activities take over 35-36% per year and could be a potential goal for revision and optimization.

Table 13: AIDS Spending Categories (ASC), 2020-2022 in US dollars and %

ASC	2020	2021	2022	% 2020	% 2021	% 2022
Prevention	977,088	2,078,704	3,718,717	2.8%	6.7%	11.8%
HIV testing and counseling (HTC)	2,831,640	2,057,380	3,525,734	8.3%	6.7%	11.2%
HIV Care and Treatment Care	18,016,180	15,807,345	12,359,979	52.5%	51.3%	39.2%
Social protection and economic support	255,971	169,220	237,814	0.7%	0.5%	0.8%
Social Enablers	156,665	24,723	220,015	0.5%	0.1%	0.7%
Programme enablers and systems strengthening	11,872,926	10,591,451	11,427,816	34.6%	34.4%	36.2%
Development synergies	8,255	24,565	35,995	0.0%	0.1%	0.1%
HIV-related research	180,371	50,000	39,623	0.5%	0.2%	0.1%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Figure 8: AIDS Spending Categories (ASC), 2020-2022, US dollars (millions) and %



3.4.1.1. AIDS Spending Categories (ASC) and Financing Entity (FE)

Figure 9 and Table 14: Financing Entity (FE) by AIDS Spending Categories (ASC), 2020-2022, US Dollars illustrate how the expenditures from the different financing entity types have been allocated across the program areas outlined by the new NASA framework over the three-year span, encompassing prevention, HIV testing and counseling, care and treatment, social protection and

economic support, alongside program enablers, system strengthening, development of synergies, and HIV-related research.

The data reveals that prevention initiatives see modest investment from public and private sectors, with less than 2% of their contributions allocated, in stark contrast to international entities, which dedicated from 5% to 17% of their total expenditures to prevention. Regarding HIV care and treatment services, public financing entities spent 57% to 60% of their total expenditure on treatment and care, while international financing entities' spending decreased from 48% of their total spending in 2020 to 24% in 2022. The private financing entities, which mainly came from households OOPPs went primarily towards care and treatment services, over 90% of these small funds, in each year.

HIV testing and counseling programs demonstrate a different funding trend; while public entities maintained around 16% of their total spending on HTC, the international entities have increased their contribution from 5.8% in 2020 to 9.4% in 2022.

The figure highlights that expenditures on social protection, economic support, social enablers, development synergies and HIV research remained very small for all financing entities. On the other hand, program enablers and system strengthening benefitted from 47.4% of international financing entities funds and 19.4% of public funding in 2022. '

Figure 9: Financing Entity (FE) by AIDS Spending Categories (ASC), 2020-2022, %

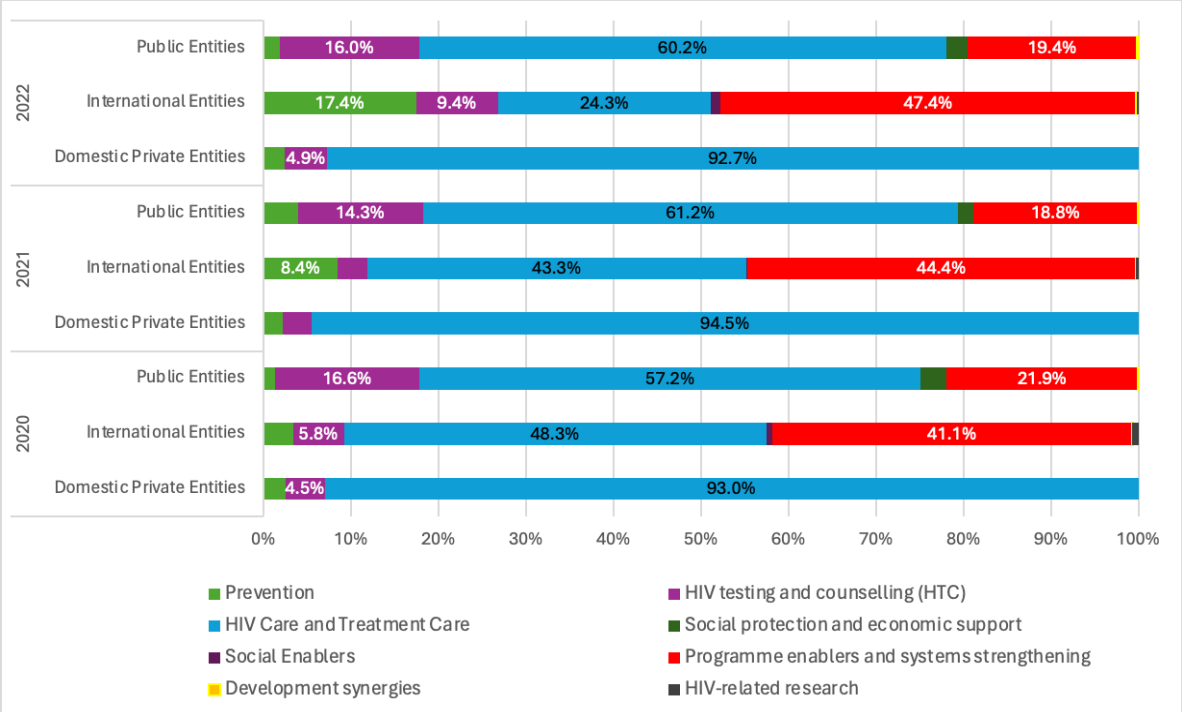


Table 14 shows spending of the financing entities (Domestic Private Entities, International Entities, Public Entities) broken down by program area (Prevention, Care & Treatment, etc.) in Cambodia from 2020 to 2022.

Table 14: Financing Entity (FE) by AIDS Spending Categories (ASC), 2020-2022, US Dollars

FE by ASC	2020			2021			2022		
	Domestic Private Entities	International Entities	Public Entities	Domestic Private Entities	International Entities	Public Entities	Domestic Private Entities	International Entities	Public Entities
Prevention	40,803	833,915	102,370	35,419	1,683,550	359,736	41,467	3,500,459	176,791
HIV testing and counseling (HTC)	74,089	1,419,277	1,338,274	53,996	688,485	1,314,898	84,561	1,887,261	1,553,912
HIV Care and Treatment Care	1,532,979	11,863,308	4,619,893	1,541,868	8,641,194	5,624,283	1,608,392	4,889,611	5,861,977
Social protection and economic support	-	15,091	240,880	-	6,109	163,111	-	5,766	232,049
Social Enablers	-	156,665	-	-	24,723	-	-	220,015	-
Programme enablers and systems strengthening	-	10,108,622	1,764,304	-	8,864,877	1,726,575	-	9,536,468	1,891,349
Development synergies	-	2,797	5,458	-	17,419	7,146	-	21,974	14,021
HIV-related research	-	180,371	-	-	50,000	-	-	39,623	-
Grand Total	1,647,871	24,580,047	8,071,179	1,631,283	19,976,356	9,195,749	1,734,420	20,101,176	9,730,098

Figure 10 provide a detailed breakdown of the funding contributions from different entities across HIV programme areas in 2022. For HIV care and treatment, public and international sources played crucial roles, contributing 47% and 40% of the financing, respectively, with the balance supported by domestic private entities. International sources were particularly dominant in financing for programme enablers and systems strengthening, providing 83% of the funds, with public entities contributing the remaining share. Prevention, social enablers, and HIV-related research saw overwhelming financial support from international entities, showcasing their critical role in these areas. Conversely, social protection and economic support were primarily funded by public entities. In the realms of HTC and development synergies, public entities accounted for 44% and 39% of the funding, respectively, with the remaining support otherwise coming from international sources.

Figure 10: Financing Entity (FE) by AIDS Spending Categories (ASC), 2020-2022, %

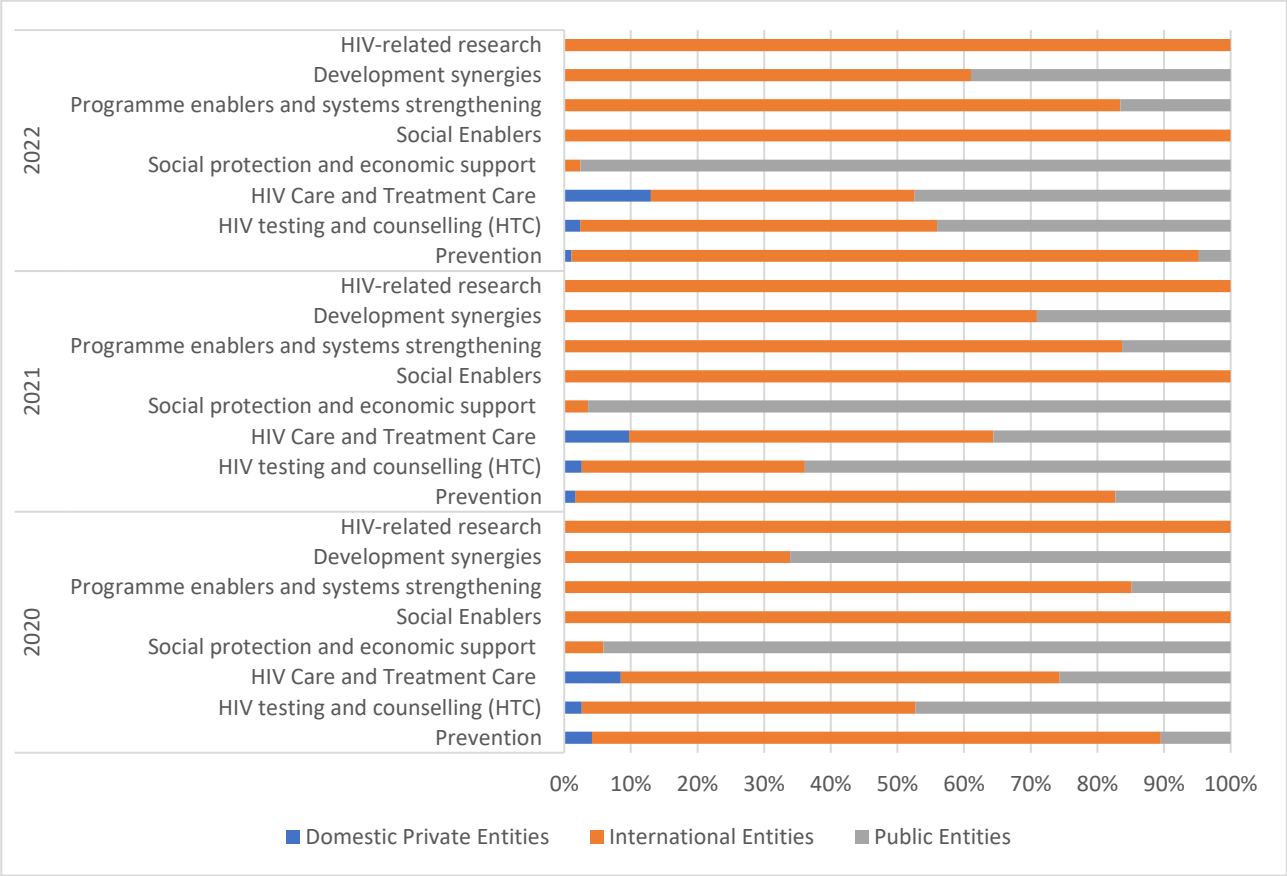


Table 15: Financing Entity (FE) by AIDS Spending Categories (ASC), 2020-2022, US dollars and %

FE by ASC	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
ASC.01 Prevention	102,370	359,736	176,791	0.3%	1.2%	0.6%
ASC.02 HIV testing and counselling (HTC)	1,338,274	1,314,898	1,553,912	3.9%	4.3%	4.9%
ASC.03 HIV Care and Treatment Care	4,619,893	5,624,283	5,861,977	13.5%	18.3%	18.6%

ASC.04 Social protection and economic support	240,880	163,111	232,049	0.7%	0.5%	0.7%
ASC.06 Programme enablers and systems strengthening	1,764,304	1,726,575	1,891,349	5.1%	5.6%	6.0%
ASC.07 Development synergies	5,458	7,146	14,021	0.0%	0.0%	0.0%
FE.02 Domestic Private Entities	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
ASC.01 Prevention	40,803	35,419	41,467	0.1%	0.1%	0.1%
ASC.02 HIV testing and counselling (HTC)	74,089	53,996	84,561	0.2%	0.2%	0.3%
ASC.03 HIV Care and Treatment Care	1,532,979	1,541,868	1,608,392	4.5%	5.0%	5.1%
FE.03 International Entities	24,580,047	19,976,356	20,101,176	71.7%	64.9%	63.7%
ASC.01 Prevention	833,915	1,683,550	3,500,459	2.4%	5.5%	11.1%
ASC.02 HIV testing and counselling (HTC)	1,419,277	688,485	1,887,261	4.1%	2.2%	6.0%
ASC.03 HIV Care and Treatment Care	11,863,308	8,641,194	4,889,611	34.6%	28.1%	15.5%
ASC.04 Social protection and economic support	15,091	6,109	5,766	0.0%	0.0%	0.0%
ASC.05 Social Enablers	156,665	24,723	220,015	0.5%	0.1%	0.7%
ASC.06 Programme enablers and systems strengthening	10,108,622	8,864,877	9,536,468	29.5%	28.8%	30.2%
ASC.07 Development synergies	2,797	17,419	21,974	0.0%	0.1%	0.1%
ASC.08 HIV-related research	180,371	50,000	39,623	0.5%	0.2%	0.1%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.4.1.2. Financing Agent-Purchaser (FAP) and AIDS Spending Categories (ASC)

Table 16 shows the total spending on AIDS by these financing agents and purchasers from 2020 to 2022. Public Sector was the largest FAP across the 3 years from 21.0 million United States dollars in 2020 to 19.4 million United States dollars in 2022. The percentage of total spending also decreased slightly from 61.1% to 61.5%. The percentage of total spending remained relatively stable around 16%-17% across the 3 consecutive years. Whereas, the International Purchasing Organizations spending ending slightly lower at 7.1 million United States dollars in 2022 compared to 7.3 million United States dollars in 2020.

From HIV program areas spending, the public sector spent on prevention, HTC, HIV care and treatment, social protection and economic support, social enablers, program enabler and system strengthening, and development synergy. The HIV care and treatment consumed around 42.5% in 2020, 44.5% in 2021 and 32.0% in 2022. The program enabler and system strengthen was lying between 12% to 14% spending by public sectors. The private sector focused on prevention, HTC, care and treatment, and program enabler. Each program area was spent around 1 to 5% each year by private sectors. The international purchasing organizations focused the all program areas. However, it is noted that program management and system strengthening was the highest expenditure at around 16% in 2020, 16.5% in 2021 and 16.7% in 2022.

Table 16: Financing Agent-Purchaser (FAP) by AIDS Spending Categories (ASC), 2020-2022, US dollars and %

FAP by ASC	2020	2021	2022	% 2020	% 2021	% 2022
FAP.01 Public sector	20,952,384	19,897,154	19,427,545	61.1%	64.6%	61.5%
ASC.01 Prevention	158,891	476,318	1,281,777	0.5%	1.5%	4.1%
ASC.02 HIV testing and counselling (HTC)	1,458,197	1,759,658	3,149,476	4.3%	5.7%	10.0%
ASC.03 HIV Care and Treatment Care	14,572,922	13,716,123	10,100,253	42.5%	44.5%	32.0%
ASC.04 Social protection and economic support	240,880	163,111	232,049	0.7%	0.5%	0.7%
ASC.05 Social Enablers	119,127	6,010	141,749	0.3%	0.0%	0.4%
ASC.06 Programme enablers and systems strengthening	4,396,908	3,768,788	4,508,219	12.8%	12.2%	14.3%
ASC.07 Development synergies	5,458	7,146	14,021	0.0%	0.0%	0.0%
FAP.02 Private sector	6,039,112	4,724,434	5,001,928	17.6%	15.3%	15.8%
ASC.01 Prevention	392,234	1,279,973	1,406,028	1.1%	4.2%	4.5%
ASC.02 HIV testing and counselling (HTC)	1,069,052	142,228	248,199	3.1%	0.5%	0.8%
ASC.03 HIV Care and Treatment Care	2,567,571	1,573,616	1,694,604	7.5%	5.1%	5.4%
ASC.06 Programme enablers and systems strengthening	2,009,855	1,728,616	1,653,097	5.9%	5.6%	5.2%
ASC.08 HIV-related research	400	-	-	0.0%	0.0%	0.0%
FAP.03 International purchasing organizations	7,307,601	6,181,800	7,136,221	21.3%	20.1%	22.6%
ASC.01 Prevention	425,963	322,413	1,030,912	1.2%	1.0%	3.3%
ASC.02 HIV testing and counselling (HTC)	304,391	155,494	128,058	0.9%	0.5%	0.4%
ASC.03 HIV Care and Treatment Care	875,687	517,606	565,123	2.6%	1.7%	1.8%
ASC.04 Social protection and economic support	15,091	6,109	5,766	0.0%	0.0%	0.0%
ASC.05 Social Enablers	37,537	18,713	78,266	0.1%	0.1%	0.2%
ASC.06 Programme enablers and systems strengthening	5,466,163	5,094,047	5,266,500	15.9%	16.5%	16.7%
ASC.07 Development synergies	2,797	17,419	21,974	0.0%	0.1%	0.1%
ASC.08 HIV-related research	179,971	50,000	39,623	0.5%	0.2%	0.1%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.4.1.3. AIDS Spending Categories (ASC) and Production Factors (PF)

Table 17 offers a detailed analysis of expenditures within HIV program areas by production factor from 2020 to 2022, across eight primary areas including prevention, HIV testing and counseling, care and treatment, social protection and economic support, social enablers, program enablers and system strengthening, development synergies, and HIV-related research.

In prevention programs, the lion's share of funding was allocated to current direct and indirect expenditures, escalating from $0.98 million in 2020 to 3.72 million United States dollars in 2022. This category consistently represented the bulk of prevention spending, growing from 2.6% of the

total budget in 2020 to 10.6% in 2022, while capital expenditures remained below 1% across the three years.

HIV testing and counseling programs mirrored this trend, with a heavy reliance on current direct and indirect expenditures—2.83 million United States dollars in 2020 to 3.53 million United States dollars in 2022—and these costs constituting an increasing percentage of the total budget over the years.

HIV care and treatment programs also focused predominantly on current direct and indirect expenditures, which decreased from 18.01 million United States dollars in 2020 to 12.36 million United States dollars in 2022, still accounting for a substantial portion of the budget throughout the period.

Other program areas, though receiving lower total expenditures, followed a similar pattern, with current direct and indirect expenditures dominating. Notably, program enablers and system strengthening saw significant investment, with spending in this area reaching up to 11.87 million United States dollars in 2020, showcasing the importance of infrastructure and capacity building within the broader HIV response. Across all areas, capital expenditures remained a minor component of the total budget, underscoring a strategic focus on operational and programmatic needs.

Table 17: AIDS Spending Categories (ASC) by Production Factors (PF), 2020-2022, US dollars and %

ASC by PF	2020	2021	2022	% 2020	% 2021	% 2022
ASC.01 Prevention	977,088	2,078,704	3,718,717	2.8%	6.7%	11.8%
PF.01 Current direct and indirect expenditures	908,231	1,929,297	3,361,226	2.6%	6.3%	10.6%
PF.02 Capital expenditures	28,054	105,715	316,024	0.1%	0.3%	1.0%
PF.98 Production factors not disaggregated	40,803	43,692	41,467	0.1%	0.1%	0.1%
ASC.02 HIV testing and counselling (HTC)	2,831,640	2,057,380	3,525,734	8.3%	6.7%	11.2%
PF.01 Current direct and indirect expenditures	2,716,689	1,986,832	3,437,333	7.9%	6.5%	10.9%
PF.02 Capital expenditures	8,641	16,551	3,840	0.0%	0.1%	0.0%
PF.98 Production factors not disaggregated	106,311	53,996	84,561	0.3%	0.2%	0.3%
ASC.03 HIV Care and Treatment Care	18,016,180	15,807,345	12,359,979	52.5%	51.3%	39.2%
PF.01 Current direct and indirect expenditures	17,644,703	15,697,531	12,226,801	51.4%	51.0%	38.7%
PF.02 Capital expenditures	167,996	88,986	111,086	0.5%	0.3%	0.4%
PF.98 Production factors not disaggregated	203,482	20,828	22,092	0.6%	0.1%	0.1%
ASC.04 Social protection and economic support	255,971	169,220	237,814	0.7%	0.5%	0.8%
PF.01 Current direct and indirect expenditures	255,971	169,220	237,814	0.7%	0.5%	0.8%
ASC.05 Social Enablers	156,665	24,723	220,015	0.5%	0.1%	0.7%
PF.01 Current direct and indirect expenditures	156,665	24,723	220,015	0.5%	0.1%	0.7%

ASC.06 Programme enablers and systems strengthening	11,872,926	10,591,451	11,427,816	34.6%	34.4%	36.2%
PF.01 Current direct and indirect expenditures	10,796,442	10,003,999	11,312,924	31.5%	32.5%	35.8%
PF.02 Capital expenditures	346,043	233,059	106,977	1.0%	0.8%	0.3%
PF.98 Production factors not disaggregated	730,442	354,393	7,914	2.1%	1.2%	0.0%
ASC.07 Development synergies	8,255	24,565	35,995	0.0%	0.1%	0.1%
PF.01 Current direct and indirect expenditures	8,255	24,565	35,995	0.0%	0.1%	0.1%
ASC.08 HIV-related research	180,371	50,000	39,623	0.5%	0.2%	0.1%
PF.01 Current direct and indirect expenditures	180,371	50,000	39,623	0.5%	0.2%	0.1%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.4.1.4. AIDS Spending Categories (ASC) disaggregated by program areas

3.4.1.4.1. Spending on prevention interventions

The prevention program area is split into 2 main categories, namely the five pillars of prevention and other prevention activities. The former encompasses targeted strategies for adolescent girls and young women (AGYW) and their male partners in high HIV prevalence areas, services for key populations, distribution of condoms, Voluntary Medical Male Circumcision (VMMC), and Pre-Exposure Prophylaxis (PrEP). Table 18 highlights a marked escalation in total HIV prevention funding from 2020 to 2022, with the total investment tripling from 1.0 million United States dollars to 3.7 million United States dollars.

Throughout this period, the majority of the prevention funding was allocated to the five pillars, claiming 57% of the total prevention spending in 2020, surging to nearly 80% in 2021, and maintaining a high of 78.3% in 2022. Among the five pillars, activities directed at key populations commanded the major share, accounting for approximately 70% of the overall prevention funds. Conversely, spending on other (non-five pillar) prevention efforts saw a decline, falling from 43% of the prevention budget in 2020 to 22% in 2022. Notably, PrEP spending significantly increased from 0.02 million United States dollars United States Dollars in 2020 to 0.3 million United States dollars in 2022. Spending on condoms remained relatively low across the years, only slightly rising in absolute terms from 0.04 million United States dollars in 2020 to 0.05 million United States dollars in 2022, while decreasing in relative terms to 1% in 2022. Spending on prevention for children and youth was fluctuating considerably, reaching 0.2 million United States dollars in 2020, which accounted for 23% of total HIV spending in prevention program, decreasing to 0.1 million United States dollars in 2021 (5% of total HIV spending in prevention program), then increasing again to 0.4 million United States dollars in 2022 (11% of total HIV spending in prevention program). The same pattern can be observed for prevention spending for PLHIV: After experiencing an increase from 0.1 million United States dollars in 2020 to 0.2 million United States dollars in 2021, spending fell back to 0.2 million United States dollars in 2022.

Table 18: HIV spending in prevention program, 2020-2022, US dollars and %

Prevention intervention	2020	2021	2022	% 2020	% 2021	% 2022
ASC.01.01 Five Pillars of Prevention	413,986	1,174,185	2,186,668	42.4%	56.5%	58.8%
ASC.01.01.02 Services for key populations	355,950	1,104,447	1,863,244	36.4%	53.1%	50.1%

ASC.01.01.03 Condoms (for HIV prevention) for the general population (excluding KPs and AGYW above)	38,035	41,653	45,473	3.9%	2.0%	1.2%
ASC.01.01.05 Pre-Exposure Prophilaxis (PrEP)	20,000	28,085	277,951	2.0%	1.4%	7.5%
ASC.01.02 Other prevention activities	563,103	904,520	1,532,049	57.6%	43.5%	41.2%
ASC.01.02.01 Prevention of vertical transmission of HIV infection (PMTCT)	104,870	368,136	199,170	10.7%	17.7%	5.4%
ASC.01.02.03 Community mobilization for populations other than key populations	-	-	3,377	0.0%	0.0%	0.1%
ASC.01.02.04 Programmatic activities for other vulnerable and accessible populations	-	-	73,415	0.0%	0.0%	2.0%
ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)	223,396	97,857	420,476	22.9%	4.7%	11.3%
ASC.01.02.06 Prevention of HIV transmission aimed at people living with HIV and their partners (including sero-discordant couples)	120,478	211,799	172,607	12.3%	10.2%	4.6%
ASC.01.02.98 Prevention activities not disaggregate	73,556	175,836	566,458	7.5%	8.5%	15.2%
ASC.01.02.10 STI prevention and treatment programmes for populations other than key populations	40,803	50,892	96,545	4.2%	2.4%	2.6%
Grand Total	977,088	2,078,704	3,718,717	100.0%	100.0%	100.0%

A. Program area: Financing Entity (FE) by Prevention intervention

HIV prevention programs are primarily funded by three main financing entities: public entities, domestic private entities, and international entities. In 2020, international entities were the most substantial contributors, providing 85.3% of the funding for prevention interventions. Public entities contributed 10.5% in 2020, while domestic private entities accounted for 4.2% of the financial support. By 2022, the contribution from international entities had escalated to cover 94.1% of the funding, leading to a corresponding reduction in the contributions from public entities to 4.8% and domestic private entities to a mere 1.1%.

Specifically, the interventions funded by public and domestic private entities predominantly focused on PMTCT, with public expenditures amounting to 0.1 million United States dollars in 2020 and increasing to 0.2 million United States dollars by 2022. On the other hand, international entities allocated funds across a spectrum of activities, including community mobilization, condom distribution, prevention of mother-to-child transmission (PMTCT), Pre-Exposure Prophylaxis (PrEP), and other prevention activities targeting both the general population and key populations, as detailed in Table 19.

Table 19: Financing Entity (FE) by prevention intervention, 2020-2022, US dollars and %

FE by prevention intervention	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	102,370	359,736	176,791	10.5%	17.3%	4.8%
PMTCT	102,370	359,736	176,791	10.5%	17.3%	4.8%
FE.02 Domestic Private Entities	40,803	35,419	41,467	4.2%	1.7%	1.1%
STI prevention and treatment programmes	40,803	35,419	41,467	4.2%	1.7%	1.1%
FE.03 International Entities	833,915	1,683,550	3,500,459	85.3%	81.0%	94.1%
Community Mobilization	38,035	41,653	45,473	3.9%	2.0%	1.2%
Condoms	20,000	28,085	277,951	2.0%	1.4%	7.5%
PMTCT	73,556	175,836	566,458	7.5%	8.5%	15.2%
PrEP	223,396	97,857	420,476	22.9%	4.7%	11.3%
Prevention activities not disaggregate	120,478	211,799	172,607	12.3%	10.2%	4.6%
Prevention for children and youth	355,950	1,104,447	1,863,244	36.4%	53.1%	50.1%
Prevention of HIV transmission aimed at people living with HIV and their partners	-	15,473	55,078	0.0%	0.7%	1.5%
Programme Activity for vulnerability	-	-	73,415	0.0%	0.0%	2.0%
Services for key populations	2,500	8,400	22,379	0.3%	0.4%	0.6%
STI prevention and treatment programmes	-	-	3,377	0.0%	0.0%	0.1%
Grand Total	977,088	2,078,704	3,718,717	100.0%	100.0%	100.0%

B. Program area: Financing Agent-Purchaser (FAP) by prevention intervention

Table 20 details spending on various HIV prevention interventions across three financing agents (public sector, private sector, international purchasing organizations) from 2020 to 2022. Public sector is the largest contributor to prevention spending. Their allocation increased significantly (from 16.3% in 2020 to 34.5% in 2022) with a focus on PMTCT, services for key population, STI and other prevention. The spending on PMTCT increased from 0% in 2020 to 11.7% in 2022 while STI decreased almost half in the year period. Private sector spending increased but with a shift in focus. While prevention of HIV transmission aimed at people living with HIV and their partners remained significant, funding for Community Mobilization and other disaggregated prevention activities decreased. Whereas the International purchasing organizations showed a decrease in total spending on prevention. However, their allocation to PMTCT increased substantially (from 2.0% in 2020 to 7.5% in 2022).

Table 20: Financing Agent-Purchaser (FAP) by prevention intervention, 2020-2022, US dollars and %

FAP by prevention intervention	2020	2021	2022	% 2020	% 2021	% 2022
FAP.01 Public sector	158,891	476,318	1,281,777	16.3%	22.9%	34.5%
PMTCT	-	64,630	433,264	0.0%	3.1%	11.7%

Prevention activities not disaggregate	56,521	36,479	597,871	5.8%	1.8%	16.1%
Services for key populations	-	15,473	55,078	0.0%	0.7%	1.5%
STI prevention and treatment programmes	102,370	359,736	195,564	10.5%	17.3%	5.3%
FAP.02 Private sector	392,234	1,279,973	1,406,028	40.1%	61.6%	37.8%
Community Mobilization	7,064	41,000	44,816	0.7%	2.0%	1.2%
Prevention activities not disaggregate	44,938	135,587	50,993	4.6%	6.5%	1.4%
Prevention of HIV transmission aimed at people living with HIV and their partners	299,429	1,067,968	1,265,373	30.6%	51.4%	34.0%
Services for key populations	40,803	35,419	41,467	4.2%	1.7%	1.1%
STI prevention and treatment programmes	-	-	3,377	0.0%	0.0%	0.1%
FAP.03 International purchasing organizations	425,963	322,413	1,030,912	43.6%	15.5%	27.7%
Condoms	38,035	41,653	45,473	3.9%	2.0%	1.2%
PMTCT	20,000	28,085	277,951	2.0%	1.4%	7.5%
PrEP	66,492	70,206	88,378	6.8%	3.4%	2.4%
Prevention activities not disaggregate	223,396	97,857	420,476	22.9%	4.7%	11.3%
Prevention for children and youth	75,540	76,211	121,614	7.7%	3.7%	3.3%
Prevention of HIV transmission aimed at people living with HIV and their partners	-	-	73,415	0.0%	0.0%	2.0%
Programme Activity for vulnerability	2,500	8,400	3,606	0.3%	0.4%	0.1%
Grand Total	977,088	2,078,704	3,718,717	100.0%	100.0%	100.0%

C. Program area: Provider of services (PS) by prevention intervention

Table 21 shows how funding for HIV prevention activities was allocated by different sectors (Public Sector, Private Sector, International NGOs) from 2020 to 2022. Public Sector was the major providers to prevention efforts, with their funding increasing significantly from 0.3 million United States dollars in 2020 to 1.5 million United States dollars in 2022. Public sector's providers role for this category has grown substantially from 28.8% in 2020 to 40.2% in 2022 for condom, PrEP, key population, PMTCT and others. Private Sector also implemented activities for around 0.4 million United States dollars in 2020, 1.3 million United States dollars in 2021, and 1.6 million United Stated dollars in 2022 targeted Services for key populations (especially prevention of HIV transmission among people living with HIV and their partners) and Community Mobilization activities (which appeared only in 2022). International NGOs have implemented some activities as well, but their role has decreased overall. They primarily support Prevention for children and youth and Condom distribution. Notably, a significant portion offunding went towards PrEP in 2022, which wasn't observed in previous years.

Table 21: Provider of Services (PS) by prevention intervention, 2020-2022, US dollars and %

PS by prevention intervention	2020	2021	2022	% 2020	% 2021	% 2022
PS.01 Public sector providers	281,859	603,662	1,493,886	28.8%	29.0%	40.2%
Condoms	-	300	470	0.0%	0.0%	0.0%

PrEP	20,000	19,811	24,550	2.0%	1.0%	0.7%
Prevention activities not disaggregate	62,055	131,721	512,673	6.4%	6.3%	13.8%
Prevention for children and youth	40,913	40,142	104,074	4.2%	1.9%	2.8%
Services for key populations	56,521	36,479	597,871	5.8%	1.8%	16.1%
STI prevention and treatment programmes	-	15,473	55,078	0.0%	0.7%	1.5%
Prevention of vertical transmission of HIV infection (PMTCT)	102,370	359,736	199,170	10.5%	17.3%	5.4%
PS.02 Private sector providers	385,170	1,288,247	1,594,429	39.4%	62.0%	42.9%
PrEP	-	8,274	-	0.0%	0.4%	0.0%
Prevention activities not disaggregate	-	41,000	44,816	0.0%	2.0%	1.2%
Prevention for children and youth	-	-	188,401	0.0%	0.0%	5.1%
Prevention of HIV transmission aimed at people living with HIV and their partners	44,938	135,587	50,993	4.6%	6.5%	1.4%
Services for key populations	299,429	1,067,968	1,265,373	30.6%	51.4%	34.0%
STI prevention and treatment programmes	40,803	35,419	41,467	4.2%	1.7%	1.1%
Community Mobilization activities	-	-	3,377	0.0%	0.0%	0.1%
PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices	310,059	186,795	630,403	31.7%	9.0%	17.0%
Condoms	38,035	41,353	45,003	3.9%	2.0%	1.2%
PrEP	-	-	253,401	0.0%	0.0%	6.8%
Prevention activities not disaggregate	11,501	3,116	8,969	1.2%	0.1%	0.2%
Prevention for children and youth	182,483	57,715	128,001	18.7%	2.8%	3.4%
Prevention of HIV transmission aimed at people living with HIV and their partners	75,540	76,211	121,614	7.7%	3.7%	3.3%
Programmatic activities for other vulnerable and accessible populations	-	-	73,415	0.0%	0.0%	2.0%
Prevention of vertical transmission of HIV infection (PMTCT)	2,500	8,400	-	0.3%	0.4%	0.0%
Grand Total	977,088	2,078,704	3,718,717	100.0%	100.0%	100.0%

3.4.1.4.2. Spending on HIV Testing and Counseling (HTC) intervention

Table 22 outlines the allocation of funds for various interventions in HIV testing and counseling from 2020 to 2022. A significant portion of the budget is dedicated to HIV testing at blood banks: 1.3 million United States dollars was spent in 2020 and 2021, increasing to almost 1.6 million United States dollars in 2022, which is equivalent to a proportion of 44% of the total HTC spending. Expenditures on HTC for female sex workers significantly fluctuated over the period: it dropped from 0.5 million United States dollars in 2020 to 9,000 United States dollars in 2021 and 18,000 United States dollars in 2022, not even reaching 1%, respectively. Spending on HTC for inmates, people who inject drugs (PWID), and transgender individuals (TG) stays well below 1% of overall expenditure throughout all years. Notably, the expenditure on HTC for pregnant women saw a remarkable

increase, starting from 0% in 2020 and surging to 24% by 2022. Large portions of the HTC spending could not be split by specific intervention due to data limitations, but reduced from 44% to 28% of total HTC spending over the period.

Table 22: HIV spending on HIV testing and counseling (HTC) intervention, 2020-2022, US dollars and %

HTC	2020	2021	2022	% 2020	% 2021	% 2022
HIV screening in blood banks	1,338,274	1,314,898	1,553,912	47.3%	63.9%	44.1%
HTC activities not disaggregated	428,702	427,438	1,032,572	15.1%	20.8%	29.3%
HTC for for sex workers	553,283	9,291	18,300	19.5%	0.5%	0.5%
HTC for Inmates	5,219	-	-	0.2%	0.0%	0.0%
HTC for MSM	479,760	62,975	71,943	16.9%	3.1%	2.0%
HTC for pregnant women	-	231,786	834,791	0.0%	11.3%	23.7%
HTC for PWID	-	1,916	1,899	0.0%	0.1%	0.1%
HTC for TG	26,402	9,075	12,317	0.9%	0.4%	0.3%
Grand Total	2,831,640	2,057,380	3,525,734	100.0%	100.0%	100.0%

*Non disaggregated HTC activities are caused by a limitation of donors' reporting systems where data were not tracked by target population. This brings significant limitation into analysis.

A. Program area: Financing Entity (FE) by HIV testing and counseling (HTC) intervention

Table 23 presents an overview of the financing entities funding HIV testing and counseling interventions. In this breakdown, public entities only financed HIV screening in blood banks, and allocated $1,338,000 (47% of the total HTC funding) in 2020, and despite a nominal decrease to 1.3 million United States dollars in 2021, their relative contribution rose to 64% of the total. In 2022, their investment increased to 1.6 million United States dollars which constituted 44% of the overall HTC expenditure. International entities displayed more variability in their support to HTC interventions, contributing 1.4 million United States dollars (50%) in 2020, which then decreased to 0.7 million United States dollars (36%) in 2021, followed by an upswing to 1.9 million United States dollars (54%) in 2022. Domestic private entities consistently provided a smaller portion of the HTC funding, contributing 2.6% in both 2020 and 2021, and a slightly reduced 2.4% in 2022.

Table 23: Financing Entity (FE) by HIV testing and counseling (HTC) intervention, 2020-2022, US dollars and %

FE by HTC	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	1,338,274	1,314,898	1,553,912	47.3%	63.9%	44.1%
HIV screening in blood banks	1,338,274	1,314,898	1,553,912	47.3%	63.9%	44.1%
FE.02 Domestic Private Entities	74,089	53,996	84,561	2.6%	2.6%	2.4%
HTC activities not disaggregated	74,089	53,996	84,561	2.6%	2.6%	2.4%
FE.03 International Entities	1,419,277	688,485	1,887,261	50.1%	33.5%	53.5%
HTC activities not disaggregated	354,613	373,442	948,011	12.5%	18.2%	26.9%
HTC for for sex workers	553,283	9,291	18,300	19.5%	0.5%	0.5%
HTC for Inmates	5,219	-	-	0.2%	0.0%	0.0%
HTC for MSM	479,760	62,975	71,943	16.9%	3.1%	2.0%

HTC for pregnant women	-	231,785	834,790	0.0%	11.3%	23.7%
HTC for PWID	-	1,916	1,899	0.0%	0.1%	0.1%
HTC for TG	26,402	9,075	12,317	0.9%	0.4%	0.3%
Grand Total	2,831,640	2,057,380	3,525,734	100.0%	100.0%	100.0%

B. Program area: Provider of Services (PS) by HIV testing and counseling (HTC) intervention.

Table 24 highlights the role of governmental organizations and development partners in implementation HIV testing and counseling (HTC) services from 2020 to 2022. Governmental organizations dominated as providers, with their role increasing significantly from 55.8% in 2020 to 92.9% in 2022. Focus shifted towards HTC activities not disaggregated: Implementation of this category grew substantially from 6.0% in 2020 to 25.2% in 2022, while implementation of specific programs like HIV screening in blood banks fluctuated in between 44% and 63%. Government providers role also increased for HTC services reaching pregnant women (from zero to 23.7%).

Non-profit providers played a smaller role but their contribution to implementation of HTC activities not disaggregated has grown (from 5.6% to 1.7%).
Minimal participation from the private sector and International NGOs: Their role remained low throughout the period, primarily for HTC activities not disaggregated.

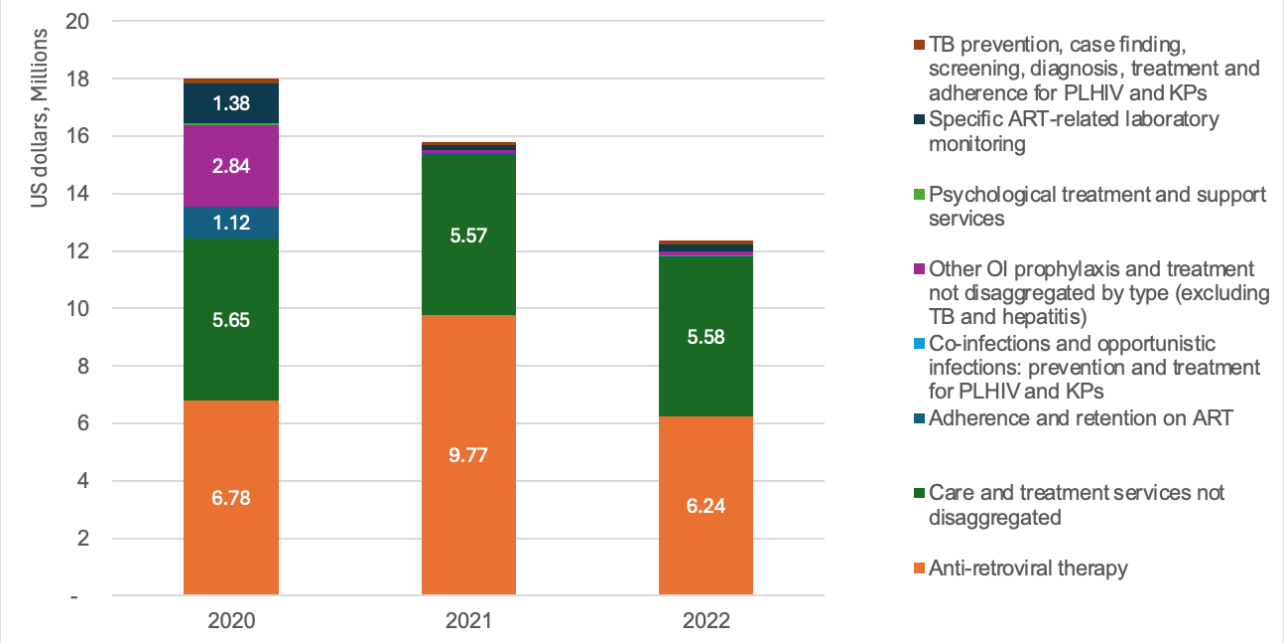
Table 24: Provider of Services (PS) by HIV testing and counseling (HTC) intervention, 2020-2022, US dollars and %

PS by HTC	2020	2021	2022	% 2020	% 2021	% 2022
PS.01.01 Governmental organizations	1,579,088	1,900,949	3,275,673	55.8%	92.4%	92.9%
HIV screening in blood banks	1,338,274	1,314,898	1,553,912	47.3%	63.9%	44.1%
HTC activities not disaggregated	170,475	354,265	886,971	6.0%	17.2%	25.2%
HTC for for sex workers	65,120	-	-	2.3%	0.0%	0.0%
HTC for Inmates	5,219	-	-	0.2%	0.0%	0.0%
HTC for pregnant women	-	231,786	834,791	0.0%	11.3%	23.7%
PS.02.01 Non-profit providers	1,152,822	88,232	163,638	40.7%	4.3%	4.6%
HTC activities not disaggregated	158,497	4,975	59,179	5.6%	0.2%	1.7%
HTC for for sex workers	488,164	9,291	18,300	17.2%	0.5%	0.5%
HTC for MSM	479,760	62,975	71,943	16.9%	3.1%	2.0%
HTC for PWID	-	1,916	1,899	0.0%	0.1%	0.1%
HTC for TG	26,402	9,075	12,317	0.9%	0.4%	0.3%
PS.02.02 Profit-making private sector providers	74,089	53,996	84,561	2.6%	2.6%	2.4%
HTC activities not disaggregated	74,089	53,996	84,561	2.6%	2.6%	2.4%
PS.03.03 International NGOs and foundations	25,641	14,203	1,862	0.9%	0.7%	0.1%
HTC activities not disaggregated	25,641	14,203	1,862	0.9%	0.7%	0.1%
Grand Total	2,831,640	2,057,380	3,525,734	100.0%	100.0%	100.0%

3.4.1.4.3. Spending for HIV care and treatment intervention

Figure 11 shows the AIDS spending category among HIV care and treatment between 2020-2022. The care and treatment categories reported in this round were Adherence and retention on ART, Anti-retroviral therapy, Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs, Psychological treatment and support services, Specific ART-related laboratory monitoring, TB prevention, case finding, screening, diagnosis, treatment and adherence for PLHIV and KPs and other. The report shows that Anti-retroviral therapy (ART) consistently received the most funding at 37.6% in 2020, 61.8% in 2021, and 50.5% in 2022. followed by Care and treatment services not disaggregated. However, ART funding shows a significant decrease in 2022 (from 61.8% to 50.5%), while spending for disaggregated services has increased from 35.2% in 2020 to 45.1% in 2022. The Adherence and retention on ART, Specific ART-related laboratory monitoring and TB prevention receive a smaller but consistent portion of the funds. Psychological treatment and support services received funding only in 2020. Other OI prophylaxis and treatment and Co-infections and opportunistic infections funding is minimal.

Figure 11: HIV care and treatment, 2020-2022, US dollars (millions)



A. Program area: Financing Entity (FE) by HIV care and treatment intervention

Table 25 directs the focus on spending on care and treatment disaggregated by production factor for each financing entity. Spending on overall care and treatment in 2022 was highest among public entities, reaching a total of 5.9 million United States dollars (share of 47%) in 2022, an increase from 4.6 million United States dollars in 2020 (share of 26%). Public entities spent the largest share on care and treatment services not disaggregated. In 2022, international entities contributed 4.9 million United States dollars - a considerable downfall from 11.9 million United States dollars in 2020. Across all years, the largest proportion was spent on ART. Domestic private entities saw a small increase in expenditure from 1.5 million United States dollars in 2020 (share of 9%) to 1.6

million United States dollars in 2022 (share of 13%), mostly dedicated towards care and treatment services not disaggregated.

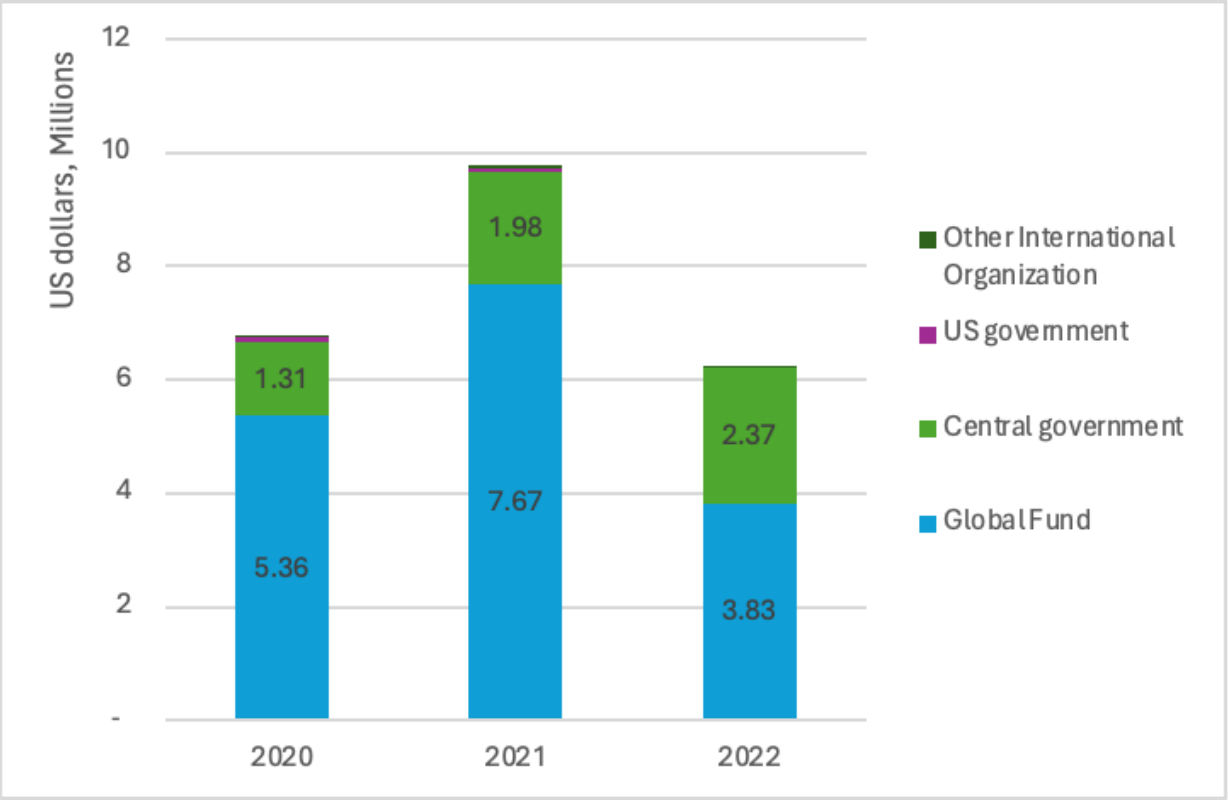
Table 25: Financing Entity (FE) by HIV care and treatment intervention, 2020-2022, US dollars and %

FE by HIV care and treatment intervention	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	4,619,893	5,624,283	5,861,977	25.6%	35.6%	47.4%
Anti-retroviral therapy	1,313,031	1,983,445	2,373,260	7.3%	12.5%	19.2%
Care and treatment services not disaggregated	3,129,142	3,536,501	3,358,391	17.4%	22.4%	27.2%
TB prevention, case finding, screening, diagnosis, treatment and adherence for PLHIV and KPs	177,720	104,337	130,326	1.0%	0.7%	1.1%
FE.02 Domestic Private Entities	1,532,979	1,541,868	1,608,392	8.5%	9.8%	13.0%
Care and treatment services not disaggregated	1,515,675	1,527,000	1,586,300	8.4%	9.7%	12.8%
Specific ART-related laboratory monitoring	17,304	14,868	22,092	0.1%	0.1%	0.2%
FE.03 International Entities	11,863,308	8,641,194	4,889,611	65.8%	54.7%	39.6%
Adherence and retention on ART	1,116,205	68,942	14,846	6.2%	0.4%	0.1%
Antiretroviral therapy	5,469,744	7,789,957	3,865,680	30.4%	49.3%	31.3%
Care and treatment services not disaggregated	1,001,862	502,550	631,493	5.6%	3.2%	5.1%
Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	14,291	10,883	13,855	0.1%	0.1%	0.1%
Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)	2,836,722	101,812	145,913	15.7%	0.6%	1.2%
Psychological treatment and support services	49,638	-	-	0.3%	0.0%	0.0%
Specific ART-related laboratory monitoring	1,363,220	167,050	205,784	7.6%	1.1%	1.7%
TB prevention, case finding, screening, diagnosis, treatment and adherence for PLHIV and KPs	11,627	-	12,041	0.1%	0.0%	0.1%
Grand Total	18,016,180	15,807,345	12,359,979	100.0%	100.0%	100.0%

Figure 12 illustrates the financing entities who contributed in ART program. There are 4 main financial contributors: the central government of Cambodia, the US government, the Global Fund, and other international organizations. The central government has notably augmented its investment in antiretroviral drugs and other commodities, as well as facility running costs and salaries elevating its contribution from 1.3 million United States dollars in 2020 to 2.4 million United Stated dollars in 2022. This increase reflects a rise in their share of the total cost from 19.4% in 2020 to an impactful 38.0% in 2022. This trend underscores the growing prominence of public entities in financing ART, set against the backdrop of significant reductions in funding from international counterparts. In effect, the central government's proportion of ART financing has more than doubled, marking an increment of over 1 million United Stated dollars. Figure 16 further illustrates

the dynamics of international funding, highlighting contributions from the Global Fund, the US government, and other international agencies. It captures a noteworthy shift: the discontinuation of the US government's funding for antiretroviral drugs and commodities in 2022, alongside a reduction in the Global Fund's contribution from 79.1% to 61.3%, signaling a pivotal change in the financial landscape of ART support in Cambodia.

Figure 12: ART spending by Financing Entity (FE), 2020-2022, US dollars (millions)



B. Program area: Financing Agent-Purchaser (FAP) by HIV care and treatment intervention

Table 26 illustrates the ASC financing by various FAPs. The data shows a downward trend in total expenditure, from 18.0 million United States dollars in 2020 to 15.8 million United States dollars in 2021, dipping further to 12.4 million United States dollars in 2022. A significant portion of this spending was dedicated to antiretroviral therapy, accounting for 37.6% in 2020, increasing to 61.8% in 2021, and maintaining a majority of 50.5% in 2022. The second major expenditure category was for care and treatment services that were not further broken down. This category represented approximately 18.2% of the total in 2020, growing to 22.4% in 2021, and rising again to 27.8% in 2022, with public sectors being the primary funders. The private sector also played a role, being responsible for 14.3% of the funding in 2020, decreasing to 10.0% in 2021, and then rebounding to 13.7% in 2022. Notably, international sector spending remained below 5% annually over the last

three years, indicating a relatively small contribution in the broader context of HIV care and treatment funding.

Table 26: Financing Agent-Purchaser (FAP) by HIV care and treatment intervention, 2020-2022, US dollars and %

FAP by HIV care and treatment intervention	2020	2021	2022	% 2020	% 2021	% 2022
FAP.01 Public sector	14,572,922	13,716,123	10,100,253	80.9%	86.8%	81.7%
Adherence and retention on ART	82,052	37,366	-	0.5%	0.2%	0.0%
Anti-retroviral therapy	6,782,775	9,773,402	6,238,939	37.6%	61.8%	50.5%
Care and treatment services not disaggregated	3,277,170	3,536,501	3,438,710	18.2%	22.4%	27.8%
Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)	2,828,721	97,468	74,453	15.7%	0.6%	0.6%
Psychological treatment and support services	49,638	-	-	0.3%	0.0%	0.0%
Specific ART-related laboratory monitoring	1,363,220	167,050	205,784	7.6%	1.1%	1.7%
TB prevention, case finding, screening, diagnosis, treatment and adherence for PLHIV and KPs	189,347	104,337	142,367	1.1%	0.7%	1.2%
FAP.02 Private sector	2,567,571	1,573,616	1,694,604	14.3%	10.0%	13.7%
Adherence and retention on ART	1,034,153	31,576	14,846	5.7%	0.2%	0.1%
Care and treatment services not disaggregated	1,516,114	1,527,000	1,587,804	8.4%	9.7%	12.8%
Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)	-	172	69,861	0.0%	0.0%	0.6%
Specific ART-related laboratory monitoring	17,304	14,868	22,092	0.1%	0.1%	0.2%
FAP.03 International purchasing organizations	875,687	517,606	565,123	4.9%	3.3%	4.6%
Care and treatment services not disaggregated	853,395	502,550	549,669	4.7%	3.2%	4.4%
Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	14,291	10,883	13,855	0.1%	0.1%	0.1%
Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)	8,001	4,173	1,598	0.0%	0.0%	0.0%
Grand Total	18,016,180	15,807,345	12,359,979	100.0%	100.0%	100.0%

C. Program area: Provider of Services (PS) by HIV care and treatment intervention

Table 27 shows how governmental organizations and other partners participate in implementation of HIV care and treatment services (ASC) from 2020 to 2022. Governmental organizations consistently took the leading role (over 75% each year). Their role has decreased overall, but the proportion of activities on Care and treatment services not disaggregated has increased significantly (from 21.3% to 32.2%). Anti-retroviral therapy (ART) remained a major area of implementation for governmental organizations, but its share increased from 37.6% in 2020 to 41.7% in 2022. Provision

of services under Specific ART-related laboratory monitoring and Co-infections and opportunistic infections also decreased.

Non-profit providers and the private sector had a smaller role. Notably, the private sector was involved mostly in activities coded under Care and treatment services not disaggregated. Multilateral agencies and International NGOs had a minimum role, primarily for Care and treatment services not disaggregated and Adherence and retention on ART support.

Table 27: Provider of Services (PS) by HIV care and treatment intervention, 2020-2022, US dollars and %

PS by HIV care and treatment intervention	2020	2021	2022	% 2020	% 2021	% 2022
PS.01.01 Governmental organizations	15,148,920	13,296,811	9,574,488	84.1%	84.1%	77.5%
ASC.03.01 Anti-retroviral therapy	6,782,775	8,844,740	5,156,641	37.6%	56.0%	41.7%
ASC.03.02 Adherence and retention on ART - support	82,052	37,366	-	0.5%	0.2%	0.0%
ASC.03.03 Specific ART-related laboratory monitoring	1,363,220	167,050	205,784	7.6%	1.1%	1.7%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	3,040,360	216,861	232,033	16.9%	1.4%	1.9%
ASC.03.05 Psychological treatment and support services	49,638	-	-	0.3%	0.0%	0.0%
ASC.03.98 Care and treatment services not disaggregated	3,830,875	4,030,795	3,980,030	21.3%	25.5%	32.2%
PS.02.01 Non-profit providers	300,181	960,410	1,167,006	1.7%	6.1%	9.4%
ASC.03.01 Anti-retroviral therapy	-	928,662	1,082,298	0.0%	5.9%	8.8%
ASC.03.02 Adherence and retention on ART - support	6,980	31,576	14,846	0.0%	0.2%	0.1%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	-	172	69,861	0.0%	0.0%	0.6%
ASC.03.98 Care and treatment services not disaggregated	293,201	-	-	1.6%	0.0%	0.0%
PS.02.02 Profit-making private sector providers	17,304	14,868	22,092	0.1%	0.1%	0.2%
ASC.03.03 Specific ART-related laboratory monitoring	17,304	14,868	22,092	0.1%	0.1%	0.2%
PS.02.99 Private sector providers n.e.c.	1,515,675	1,527,000	1,586,300	8.4%	9.7%	12.8%
ASC.03.98 Care and treatment services not disaggregated	1,515,675	1,527,000	1,586,300	8.4%	9.7%	12.8%
PS.03.02 Multilateral agencies	6,753	-	-	0.0%	0.0%	0.0%
ASC.03.98 Care and treatment services not disaggregated	6,753	-	-	0.0%	0.0%	0.0%
PS.03.03 International NGOs and foundations	1,027,348	8,256	10,094	5.7%	0.1%	0.1%
ASC.03.02 Adherence and retention on ART - support	1,027,173	-	-	5.7%	0.0%	0.0%

ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	-	-	240	0.0%	0.0%	0.0%
ASC.03.98 Care and treatment services not disaggregated	175	8,256	9,854	0.0%	0.1%	0.1%
Grand Total	18,016,180	15,807,345	12,359,979	100.0%	100.0%	100.0%

3.4.1.4.4. Spending for Social protection and economic support intervention

Table 28 explains the expenditure on social protection and economic support interventions, with a specific focus on various types of social protection activities, including monetary, in-kind, or social services. The investment in these interventions demonstrated a degree of consistency over the three years, with spending at 0.3 million United States dollars in 2020, slightly decreasing to 0.2 million United States dollars in 2021 and rebounding to 0.2 million United States dollars in 2022. A closer look at the distribution of funds reveals that the majority of this expenditure was allocated to social protection through monetary or in-kind benefits. In 2020, this approach accounted for 89.7% of the total spending, a figure that held steady into 2021, and then saw a slight increase to 92.8% in 2022. This trend indicates that monetary or in-kind benefits are the dominant form of social protection funding, occupying the largest share of spending within this category (PLWHIV Utilization Cost covered by HEF (Poor and Informal Worker)).

Table 28: Social protection and economic support intervention, 2020-2022, US dollars and %

Social Protection and Economic support intervention	2020	2021	2022	% 2020	% 2021	% 2022
Social protection activities n.e.c	11,288	11,272	11,263	4.4%	6.7%	4.7%
Social protection services and social services not disaggregated by type	10,550	-	-	4.1%	0.0%	0.0%
Social protection through monetary or in-kind benefits	229,591	151,840	220,786	89.7%	89.7%	92.8%
Social protection through provision of social services	4,541	6,109	5,766	1.8%	3.6%	2.4%
Grand Total	255,971	169,220	237,814	100.0%	100.0%	100.0%

A. Program area: Financing Entity (FE) by Social protection & economic support intervention

An analysis of the financing sources for social protection and economic support interventions shows that public entities are the predominant funders, consistently contributing over 90% of the total expenditure in each of the years 2020, 2021, and 2022. As indicated in Table 29, international entities also contribute to social protection funding, though their share of expenditure has diminished from just under 6% in 2020 to 2% in 2022.

Table 29: Financing Entity (FE) by Social protection & economic support intervention, 2020-2022, US dollars and %

FE by Social protection and economic support intervention	2020	2021	2022	% 2020	%f 2021	% 2022

FE.01 Public Entities	240,880	163,111	232,049	94.1%	96.4%	97.6%
Social protection activities n.e.c	11,288	11,272	11,263	4.4%	6.7%	4.7%
Social protection through monetary or in-kind benefits	229,591	151,840	220,786	89.7%	89.7%	92.8%
FE.03 International Entities	15,091	6,109	5,766	5.9%	3.6%	2.4%
Social protection services and social services not disaggregated by type	10,550	-	-	4.1%	0.0%	0.0%
Social protection through provision of social services	4,541	6,109	5,766	1.8%	3.6%	2.4%
Grand Total	255,971	169,220	237,814	100.0%	100.0%	100.0%

B. Program area: Financing Agent-Purchaser (FAP) by Social protection and economic support intervention

Table 30 elucidates how social protection resources are allocated by various financing agents and purchasers, highlighting the management role of public sectors in this domain. It reveals that a substantial majority of the spending, approximately 90% in 2020 and 2021, increasing to 93% in 2022, was channeled into monetary and in-kind forms of assistance. The remaining funds were directed towards the provision of social protection services.

Table 30: Financing Agent-Purchaser (FAP) by Social protection and economic support intervention, 2020-2022, US dollars and %

FAP by Social protection and economic support intervention	2020	2021	2022	% 2020	% 2021	% 2022
FAP.01 Public sector	240,880	163,111	232,049	94.1%	96.4%	97.6%
Social protection activities n.e.c	11,288	11,272	11,263	4.4%	6.7%	4.7%
Social protection through monetary or in-kind benefits	229,591	151,840	220,786	89.7%	89.7%	92.8%
FAP.03 International purchasing organizations	15,091	6,109	5,766	5.9%	3.6%	2.4%
Social protection services and social services not disaggregated by type	10,550	-	-	4.1%	0.0%	0.0%
Social protection through provision of social services	4,541	6,109	5,766	1.8%	3.6%	2.4%
Grand Total	255,971	169,220	237,814	100.0%	100.0%	100.0%

3.4.1.4.5. Spending for Social Enablers intervention

Social enablers encompass a suite of activities aimed at advocacy, enhancing human rights capacities, reducing discrimination and violence against women within the context of HIV, and curbing stigma. Table 31 provides an overview of the financial commitments to these social enablers. Of the total AIDS spending, 0.16 million United States dollars was allocated in 2020, which saw an increase to 0.22 million United States dollars by 2022. Notably, the lion's share of this budget was directed toward human rights programs, accounting for 76% of the spending in 2020, though this proportion declined to 55% by 2022.

Advocacy and capacity building in human rights were the second major expenditure areas, receiving 10% and 14% of the funding in 2020, respectively. By 2022, the investment in capacity building in human rights surged to 30%, while the funds for advocacy decreased to 3%, reflecting a strategic reallocation of resources within the spectrum of social enabler activities.

Table 31: Social enablers intervention, 2020-2022, US dollars and %

Social enablers intervention	2020	2021	2022	% 2020	% 2021	% 2022
Advocacy	15,937	9,476	7,569	10.2%	38.3%	3.4%
Capacity building in human rights	21,600	1,837	66,222	13.8%	7.4%	30.1%
Human rights programmes not disaggregated by type	119,127	6,010	120,335	76.0%	24.3%	54.7 %
Reducing discrimination and violence against women in the context of HIV	-	2,000	23,214	0.0%	8.1%	10.6%
Social enablers not disaggregated by type	-	-	575	0.0%	0.0%	0.3%
Stigma and discrimination reduction	-	5,400	2,100	0.0%	21.8%	1.0%
Grand Total	156,665	24,723	220,015	100.0%	100.0%	100.0%

A. Program area: Financing Entity (FE) by Social enablers intervention

Table 32 details the financing entities and social enabler activities within the realm of HIV, identifying international entities as the sole financiers of these interventions over the years 2020, 2021, and 2022. The international contributions to social enablers amounted to 0.16 million United States dollars in 2020, dropped to 25,000 United States dollars in 2021, and rose significantly to 0.22 million United States dollars in 2022. A considerable part of this funding was allocated to the human rights program, which was not broken down by specific types of activities, receiving 0.12 million United States dollars in 2020, which constituted 76% of the total spending for that year. In 2022, the expenditure on the human rights program decreased proportionally, representing 55% of the year's total at 0.12 million United States dollars out of the aggregate expenditure of 0.22 million United States dollars.

Table 32: Financing Entity (FE) by Social enablers intervention, 2020-2022, US dollars and %

FE by Social enablers intervention	2020	2021	2022	% 2020	% 2021	% 2022
FE.03 International Entities	156,665	24,723	220,015	100.0%	100.0%	100.0%
Advocacy	15,937	9,476	7,569	10.2%	38.3%	3.4%
Capacity building in human rights	21,600	1,837	66,222	13.8%	7.4%	30.1%
Human rights programmes not disaggregated by type	119,127	6,010	120,335	76.0%	24.3%	54.7%
Reducing discrimination and violence against women in the context of HIV	-	2,000	23,214	0.0%	8.1%	10.6%
Social enablers not disaggregated by type	-	-	575	0.0%	0.0%	0.3%

Stigma and discrimination reduction	-	5,400	2,100	0.0%	21.8%	1.0%
Grand Total	156,665	24,723	220,015	100.0%	100.0%	100.0%

B. Program area: Financing Agent-Purchaser (FAP) by Social enablers intervention

Table 33 provides a revealing snapshot of the implementation and funding dynamics for social enablers, which include activities such as the human rights program and efforts to reduce discrimination and violence against women in the context of HIV. While these programs are carried out by public sectors and international purchasing organizations, the funding predominantly originates from international entities. The public sector was responsible for the majority of this investment, directing approximately 76% of funds in 2020 and 65% in 2022 towards the human rights program. In contrast, international purchasing organizations allocated about 24% of their budgets in 2020 and increased their share to 36% in 2022 for advocacy, capacity building in human rights, and other initiatives aimed at addressing discrimination and stigma.

Table 33: Financing Agent-Purchaser (FAP) by Social enablers intervention, 2020-2022, US dollars and %

FAP by Social enablers intervention	2020	2021	2022	% 2020	% 2021	% 2022
FAP.01 Public sector	119,127	6,010	141,749	76.0%	24.3%	64.4%
Human rights programmes not disaggregated by type	119,127	6,010	120,335	76.0%	24.3%	54.7%
Reducing discrimination and violence against women in the context of HIV	-	-	21,414	0.0%	0.0%	9.7%
FAP.03 International purchasing organizations	37,537	18,713	78,266	24.0%	75.7%	35.6%
Advocacy	15,937	9,476	7,569	10.2%	38.3%	3.4%
Capacity building in human rights	21,600	1,837	66,222	13.8%	7.4%	30.1%
Reducing discrimination and violence against women in the context of HIV	-	2,000	1,800	0.0%	8.1%	0.8%
Social enablers not disaggregated by type	-	-	575	0.0%	0.0%	0.3%
Stigma and discrimination reduction	-	5,400	2,100	0.0%	21.8%	1.0%
Grand Total	156,665	24,723	220,015	100.0%	100.0%	100.0%

3.4.1.4.6. Spending for Programme enablers and systems strengthening intervention

Table 34 categorizes the expenditures with regard to program enablers and system strengthening. Over this period, the total investment in these critical interventions was 11.9 million United States dollars in 2020, 10.6 million United States dollars in 2021, and slightly increased to 11.4 million United States dollars in 2022. Delving into the specifics of this intervention program, a significant portion of the funds was allocated to program administration and management costs above the service-delivery level, comprising approximately 40% of the total expenditure in both 2020 and 2021, with a slight dip to 38% in 2022. Furthermore, the outlay for un-itemized program enablers and system strengthening remained relatively stable, at about 16% in 2020, and a slight rise to 18% for the following two years. Concurrently, spending dedicated to strategic planning, coordination, and policy development constituted 16% of the budget in 2020, which then slightly decreased to 14% in 2021, and edged down further to 13% in 2022.

Table 34: Programme enablers and system strengthening intervention, 2020-2022, US dollars and %

Programme enablers and system strengthening intervention	2020	2021	2022	% 2020	% 2021	% 2022
Civil society institutional and NGO development	2,599	4,625	29,981	0.0%	0.0%	0.3%
Community system strengthening not disaggregated	126,964	177,215	402,304	1.1%	1.7%	3.5%

Financial and accounting systems strengthening	687,453	375,436	252,205	5.8%	3.5%	2.2%
Health and community workforce intervention(s) not disaggregated	-	-	5,875	0.0%	0.0%	0.1%
Institutional & organizational development (health, social, educational etc)	517,033	419,680	346,267	4.4%	4.0%	3.0%
Laboratory system strengthening	330,000	262,935	629,294	2.8%	2.5%	5.5%
Monitoring and evaluation	526,956	136,001	446,055	4.4%	1.3%	3.9%
Operations and implementation science research	-	63,603	1,308	0.0%	0.6%	0.0%
Procurement and supply chain	82,677	144,187	204,650	0.7%	1.4%	1.8%
Programme administration and management costs (above service-delivery level)	4,720,406	4,298,936	4,357,375	39.8%	40.6%	38.1%
Programme enablers and systems strengthening not disaggregated	1,925,720	1,887,838	2,053,278	16.2%	17.8%	18.0%
Public system strengthening not disaggregated	478,270	886,393	767,165	4.0%	8.4%	6.7%
Representation of women in key processes	-	-	20,700	0.0%	0.0%	0.2%
Strategic information not disaggregated by type	606,897	442,907	480,093	5.1%	4.2%	4.2%
Strategic planning, coordination and policy development	1,867,951	1,491,695	1,431,266	15.7%	14.1%	12.5%
Grand Total	11,872,926	10,591,451	11,427,816	100.0%	100.0%	100.0%

A. Program area: Financing Entity (FE) by Programme enablers and system strengthening intervention

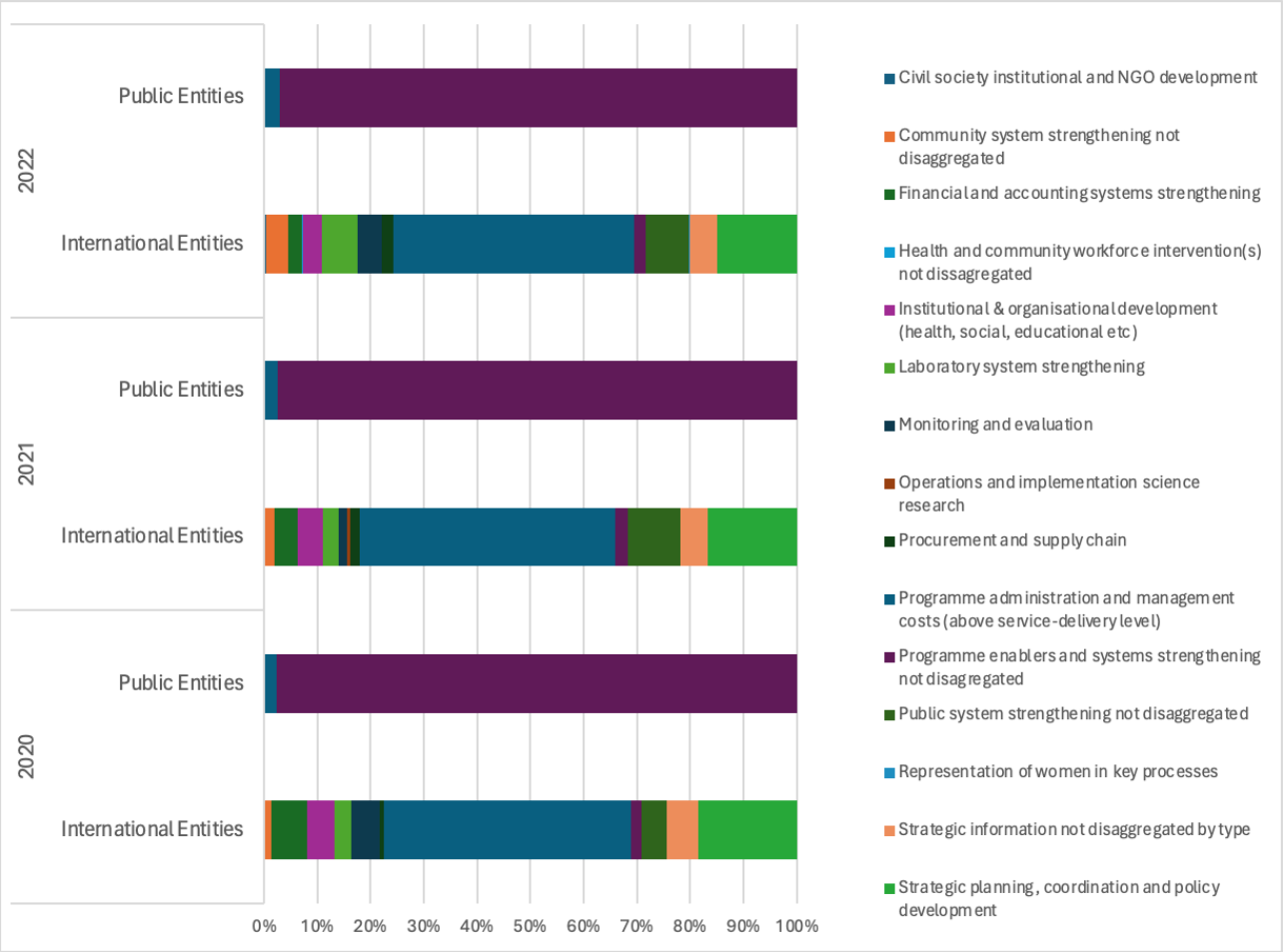
Table 35 and Figure 13 detail the funding contributions to social enablers and system strengthening by different financing entities. Within this intervention program, public entities allocated more than $1.7 million each year towards program administration and management costs, as well as towards unspecified program enablers and system strengthening efforts, with these allocations remaining consistent through 2020, 2021, and 2022. On another front, international entities directed their funds towards a variety of initiatives including civil society institutional and NGO development, community system strengthening, enhancement of financial and accounting systems, health and community workforce interventions, among others. Financial commitments from these international bodies comprised around 85% of the total expenditure in 2020, with a slight adjustment to 84% in both 2021 and 2022.

Table 35: Financing Entity (FE) by Programme enablers and system strengthening intervention, 2020-2022, US dollars and %

FE by Programme enablers and system strengthening intervention	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	1,764,304	1,726,575	1,891,349	14.9%	16.3%	16.6%
Programme administration and management costs (above service-delivery level)	40,604	45,601	57,407	0.3%	0.4%	0.5%

Programme enablers and systems strengthening not disaggregated	1,723,700	1,680,974	1,833,941	14.5%	15.9%	16.0%
FE.03 International Entities	10,108,622	8,864,877	9,536,468	85.1%	83.7%	83.4%
Civil society institutional and NGO development	2,599	4,625	29,981	0.0%	0.0%	0.3%
Community system strengthening not disaggregated	126,964	177,215	402,304	1.1%	1.7%	3.5%
Financial and accounting systems strengthening	687,453	375,436	252,205	5.8%	3.5%	2.2%
Health and community workforce intervention(s) not disaggregated	-	-	5,875	0.0%	0.0%	0.1%
Institutional & organizational development (health, social, educational etc)	517,033	419,680	346,267	4.4%	4.0%	3.0%
Laboratory system strengthening	330,000	262,935	629,294	2.8%	2.5%	5.5%
Monitoring and evaluation	526,956	136,001	446,055	4.4%	1.3%	3.9%
Operations and implementation science research	-	63,603	1,308	0.0%	0.6%	0.0%
Procurement and supply chain	82,677	144,187	204,650	0.7%	1.4%	1.8%
Programme administration and management costs (above service-delivery level)	4,679,802	4,253,335	4,299,968	39.4%	40.2%	37.6%
Programme enablers and systems strengthening not disaggregated	202,020	206,864	219,337	1.7%	2.0%	1.9%
Public system strengthening not disaggregated	478,270	886,393	767,165	4.0%	8.4%	6.7%
Representation of women in key processes	-	-	20,700	0.0%	0.0%	0.2%
Strategic information not disaggregated by type	606,897	442,907	480,093	5.1%	4.2%	4.2%
Strategic planning, coordination and policy development	1,867,951	1,491,695	1,431,266	15.7%	14.1%	12.5%
Grand Total	11,872,926	10,591,451	11,427,816	100.0%	100.0%	100.0%

Figure 13: Financing Entity (FE) by Programme enablers and system strengthening intervention, 2020-2022, %



B. Program area: Financing Agent-Purchaser (FAP) by Program enablers and system strengthening intervention

Table 36 delineates the expenditure distribution by financing agents and purchasers (FAP), highlighting three primary entities. In 2020, the total expenditure amounted to 11.9 million United States dollars with public sectors contributing 4.4 million United States dollars private sectors allocating 2 million United States dollars and international purchasing organizations providing around 5.5 million United States dollars. By 2021, there was a dip in the total expenditure to 10.6 million United States dollars, with a slight decrease in the funding for program enablers and system strengthening, although the spending ratio among the three sectors remained consistent with the previous year. In 2022, total spending witnessed a resurgence to 11.4 million United States dollars. Notably, the spending share of public sectors in 2022 constituted 39%, while private sectors saw a reduction in their share to 14% from 17% in 2020. Meanwhile, international purchasing organizations maintained their funding proportion, mirroring their 2020 contribution at 46% in 2022.

Table 36: Financing Agent-Purchaser (FAP) by Programme enablers and system strengthening intervention, 2020-2022, US dollars and %

FE by Programme Enablers and system strengthening intervention	2020	2021	2022	% 2020	% 2021	% 2022
FAP.01 Public sector	4,396,908	3,768,788	4,508,219	37.0%	35.6%	39.4%
Civil society institutional and NGO development	-	-	20,536	0.0%	0.0%	0.2%
Laboratory system strengthening	330,000	262,935	629,294	2.8%	2.5%	5.5%
Monitoring and evaluation	520,169	131,647	424,392	4.4%	1.2%	3.7%
Procurement and supply chain	65,438	142,233	204,650	0.6%	1.3%	1.8%
Programme administration and management costs (above service-delivery level)	883,578	722,604	758,895	7.4%	6.8%	6.6%
Programme enablers and systems strengthening not disaggregated	1,723,700	1,680,974	1,833,941	14.5%	15.9%	16.0%
Strategic information not disaggregated by type	290,154	183,555	111,829	2.4%	1.7%	1.0%
Strategic planning, coordination and policy development	583,869	644,839	524,682	4.9%	6.1%	4.6%
FAP.02 Private sector	2,009,855	1,728,616	1,653,097	16.9%	16.3%	14.5%
Community system strengthening not disaggregated	53,458	56,249	62,193	0.5%	0.5%	0.5%
Health and community workforce intervention(s) not disaggregated	-	-	5,875	0.0%	0.0%	0.1%
Monitoring and evaluation	4,631	1,028	11,428	0.0%	0.0%	0.1%
Operations and implementation science research	-	63,218	900	0.0%	0.6%	0.0%
Programme administration and management costs (above service-delivery level)	1,951,766	1,608,120	1,572,702	16.4%	15.2%	13.8%
FAP.03 International purchasing organizations	5,466,163	5,094,047	5,266,500	46.0%	48.1%	46.1%
Civil society institutional and NGO development	2,599	4,625	9,445	0.0%	0.0%	0.1%
Community system strengthening not disaggregated	73,507	120,966	340,111	0.6%	1.1%	3.0%
Financial and accounting systems strengthening	687,453	375,436	252,205	5.8%	3.5%	2.2%
Institutional & organizational development (health, social, educational etc)	517,033	419,680	346,267	4.4%	4.0%	3.0%
Monitoring and evaluation	2,156	3,326	10,236	0.0%	0.0%	0.1%
Operations and implementation science research	-	384	408	0.0%	0.0%	0.0%

Procurement and supply chain	17,239	1,954	-	0.1%	0.0%	0.0%
Programme administration and management costs (above service-delivery level)	1,885,062	1,968,212	2,025,778	15.9%	18.6%	17.7%
Programme enablers and systems strengthening not disaggregated	202,020	206,864	219,337	1.7%	2.0%	1.9%
Public system strengthening not disaggregated	478,270	886,393	767,165	4.0%	8.4%	6.7%
Representation of women in key processes	-	-	20,700	0.0%	0.0%	0.2%
Strategic information not disaggregated by type	316,743	259,352	368,264	2.7%	2.4%	3.2%
Strategic planning, coordination and policy development	1,284,OOP	846,856	906,584	10.8%	8.0%	7.9%
Grand Total	11,872,926	10,591,451	11,427,816	100.0%	100.0%	100.0%

The administration costs, when aggregated across the three sectors—public sectors, private sectors, and international purchasing organizations—represent a significant portion of the total expenditure. Specifically, the program administration and management costs totaled 4.72 million United States dollars in 2020, with a slight decrease to 4.36 million United States dollars in both 2021 and 2022. These costs accounted for 39.76% of the total expenditure in 2020, increasing slightly to 41.17% in 2021, and then dipping to 38.14% in 2022. Breaking down the expenditure further, the public sectors allocated approximately 7.4% of their total spending to this category in 2020, which slightly decreased to 6.8% in 2021 and further to 6.6% in 2022. Meanwhile, the private sectors contributed 16.4% of their total expenditure to administration and management costs in 2020, with a gradual decrease to 15.2% in 2021 and 13.8% in 2022. On the other hand, the international purchasing organizations allocated 15.9% of their spending to these costs in 2020, which increased to 18.6% in 2021 and adjusted to 17.7% in 2022, indicating a fluctuating yet substantial investment in program administration and management across the sectors.

3.4.1.4.7. Spending for Development synergies intervention

Table 37 showcases the distribution of funds for development synergy interventions, which focus on two primary activities: development synergies not disaggregated and formative education along with other training that does not pertain to any particular activity. In 2020, the entirety of the budget was allocated to development synergies. However, the scenario evolved in the subsequent years, with these synergies receiving only 30.5% of the total funding in 2021 and 47.9% in 2022. Conversely, the investment in formative education aimed at bolstering the HIV workforce, alongside other training, significantly increased, accounting for 69.5% of the expenditures in 2021 and 52.1% in 2022, indicating a strategic shift towards educational and capacity-building efforts within the framework of development synergy interventions.

Table 37: Development synergies intervention, 2020-2022, US dollars and %

Development Synergies intervention	2020	2021	2022	% 2020	% 2021	% 2022
Development synergies not disaggregated	8,255	7,500	17,231	100.0%	30.5%	47.9%
Formative education to build-up an HIV workforce and other trainings not related to any specific activity	-	17,065	18,764	0.0%	69.5%	52.1%
Grand Total	8,255	24,565	35,995	100.0%	100.0%	100.0%

A. Program area: Financing Entity (FE) by Development synergies intervention

Table 38 illustrates the breakdown of financing by entities reveals that public entities were the predominant financiers in 2020, accounting for 66.1% of the total expenditure, amounting to $8,300, while international entities contributed approximately 34% (approx. 2,800 United States dollars). From 2021 to 2022, the role of main financier shifted to international entities, which were responsible for 70.9% of the total funding in 2021 and 61.0% in 2022, as detailed in the table below. Conversely, the share of expenditure by public entities decreased to 29.1% in 2021, but saw an increase to 39.0% in 2022, indicating a dynamic shift in the sources of funding over these years.

Table 38: Financing entity (FE) by Development synergies intervention, 2020-2022, US dollars and %

FE by Development synergies intervention	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	5,458	7,146	14,021	66.1%	29.1%	39.0%
Development synergies not disaggregated	5,458	7,146	14,021	66.1%	29.1%	39.0%
FE.03 International Entities	2,797	17,419	21,974	33.9%	70.9%	61.0%
Development synergies not disaggregated	2,797	353	3,210	33.9%	1.4%	8.9%
Formative education to build-up an HIV workforce and other trainings not related to any specific activity	-	17,065	18,764	0.0%	69.5%	52.1%
Grand Total	8,255	24,565	35,995	100.0%	100.0%	100.0%

B. Program area: Financing Agent-Purchaser (FAP) by Development synergies intervention

Table 39 offers a detailed breakdown of the expenditures by FAP within the development synergy interventions. In this context, the primary financiers comprise public sectors and international purchasing organizations. In 2020, the public sectors allocated approximately $5,500 towards this initiative, while international purchasing organizations contributed $2,800. Over the next two years, there was a slight increase in the funding from international purchasing organizations for the development synergy intervention. Concurrently, in 2022, the public sectors' contribution was roughly three-fifths of the total expenditure, indicating a strategic distribution of financial resources between these two main entities across the specified period.

Table 39: Financing Agent-Purchaser (FAP) by Development synergies intervention, 2020-2022, US dollars and %

FAP by Development synergies intervention	2020	2021	2022	% 2020	% 2021	% 2022
FAP.01 Public sector	5,458	7,146	14,021	66.1	29.1%	39.0%
Development synergies not disaggregated	5,458	7,146	14,021	66.1%	29.1%	39.0%
FAP.03 International purchasing organizations	2,797	17,419	21,974	33.9%	70.9%	61.0%
Development synergies not disaggregated	2,797	353	3,210	33.9%	1.4%	8.9%
Formative education to build-up an HIV workforce and other trainings not related to any specific activity	-	17,065	18,764	0.0%	69.5%	52.1%
Grand Total	8,255	24,565	35,995	100.0%	100.0%	100.0

3.4.1.4.8. Spending for HIV-Related Research by Financing Entity (FE) and Provider of Services (PS)

Table 40 shows the HIV-related research between 2020 and 2022. There was only one item that reported in the NASA round 7, socio-behavioural research. The spending decreased from 180,371 United States dollars in 2020 to 39,623 United States dollars in 2022.

The broken down data analysis by financing entities and Providers of services (PS), Table 41 and Table 42 provide an overview of the funding dynamics for HIV-related research interventions, identifying both FE and PS involved. It is evident that international entities have consistently been the primary financiers over three consecutive years. The focus of the HIV-related research conducted during this period, spanning from 2020 to 2022, was on socio-behavioral studies. However, there has been a noticeable decline in funding for HIV-related research over these years. Initially, in 2020, the total investment amounted to 0.18 million United States dollars, which then decreased significantly to 0.05 million United States dollars in 2021, and further dropped to 0.04 million United States dollars in 2022, highlighting a downward trend in financial commitment to this critical area of study.

Table 40: HIV-related research, 2020-2022, US dollars and %

HIV-related research	2020	2021	2022	% 2020	% 2021	% 2022
Socio-behavioral research	180,371	50,000	39,623	100.0%	100.0%	100.0%
Grand Total	180,371	50,000	39,623	100.0%	100.0%	100.0%

Table 41: Financing Entity (FE) by HIV-related research, 2020-2022 (ASC), US dollars and %

FE by HIV-related research	2020	2021	2022	% 2020	% 2021	% 2022
FE.03 International Entities	180,371	50,000	39,623	100.0%	100.0%	100.0%
Socio-behavioural research	180,371	50,000	39,623	100.0%	100.0%	100.0%
Grand Total	180,371	50,000	39,623	100.0%	100.0%	100.0%

Table 42: Provider of Services (PS) by HIV-related research, 2020-2022, US dollars and %

PS by HIV-related research	2020	2021	2022	% 2020	% 2021	% 2022
PS.01 Public sector providers	170,194	50,000	39,623	99.8%	100.0%	100.0%
Socio-behavioural research	170,194	50,00	39,623	99.8%	100.0%	100.0%
PS.02 Private sector providers	10,177	-	-	0.2%	0.0%	0.0%
Socio-behavioural research	10,177	-	-	0.2%	0.0%	0.0%
Grand Total	180,371	50,000	39,623	100.0%	100.0%	100.0%

3.4.2. Service Delivery Modalities (SDM)

Table 43 presents an analysis of the service delivery modalities employed between 2020 and 2022, encompassing facility-based services, community-based initiatives, HIV self-testing, and others. Within this framework, the bulk of the expenditure was allocated to health facility-based services, which include outpatient, inpatient, and unspecified facility-based services. This category accounted for 17.5 million United States dollars in 2020, 16.4 million United States dollars in 2021, and 14.9 million United States dollars in 2022, representing the lion's share of the total spending. The second major category of service delivery modality expenditure was labeled as non-applicable (ASC without a specific service delivery modality), capturing a substantial portion of the budget with 35.6% in 2020, 34.7% in 2021, and an increase to 37.1% in 2022. In comparison, spending on community-based interventions was significantly lower. This category, which encompasses community-based centers, mobile units, outreach activities, and HIV self-testing, constituted less than 2% of the total expenditure in 2020, and slightly increased to under 5% in both 2021 and 2022. This distribution highlights the primary focus on facility-based services while underscoring the relatively limited financial commitment to community-based interventions during the reported period.

Table 43: Service Delivery Modalities (SDM), 2020-2022, US dollars and %

SDM	2020	2021	2022	% 2020	% 2021	% 2022
Facility-based: Outpatient	1,762,435	1,778,741	2,389,051	5.1%	5.8%	7.6%
Facility-based: Inpatient	15,635	14,444	16,980	0.0%	0.0%	0.1%
Facility-based not disaggregated	15,787,681	14,520,076	12,576,513	46.0%	47.1%	39.8%
Community-based: center	6,980	31,576	14,846	0.0%	0.1%	0.0%
Community-based: mobile unit	-	-	25,962	0.0%	0.0%	0.1%
Community-based: outreach	419,484	1,023,076	1,075,013	1.2%	3.3%	3.4%
HIV self-testing	-	31,153	54,445	0.0%	0.1%	0.2%
Home and community based not disaggregated	1,726,053	1,056,405	1,370,181	5.0%	3.4%	4.3%
Non applicable (ASC which does not have a specific SDM)	12,218,217	10,690,739	11,723,449	35.6%	34.7%	37.1%
Modalities not disaggregated	846,937	130,179	732,952	2.5%	0.4%	2.3%
Modalities n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.4.2.1. Financing Entity (FE) and Service Delivery Modalities (SDM)

Table 44 highlights the financial contributions of three key HIV financing entities towards facility-based service modalities. The data reveals that public entities progressively increased their investment, funding facility-based services with 8.07 million United States dollars in 2020, 9.2 million United States dollars in 2021, and further up to 9.73 million United States dollars in 2022. On the other hand, domestic private entities also showed consistent support, albeit at lower levels, spending 1.65 million United States dollars in 2020, slightly adjusting to 1.63 million United States dollars in 2021, and then increasing their contribution to 1.73 million United States dollars in 2022. Moreover, international entities extended their support not only to facility-based services but to community services as well, marking significant financial input across the board. Their total expenditures amounted to 24.58 million United States dollars in 2020, which saw a decrease to 19.98 million United States dollars in 2021, before making a marginal increase to 20.1 million United States dollars in 2022, indicating a sustained commitment to supporting various service delivery modalities over these years.

Table 44: Financing Entity (FE) by Service Delivery Modalities (SDM), 2020-2022, US dollars and %

FE by SDM	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
SDM.01 Facility-based service modalities	6,301,417	7,462,028	7,824,728	18.4%	24.2%	24.8%
SDM.03 Non applicable (ASC which does not have a specific SDM)	1,769,762	1,733,721	1,905,370	5.2%	5.6%	6.0%
FE.02 Domestic Private Entities	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
SDM.01 Facility-based service modalities	132,196	104,283	148,120	0.4%	0.3%	0.5%
SDM.99 Modalities n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
FE.03 International Entities	24,580,047	19,976,356	20,101,176	71.7%	64.9%	63.7%
SDM.01 Facility-based service modalities	11,132,137	8,746,949	7,009,697	32.5%	28.4%	22.2%
SDM.02 Home and community based service modalities	2,107,580	1,995,348	2,416,040	6.1%	6.5%	7.7%
SDM.03 Non applicable (ASC which does not have a specific SDM)	10,493,393	9,103,879	9,942,487	30.6%	29.6%	31.5%
SDM.98 Modalities not disaggregated	846,937	130,179	732,952	2.5%	0.4%	2.3%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.4.2.2. AIDS Spending Categories (ASC) and Service Delivery Modalities (SDM)

The NASA classification delineates 8 primary program areas, with service delivery modalities across these areas detailed in Table 45. In the realm of prevention intervention, facility-based and community-based services consistently accounted for less than 5% of total spending in each of the three assessment years, indicating a balanced approach to service delivery in this area.

For HIV testing and counseling (HTC), facility-based services dominated expenditure with 1.65 million United States dollars (4.8%) in 2020, 1.92 million United States dollars (6.2%) in 2021, and a notable increase to 3.32 million United States dollars in 2022. Community-based HTC also played a role, though spending decreased from 1 million United States dollars in 2020 to 0.13 million United States dollars in 2021 and slightly rose to 0.21 million United States dollars in 2022, as shown in Table 45.

HIV care and treatment saw the majority of funds directed towards facility-based services, with expenditures of 15.17 million United States dollars in 2020, $13.47 million in 2021, and 9.84 million United States dollars in 2022. Community-based spending in this area remained below 1 million United States dollars annually over the three years. Spending on other service delivery modalities, not further categorized, amounted to 1.97 million United States dollars in 2020, 1.55 million United States dollars in 2021, and 1.63 million United States dollars in 2022.

Social protection and economic support interventions were primarily facility-based, with total expenditures at 0.26 million United States dollars in 2020, 0.17 million United States dollars in 2021, and 0.24 million United States dollars in 2022, representing less than 1% of the overall spending.

The remaining interventions, including social enablers, program enablers and system strengthening, development synergies, and HIV-related research, predominantly targeted service delivery modalities categorized as non-applicable (ASC without a specific SDM), each accounting for less than 1% of the total expenditure. An exception is program enablers and system strengthening, which commanded substantial investments of 11.87 million United States dollars (34.6%) in 2020, 10.59 million United States dollars (34.4%) in 2021, and 11.43 million United States dollars (36.2%) in 2022, underscoring the significant focus on these critical areas.

Table 45: AIDS Spending Categories (ASC) by Service Delivery Modalities (SDM), 2020-2022, US dollars and %

ASC by SDM	2020	2021	2022	% 2020	% 2021	% 2022
ASC.01 Prevention	977,088	2,078,704	3,718,717	2.8%	6.7%	11.8%
SDM.01 Facility-based service modalities	489,766	750,282	1,590,073	1.4%	2.4%	5.0%
SDM.02 Home and community based service modalities	207,488	1,080,588	1,321,390	0.6%	3.5%	4.2%
SDM.03 Non applicable (ASC which does not have a specific SDM)	44,938	146,861	124,408	0.1%	0.5%	0.4%

SDM.98 Modalities not disaggregated	234,897	100,973	682,846	0.7%	0.3%	2.2%
ASC.02 HIV testing and counseling (HTC)	2,831,640	2,057,380	3,525,734	8.3%	6.7%	11.2%
SDM.01 Facility-based service modalities	1,653,177	1,924,278	3,318,794	4.8%	6.2%	10.5%
SDM.02 Home and community based service modalities	1,020,605	133,102	206,940	3.0%	0.4%	0.7%
SDM.98 Modalities not disaggregated	157,859	-	-	0.5%	0.0%	0.0%
ASC.03 HIV Care and Treatment Care	18,016,180	15,807,345	12,359,979	52.5%	51.3%	39.2%
SDM.01 Facility-based service modalities	15,166,837	13,469,480	9,835,863	44.2%	43.7%	31.2%
SDM.02 Home and community based service modalities	879,487	781,658	887,710	2.6%	2.5%	2.8%
SDM.98 Modalities not disaggregated	454,181	29,206	50,106	1.3%	0.1%	0.2%
SDM.99 Modalities n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
ASC.04 Social protection and economic support	255,971	169,220	237,814	0.7%	0.5%	0.8%
SDM.01 Facility-based service modalities	255,971	169,220	237,814	0.7%	0.5%	0.8%
ASC.05 Social Enablers	156,665	24,723	220,015	0.5%	0.1%	0.7%
SDM.03 Non applicable (ASC which does not have a specific SDM)	156,665	24,723	220,015	0.5%	0.1%	0.7%
ASC.06 Programme enablers and systems strengthening	11,872,926	10,591,451	11,427,816	34.6%	34.4%	36.2%
SDM.03 Non applicable (ASC which does not have a specific SDM)	11,872,926	10,591,451	11,427,816	34.6%	34.4%	36.2%
ASC.07 Development synergies	8,255	24,565	35,995	0.0%	0.1%	0.1%
SDM.03 Non applicable (ASC which does not have a specific SDM)	8,255	24,565	35,995	0.0%	0.1%	0.1%
ASC.08 HIV-related research	180,371	50,000	39,623	0.5%	0.2%	0.1%
SDM.03 Non applicable (ASC which does not have a specific SDM)	180,371	50,000	39,623	0.5%	0.2%	0.1%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.4.3. Beneficiary Population (BP)

In order to identify who were the HIV beneficiaries across the years 2020-2022, Table 46 disaggregates overall HIV spending by groups of beneficiaries. In 2022, PLHIV received the largest share of HIV expenditure at 40%, a decrease from the 54% in 2020 and 53% in 2021. This decline enabled a redistribution of funds towards other areas: non-targeted interventions saw a relative increase in funding, capturing 37% in 2022, up from 36% in 2020 and 35% in 2021. Funding allocated to key populations (KP) rose to 7% in 2022, alongside a boost in expenditure towards vulnerable, accessible, and other specifically targeted groups, which collectively accounted for nearly 10% of the total spending. The general population benefited from nearly 1% of the funding, while specific

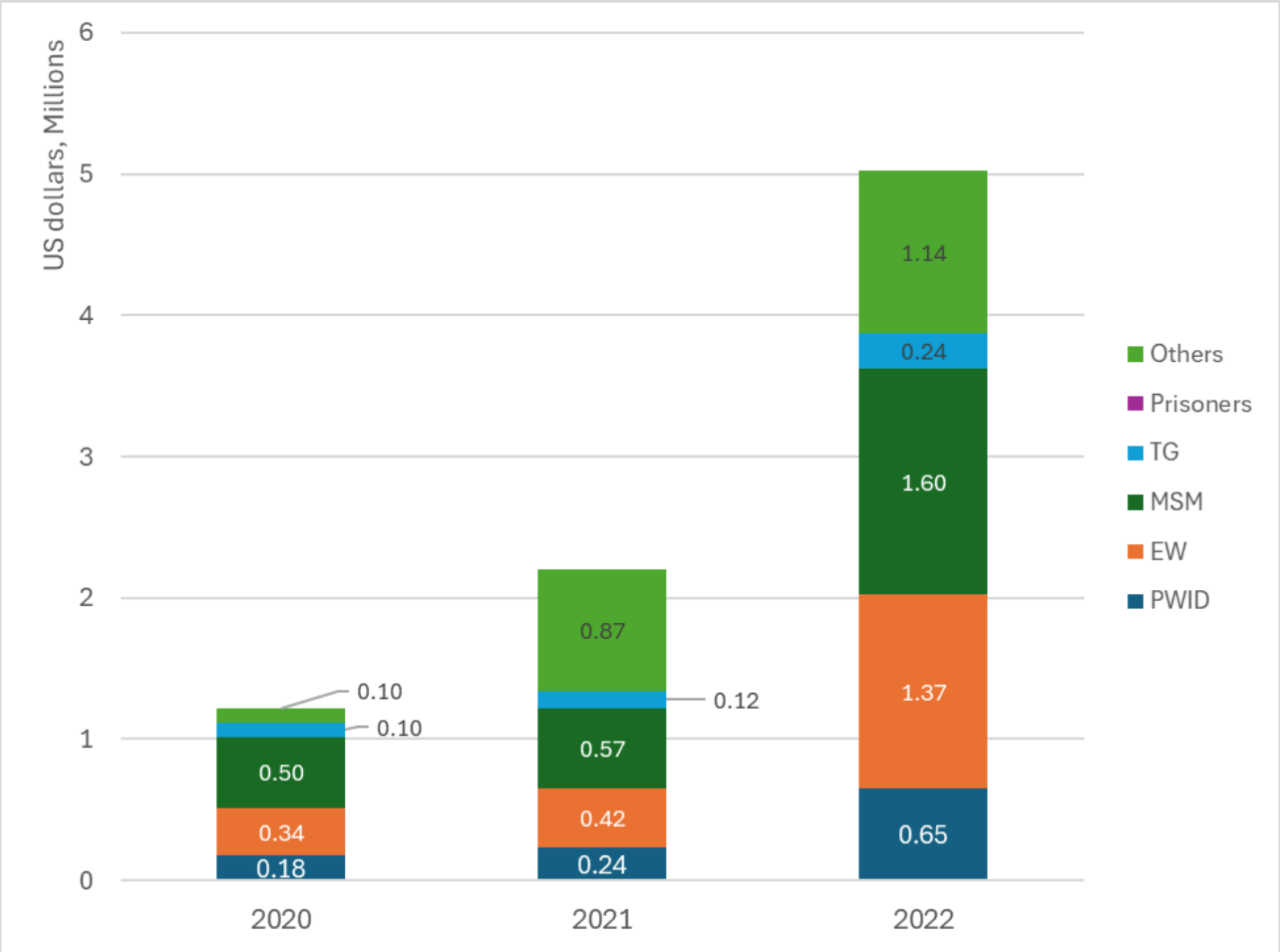
target populations n.e.c. received about 5% of the total HIV expenditure in 2022, marking a significant proportional rise from earlier years.

Table 46: Beneficiary Population (BP), 2020-2022, US dollars and %

BP	2020	2021	2022	% 2020	% 2021	% 2022
People living with HIV	18,373,953	16,158,510	12,743,222	53.6%	52.5%	40.4%
Key populations	1,599,112	1,215,789	2,205,867	4.7%	3.9%	7.0%
Vulnerable, accessible and other target populations	1,666,540	2,012,677	3,081,763	4.9%	6.5%	9.8%
General population	152,928	146,541	269,986	0.4%	0.5%	0.9%
Non-targeted interventions	12,236,893	10,720,593	11,750,628	35.7%	34.8%	37.2%
Specific targeted populations not elsewhere classified (n.e.c.)	269,672	549,278	1,514,227	0.8%	1.8%	4.8%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Figure 14 provides a detailed breakdown of HIV funding allocations targeted at key populations (KPs), illustrating shifts in financial support over time. Men who have sex with men (MSM) emerged as the principal recipients in both 2020 and 2022, with their funding significantly increasing from 0.5 million United States dollars in 2020 and 0.57 million United States dollars in 2021 to 1.6 million United States dollars in 2022. Female entertainment workers (FEW) also saw a notable rise in support, from 0.34 million United States dollars in 2020 and 0.42 million United States dollars in 2021 to 1.37 million United States dollars in 2022. Furthermore, people who inject drugs (PWID) experienced a steady increase in funding, receiving $0.18 million in 2020, 0.24 million United States dollars in 2021, and 0.65 million United States dollars in 2022. The transgender (TG) community's allocations also grew, from 0.10 million United States dollars in 2020 and 0.12 million United States dollars in 2021 to 0.24 million United States dollars in 2022, reflecting a committed and escalating financial investment towards addressing the needs of key populations within the HIV response.

Figure 14: HIV spending on types of Key Population (KP), 2020-2022, US Dollars (Millions)



3.4.3.1. Financing Entity (FE) and Beneficiary Population (BP)

Table 47 reveals the support from two primary HIV financing entities towards facility-based service modalities. Public entities allocated approximately 8.07 million United Sates dollars in 2020 towards people living with HIV (PLHIV) at 14.2%, key populations at 4.2%, and non-targeted populations at 5.2%. This funding saw a yearly increase, reaching 9.2 million United Sates dollars in 2021 and 9.73 million United Sates dollars in 2022. Correspondingly, the proportion of spending on PLHIV rose to 19.3% in 2022, with key populations receiving 5.5% and non-targeted populations 6%. Domestic private entities focused their funding exclusively on PLHIV and the general population, with their contribution to PLHIV slightly increasing from 1.5 million United Sates dollars in 2020 to 1.54 million United Sates dollars in 2021, and then to 1.61 million United Sates dollars in 2022. The investment in the general population by domestic private entities was comparatively minor. Overall, the combined spending by these financing entities targeted three main groups: PLHIV, key populations, and non-targeted populations. The total investment in PLHIV was 11.98 million United Sates dollars in 2020, decreasing to 8.83 million United Sates dollars in 2021 and further to 5.0 million United

Sates dollars in 2022. Funding for key populations was 1.60 million United Sates dollars in 2020, reduced to 1.22 million United Sates dollars in 2021, but increased significantly to 2.21 million United Sates dollars in 2022. Lastly, expenditure on non-targeted populations was substantial, with 10.47 million United Sates dollars in 2020, 8.99 million United Sates dollars in 2021, and an increase to 9.85 million United Sates dollars in 2022, showcasing a dynamic allocation of resources across different beneficiary groups over the three-year period.

Table 47: Financing Entity (FE) by Beneficiary Population (BP), 2020-2022, US dollars and %

FE by BP	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
BP.01 People living with HIV	4,860,773	5,787,394	6,094,025	14.2%	18.8%	19.3%
BP.03 Vulnerable, accessible and other target populations	1,440,644	1,674,634	1,730,702	4.2%	5.4%	5.5%
BP.05 Non-targeted interventions	1,769,762	1,733,721	1,905,370	5.2%	5.6%	6.0%
FE.02 Domestic Private Entities	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
BP.01 People living with HIV	1,532,979	1,541,868	1,608,392	4.5%	5.0%	5.1%
BP.04 General population	114,892	89,415	126,028	0.3%	0.3%	0.4%
FE.03 International Entities	24,580,047	19,976,356	20,101,176	71.7%	64.9%	63.7%
BP.01 People living with HIV	11,980,201	8,829,247	5,040,805	34.9%	28.7%	16.0%
BP.02 Key populations	1,599,112	1,215,789	2,205,867	4.7%	3.9%	7.0%
BP.03 Vulnerable, accessible and other target populations	225,896	338,043	1,351,061	0.7%	1.1%	4.3%
BP.04 General population	38,035	57,126	143,957	0.1%	0.2%	0.5%
BP.05 Non-targeted interventions	10,467,131	8,986,872	9,845,258	30.5%	29.2%	31.2%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	269,672	549,278	1,514,227	0.8%	1.8%	4.8%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.4.3.2. AIDS Spending Categories (ASC) and Beneficiary Population (BP)

Table 48 provides a comprehensive breakdown of HIV program expenditures by beneficiary population and program area from 2020 to 2022, distinguishing between eight principal areas: Prevention, HIV Testing and Counseling, HIV Care and Treatment, Social Protection and Economic Support, Social Enablers, Program Enablers and System Strengthening, Development Synergies, and HIV-related Research.

In the area of prevention, there was a notable uptick in spending targeted at key populations, which saw an increase from 0.38 million United Sates dollars (1.1%) in 2020 to 2.10 million United Sates dollars (6.7%) in 2022. Funding for prevention efforts directed at vulnerable populations also saw a steady rise over the specified period.

Conversely, the expenditure for HIV Testing and Counseling on key populations decreased sharply, from 1.22 million United Sates dollars in 2020 to just 0.10 million United Sates dollars in 2022, while funding for vulnerable populations in this area grew to 2.39 million United Sates dollars in 2022.

For HIV Care and Treatment, there was a noticeable reduction in spending on people living with HIV (PLHIV), from 18.0 million United Sates dollars in 2020 to 12.33 million United Sates dollars in 2022. Spending targeting the non-targeted population remained consistent across the years.

Expenditure on other program areas such as Social Enablers, Development Synergies, and HIV-related Research mostly catered to non-targeted interventions and represented less than 1% of total spending, with the exception of Program Enablers and System Strengthening. This area received substantial funding, maintaining a significant share of the budget similar to HIV care and treatment, with figures around 11.87 million United Sates dollars in 2020 and 11.43 million United Sates dollars in 2022, accounting for approximately 34-36% of the overall budget.

The spending trends indicate a shift in priorities, with an increased focus on prevention programs for key and vulnerable populations, alongside a decrease in funding for HIV care and treatment for PLHIV. This underscores evolving strategies in the allocation of funds to address the diverse needs within HIV programs.

Table 48: AIDS Spending Categories (ASC) by Beneficiary Population (BP), 2020-2022, US Dollars

ASC by BP	2020	2021	2022	% 2020	% 2021	% 2022
ASC.01 Prevention	977,088	2,078,704	3,718,717	2.8%	6.7%	11.8%
BP.01 People living with HIV	120,478	211,799	172,607	0.4%	0.7%	0.5%
BP.02 Key populations	375,950	1,132,532	2,101,166	1.1%	3.7%	6.7%
BP.03 Vulnerable, accessible and other target populations	328,266	465,993	693,061	1.0%	1.5%	2.2%
BP.04 General population	78,838	92,545	185,425	0.2%	0.3%	0.6%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	73,556	175,836	566,458	0.2%	0.6%	1.8%
ASC.02 HIV testing and counselling (HTC)	2,831,640	2,057,380	3,525,734	8.3%	6.7%	11.2%
BP.02 Key populations	1,223,161	83,257	104,701	3.6%	0.3%	0.3%
BP.03 Vulnerable, accessible and other target populations	1,338,274	1,546,684	2,388,702	3.9%	5.0%	7.6%
BP.04 General population	74,089	53,996	84,561	0.2%	0.2%	0.3%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	196,116	373,442	947,769	0.6%	1.2%	3.0%
ASC.03 HIV Care and Treatment Care	18,016,180	15,807,345	12,359,979	52.5%	51.3%	39.2%
BP.01 People living with HIV	17,997,504	15,777,491	12,332,801	52.5%	51.2%	39.1%
BP.05 Non-targeted interventions	18,676	29,854	27,179	0.1%	0.1%	0.1%
ASC.04 Social protection and economic support	255,971	169,220	237,814	0.7%	0.5%	0.8%
BP.01 People living with HIV	255,971	169,220	237,814	0.7%	0.5%	0.8%
ASC.05 Social Enablers	156,665	24,723	220,015	0.5%	0.1%	0.7%
BP.05 Non-targeted interventions	156,665	24,723	220,015	0.5%	0.1%	0.7%
ASC.06 Programme enablers and systems strengthening	11,872,926	10,591,451	11,427,816	34.6%	34.4%	36.2%
BP.05 Non-targeted interventions	11,872,926	10,591,451	11,427,816	34.6%	34.4%	36.2%
ASC.07 Development synergies	8,255	24,565	35,995	0.0%	0.1%	0.1%

BP.05 Non-targeted interventions	8,255	24,565	35,995	0.0%	0.1%	0.1%
ASC.08 HIV-related research	180,371	50,000	39,623	0.5%	0.2%	0.1%
BP.05 Non-targeted interventions	180,371	50,000	39,623	0.5%	0.2%	0.1%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.4.3.3. Service Delivery Modalities (SDM) and Beneficiary Population (BP)

Table 49 provides an insightful analysis into the allocation of HIV expenditures by SDM and beneficiary population from 2020 to 2022, revealing nuanced spending patterns. Facility-based services initially dominated the budget, accounting for 51.2% in 2020, with a slight decrease in funding to 14.98 million United States dollars by 2022. Within this modality, the largest share went to PLHIV, approximately 44% in 2020, which then declined to 31.8% in 2022, even as allocations for other groups like vulnerable and key populations generally saw an upward trend over the three years.

Conversely, the home and community-based modality observed a slight growth in its budget share, from 6.1% in 2020 to 7.7% in 2022, predominantly supporting PLHIV and key populations, with the latter seeing a more noticeable increase in funding from 2.8% in 2020 to 3.2% in 2022.

A significant part of the budget, over 35% each year, was categorized under non-applicable or modalities not elsewhere classified (n.e.c.), especially directed towards "Non-targeted interventions." This considerable allocation raises questions and highlights the need for a deeper exploration into the allocation strategies.

The overarching trend indicates a gradual reallocation of resources; while facility-based modalities continue to receive the lion's share of the budget, there is a discernible shift towards enhancing home and community-based modalities, reflecting an evolving strategy in addressing the needs of the HIV-affected communities.

Table 49: Service Delivery Modalities (SDM) by Beneficiary Population (BP), 2020-2022, US Dollars

SDM by BP	2020	2021	2022	% 2020	% 2021	% 2022
SDM.01 Facility-based service modalities	17,565,751	16,313,260	14,982,544	51.2%	53.0%	47.5%
BP.01 People living with HIV	15,404,132	13,608,846	10,046,499	44.9%	44.2%	31.8%
BP.02 Key populations	314,341	157,881	696,183	0.9%	0.5%	2.2%
BP.03 Vulnerable, accessible and other target populations	1,443,144	1,914,820	2,587,873	4.2%	6.2%	8.2%
BP.04 General population	152,928	146,541	266,608	0.4%	0.5%	0.8%
BP.05 Non-targeted interventions	18,676	29,854	27,179	0.1%	0.1%	0.1%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	232,530	455,319	1,358,203	0.7%	1.5%	4.3%
SDM.02 Home and community based service modalities	2,107,580	1,995,348	2,416,040	6.1%	6.5%	7.7%
BP.01 People living with HIV	955,027	857,870	1,009,324	2.8%	2.8%	3.2%
BP.02 Key populations	1,126,912	1,046,634	1,256,283	3.3%	3.4%	4.0%

BP.04 General population	-	-	3,377	0.0%	0.0%	0.0%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	25,641	90,844	147,055	0.1%	0.3%	0.5%
SDM.03 Non applicable (ASC which does not have a specific SDM)	12,263,155	10,837,600	11,847,857	35.8%	35.2%	37.5%
BP.01 People living with HIV	44,938	135,587	50,993	0.1%	0.4%	0.2%
BP.02 Key populations	-	11,274	-	0.0%	0.0%	0.0%
BP.03 Vulnerable, accessible and other target populations	-	-	73,415	0.0%	0.0%	0.2%
BP.05 Non-targeted interventions	12,218,217	10,690,739	11,723,449	35.6%	34.7%	37.1%
SDM.98 Modalities not disaggregated	846,937	130,179	732,952	2.5%	0.4%	2.3%
BP.01 People living with HIV	454,181	29,206	50,106	1.3%	0.1%	0.2%
BP.02 Key populations	157,859	-	253,401	0.5%	0.0%	0.8%
BP.03 Vulnerable, accessible and other target populations	223,396	97,857	420,476	0.7%	0.3%	1.3%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	11,501	3,116	8,969	0.0%	0.0%	0.0%
SDM.99 Modalities n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
BP.01 People living with HIV	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

3.5. Technical efficiency of Treatment and care program expenditure per PLHIV

The NASA data not only show the total actual expenditures in the context of different parameters, but also make it possible to calculate the expenditures per client covered by certain services. For example, the expenditures on covering one PLHIV with different treatment and care services. Based on the NASA data, the expenditures per PLHIV per year were calculated including next:

- Expenditures for laboratory support of HIV infection and monitoring of treatment effectiveness
- HIV treatment expenditures
- Expenditures for OI prevention and treatment
  Expenditures for care and support for PLHIV

Table 50: Technical efficiency of Treatment and care program expenditure per PLWHIV

T&C Interventions	General expenditures per FE				Coverage	FE Expenditures per PLWHIV			
	Central government	Households	Expenditures of external funding sources including PEPFAR, GF and UN	Total		Expenditures per PLHIV, United States dollars by program area from Central government	Expenditures per PLHIV, United States dollars by program area from Households	Expenditures per PLHIV, United States dollars by program area From external funding sources	Total care and support expenditure per PLHIV, United States dollars
	2020					2020			
Antiretroviral therapy	1,313,031		5,469,744	6,782,775	62423	21.03		87.62	
Adherence and retention on ART			1,116,205	1,116,205	62423			17.88	
Specific ART-related laboratory monitoring		17,304	1,363,220	1,380,524	62423		0.28	21.84	
Tuberculosis prevention, screening, case finding and treatment	177,720	0	11,627	189,347	62423	2.85		0.19	288.61
Prevention and treatment of other Ois	0	0	2,851,013	2,851,013	62423			45.67	
Psychological treatment and support service	0	0	49,638	49,638	62423			0.80	
Other care and treatment services	3,129,142	1,515,675	1,001,862	5,646,679	62423	50.13	24.28	16.05	
	2021					2021			
Antiretroviral therapy	1,983,445	0	7,789,957	9,773,402	62636	31.67		124.37	
Adherence and retention on ART	0	0	68,942	68,942	62636			1.10	
Specific ART-related laboratory monitoring	0	14,868	167,050	181,918	62636		0.24	2.67	
Tuberculosis prevention, screening, case finding and treatment	104,337	0	0	104,337	62636	1.67			252.37
Prevention and treatment of other Ois	0	0	112,695	112,695	62636			1.80	
Psychological treatment and support service	0	0	0	0	62636				
Other care and treatment services	3,536,501	1,527,000	502,550	5,566,051	62636	56.46	24.38	8.02	
	2022					2022			
Antiretroviral therapy	2,373,260	0	3,865,680	6,238,939	64948	36.54		59.52	
Adherence and retention on ART	0	0	14,846	14,846	64948			0.23	190.31
Specific ART-related laboratory monitoring	0	22,092	205,784	227,876	64948		0.34	3.17	

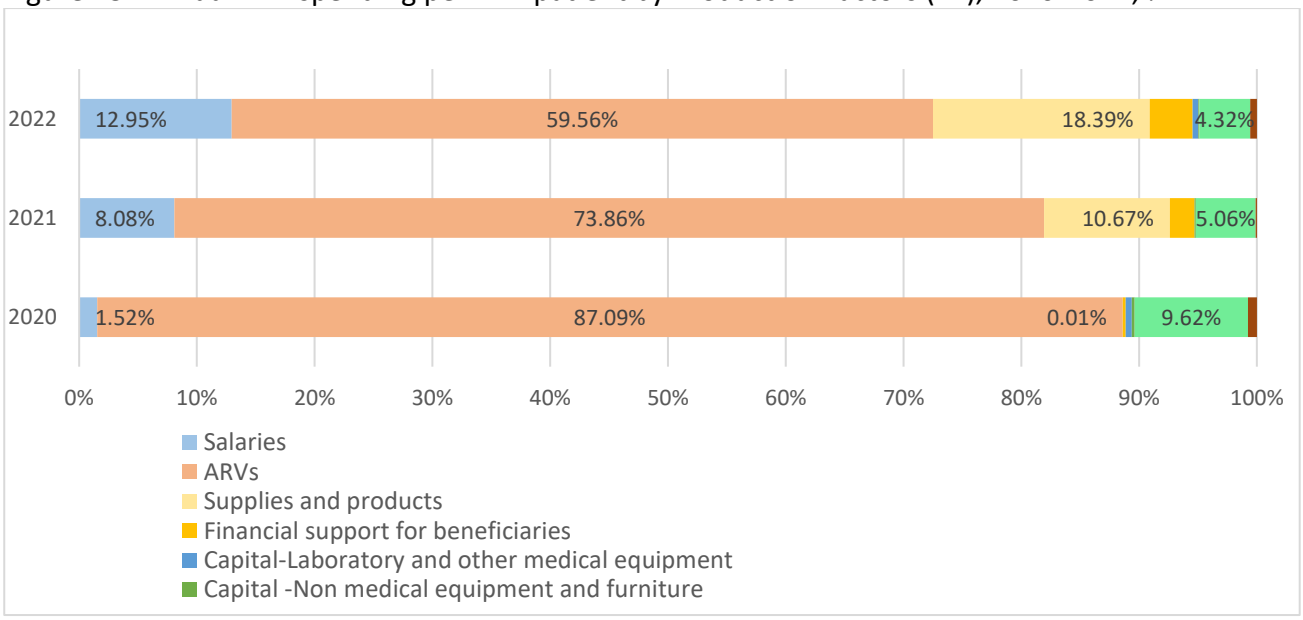
Tuberculosis prevention, screening, case finding and treatment	130,326	0	12,041	142,367	64948	2.01		0.19	
Prevention and treatment of other Ois	0	0	159,768	159,768	64948			2.46	
Psychological treatment and support service	0	0	0	0	64948			0.00	
Other care and treatment services	3,358,391	1,586,300	631,493	5,576,184	64948	51.71	24.42	9.72	

In order to calculate the actual T&C expenditures per 1 PLHIV, the total expenditures in the context of the above program areas for 2020-2022 were divided by the actual coverage for the same study years. This way, the T&C expenditures per PLHIV per year (in United States dollars) were calculated: 2020 – 288.6 United States dollars, 2021 – 252.3 United States dollars and 2022 – 190.3 United States dollars.

The cost of ART per patient on ART is 2020 - 108.66 United States dollars, 2021- 156.03 United States dollars, 2022- 96.06 United States dollars (amount excludes OOP of PLWHIV and shared running costs of the facility). This cost includes running costs of ART sites, salaries of service provider, ARVs and other medical supplies, travel costs. Laboratory expenditure was reported under Laboratory monitoring program area.

The next graph demonstrates ART spending per patient on ART in each study year. These amounts are disaggregated by the production factors. Of all the spending going on ART, the spending on ARVs consumed 87% in 2020, 74% in 2021 and 60% in 2022.

Figure 15: Annual ART spending per ART patient by Production Factors (PF), 2020-2022, %



4. SUMMARY

4.1. Key findings

- The results of this NASA round for the period of 2020-2022 show a steady decrease in spending on HIV in the country from US$ 34.30 million in 2020 to US$ 30.8 million in 2021 and US$ 31.6 million in 2022.
- Care and treatment accounted for most of the spending during the assessment period (52.5% in 2020, 51.3% in 2021 and 39.2% in 2022), followed by program enabling and system strengthening including administration (34.6% in 2020, 34.4% in 2021 and 36.2% in 2022).
- The growth is observed at the expense of the funding from state budget from US$ 8.1 million in 2020, US$ 9.2 million in 2021 and US$ 9.7 million in 2022 which is equal to 24%, 30% and 31% respectively.
- There is a trend of decreasing public funding for PLHIV treatment and increasing funding for prevention programs, particularly for general populations while services for key populations remain donor funded.
- Spending by Delivery Modality: Facility-based modalities were dominant but decreased slightly, while home and community-based modalities are gaining traction. A significant portion of spending is not related to service delivery due to the high share of strategic activities (above service provision).
- Spending by Beneficiary: Spending on prevention programs for key populations is growing while spending on HIV care and treatment for PLHIV is decreasing.
- Spending by funding entity: The public sector funding experiences positive trends with a slight increase across the years: 2020- 23.5%, 2021 - 29.9%, 2022 - 30.8%.
  While the primary funder remains the international sector. The current NASA rounds managed to capture out-of-pocket payments from PLHIV that take a share of 5% annually. However, OOP are significantly underestimated due to the limited data access and currently include only travel expenditure from PLWHIV, while excluding potential expenses on OI screening and treatment, as well as OOP from KPs.
- Public sector funding targets PLHIV, general population and non-specific interventions, while donors concentrate on services for KPs and system strengthening activites.

4.2. Recommendations

Based on the information provided, here are some recommendations for HIV spending in 2020-2022:

1. **Improve HIV program planning and implementation circle:**

   - Increased joint planning cooperation to determine where to direct public and donor funds could minimize duplication of funding and parallel planning processes, with consideration of improving the sustainability of key interventions. This will guarantee good intersectoral coordination for achieving the country's strategic goals and will allow avoiding possible duplication or underspending of the funding in the future.

2. **Optimize, re-prioritize Spending Allocation:**

- The report highlights that a significant portion of the expenditure goes towards service provision activities like care and treatment (40% in 2022), prevention (12% in 2022) and HTC (11% in 2022). However, it is important to analyze deeper efficiency of programs implementation and find potential ways for optimization and re-prioritization of program areas. Consider a more balanced approach, ensuring sufficient resources for all the country priorities based on strategic plans.
- The current public funding is concentrated on treatment, laboratory monitoring and care programs. The steady increase in donors spending on key populations across various programs is positive. However, although the funding for HIV prevention is being scaled up, the results of the assessment showed that public funding expansion is directed more towards the general population, rather than the key populations. The same trends are observed for HIV testing, public sector is limited and consists of testing at the level of the confirmation of the HIV status.
- It is strongly recommended to analyze the impact of these programs to ensure they are effectively reaching and supporting target groups. This could involve expanding outreach programs, particularly for high-risk groups, and investing in public awareness campaigns.
- As Program management and above service provision activities take over 35% per year, it is recommended to analyze these expenses in more details to insure funds are used efficiently.
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3. **Sustainability of funding:**
    - Cambodia's growing reliance on domestic resources is positive but country still has a significant dependence on the external sources of funding around 67% of the total budget. The increase in foreign aid is welcome, but there is some concern about fluctuations in contributions to HIV programs and about a significant dependence on donor aid, which makes priority programs highly unstable and unsustainable. This could mean that the country's government should be prepared for filling potential funding gaps in the event of a decrease in foreign aid. The government can explore innovative financing mechanisms to further reduce dependence on external aid. This could involve public-private partnerships and cooperation with business. The government may need technical support from international organizations to properly prepare and manage the transition in funding landscape.

    - It is important for the government to ensure that these donor-funded services are seamlessly integrated into national planning and state funding, which will ensure the sustainability of activities in the event that donors decide to cut or withdraw their funding.

4. **Institutionalization and development of country capacities in resource tracking, and improvement of data granularity**
    - In the future, it is necessary to envisage the possibility of institutionalizing the NASA in the country (as the part of routine M&E system) in order to regularly and

effectively track the costs of HIV, which will allow responding more quickly to problems and making logical decisions connected with the budget allocation, reducing duplication of services by several sources of funding.

- It is also necessary to strengthen the capacity of ministries and state agencies connected with tracking expenditures, including the provincial level.
- It is recommended to improve the inclusion of the private sector contributions.
- It is important to insure development of local human resource and involvement of local experts with knowledge of finance, resource tracking in next NASA rounds with potential minimization of external TA assistance in future.

5. ANNEXES

Annex 1: Financing Entity (FE), 2020-2022, US dollars and %

FE	2020	2021	2022	% 2020	% 2021	% 2022
FE.01 Public Entities	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
FE.01.01 Governmental	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
FE.02 Domestic Private Entities	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
FE.02.02 Households	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
FE.03 International Entities	24,580,047	19,976,356	20,101,176	71.7%	64.9%	63.7%
FE.03.01 Governments providing bilateral aid	6,148,796	5,454,695	5,641,663	17.9%	17.7%	17.9%
FE.03.02 Multilateral Organizations	16,186,848	12,468,421	12,210,864	47.2%	40.5%	38.7%
FE.03.03 International not-for-profit organizations and foundations	2,244,403	2,053,240	2,248,649	6.5%	6.7%	7.1%
Grand Total	34,299,097	30,803,388	31,565,694	100%	100%	100%

Annex 2: Financing Revenue (REV) for HIV, 2020-2022, US dollars and %

REV	2020	2021	2022	% 2020	% 2021	% 2022
REV.01 Transfers from government domestic revenue including reimbursable loans (allocated to HIV purposes)	8,071,179	9,195,749	9,730,098	23.5%	29.9%	30.8%
REV.1.1 Internal transfers and grants	7,830,299	9,032,638	9,498,049	22.8%	29.3%	30.1%
REV.1.2 Transfers by government to social health insurance on behalf of specific groups	240,880	163,111	232,049	0.7%	0.5%	0.7%
REV.06 Other domestic revenues n.e.c.	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
REV.6.1 Other revenues from households n.e.c.	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
REV.07 Direct foreign transfers	24,580,047	19,976,356	20,101,176	71.7%	64.9%	63.7%
REV.7.1 Direct foreign financial transfers	24,410,772	19,833,809	19,997,064	71.2%	64.4%	63.4%
REV.7.2 Direct foreign aid in kind	169,274	142,547	104,112	0.5%	0.5%	0.3%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Annex 3: Financing Scheme (SCH) for HIV, 2020-2022, US dollars and %

SCH	2020	2021	2022	% 2020	% 2021	% 2022
SCH.1 Government schemes and compulsory contributory health care schemes	20,952,384	19,897,154	19,427,545	61.1%	64.6%	61.5%
SCH.1.1.1 Central Government schemes	20,952,384	19,897,154	19,427,545	61.1%	64.6%	61.5%
SCH.2 Voluntary payment schemes	11,698,842	9,274,951	10,403,729	34.1%	30.1%	33.0%
SCH.2.2.1 Voluntary insurance schemes	6,535,469	5,024,417	5,670,581	19.1%	16.3%	18.0%
SCH.2.2.2 Resident foreign agencies schemes	768,717	664,141	1,625,251	2.2%	2.2%	5.1%
SCH.2.2.98 Not-for-profit organisation schemes not disaggregated	4,394,656	3,586,393	3,107,897	12.8%	11.6%	9.8%
SCH.3 Household out-of-pocket payment	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
SCH.3.1 Out-of-pocket excluding cost-sharing	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Annex 4: Financing Agent-Purchaser (FAP), 2020-2022, US dollars and %

FAP	2020	2021	2022	% 2020	% 2021	% 2022
FAP.01 Public sector	20,952,384	19,897,154	19,427,545	61.1%	64.6%	61.5%
FAP.01.01 Territorial governments	20,952,384	19,897,154	19,427,545	61.1%	64.6%	61.5%
FAP.02 Private sector	6,039,112	4,724,434	5,001,928	17.6%	15.3%	15.8%
FAP.02.04 Private households' (out-of-pocket payments)	1,647,871	1,631,283	1,734,420	4.8%	5.3%	5.5%
FAP.02.05 Not-for-profit institutions (other than social insurance)	4,391,241	3,093,151	3,267,507	12.8%	10.0%	10.4%
FAP.03 International purchasing organizations	7,307,601	6,181,800	7,136,221	21.3%	20.1%	22.6%
FAP.03.02 Multilateral agencies managing external resources	768,717	664,141	1,625,251	2.2%	2.2%	5.1%
FAP.03.03 International not-for-profit organizations and foundations	6,538,884	5,517,659	5,510,970	19.1%	17.9%	17.5%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Annex 5: Provider of Services (PS), 2020-2022, US dollars and %

PS	2020	2021	2022	% 2020	% 2021	% 2022
PS.01 Public sector providers	22,314,922	20,313,867	19,852,488	65.1%	65.9%	62.9%
PS.01.01 Governmental organizations	22,314,922	20,313,867	19,852,488	65.1%	65.9%	62.9%
PS.02 Private sector providers	4,603,154	5,018,441	5,598,405	13.4%	16.3%	17.7%
PS.02.01 Non-profit providers	2,955,282	3,387,158	3,863,985	8.6%	11.0%	12.2%
PS.02.02 Profit-making private sector providers	132,196	104,283	148,120	0.4%	0.3%	0.5%
PS.02.99 Private sector providers n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices	7,381,021	5,471,080	6,114,801	21.5%	17.8%	19.4%
PS.03.02 Multilateral agencies	698,026	571,425	1,272,713	2.0%	1.9%	4.0%
PS.03.03 International NGOs and foundations	3,190,487	1,669,977	1,734,191	9.3%	5.4%	5.5%
PS.03.99 Bilateral, multilateral entities, international NGOs and foundations – in country offices n.e.c.	3,492,508	3,229,678	3,107,897	10.2%	10.5%	9.8%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Annex 6: AIDS Spending Categories (ASC), 2020-2022, US dollars and %

ASC	2020	2021	2022	% 2020	% 2021	% 2022
ASC.01 Prevention	977,088	2,078,704	3,718,717	2.8%	6.7%	11.8%
ASC.01.01 Five Pillars of Prevention	557,159	1,649,442	2,912,042	1.6%	5.4%	9.2%
ASC.01.02 Other prevention activities	419,930	429,262	806,676	1.2%	1.4%	2.6%
ASC.02 HIV testing and counselling (HTC)	2,831,640	2,057,380	3,525,734	8.3%	6.7%	11.2%
ASC.02.01 HIV testing and counselling for sex workers	553,283	9,291	18,300	1.6%	0.0%	0.1%
ASC.02.02 HIV testing and counselling for MSM	479,760	62,975	71,943	1.4%	0.2%	0.2%
ASC.02.03 HIV testing and counselling for TG	26,402	9,075	12,317	0.1%	0.0%	0.0%
ASC.02.04 HIV testing and counselling for PWID		1,916	1,899	0.0%	0.0%	0.0%
ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities	5,219			0.0%	0.0%	0.0%
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)		231,786	834,791	0.0%	0.8%	2.6%
ASC.02.11 HIV screening in blood banks	1,338,274	1,314,898	1,553,912	3.9%	4.3%	4.9%
ASC.02.98 HIV testing and counselling activities not disaggregated	428,702	427,438	1,032,572	1.2%	1.4%	3.3%
ASC.03 HIV Care and Treatment Care	18,016,180	15,807,345	12,359,979	52.5%	51.3%	39.2%
ASC.03.01 Anti-retroviral therapy	6,782,775	9,773,402	6,238,939	19.8%	31.7%	19.8%
ASC.03.02 Adherence and retention on ART - support	1,116,205	68,942	14,846	3.3%	0.2%	0.0%
ASC.03.03 Specific ART-related laboratory monitoring	1,380,524	181,918	227,876	4.0%	0.6%	0.7%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	3,040,360	217,032	302,134	8.9%	0.7%	1.0%
ASC.03.05 Psychological treatment and support services	49,638			0.1%	0.0%	0.0%

ASC.03.98 Care and treatment services not disaggregated	5,646,679	5,566,051	5,576,184	16.5%	18.1%	17.7%
ASC.04 Social protection and economic support	255,971	169,220	237,814	0.7%	0.5%	0.8%
ASC.04.02 Other social protection and economic support (non-OVC)	244,683	157,948	226,551	0.7%	0.5%	0.7%
ASC.04.99 Social protection activities n.e.c	11,288	11,272	11,263	0.0%	0.0%	0.0%
ASC.05 Social Enablers	156,665	24,723	220,015	0.5%	0.1%	0.7%
ASC.05.02 Human rights programmes	140,727	15,246	211,871	0.4%	0.0%	0.7%
ASC.05.1 Advocacy	15,937	9,476	7,569	0.0%	0.0%	0.0%
ASC.05.98 Social enablers not disaggregated by type			575	0.0%	0.0%	0.0%
ASC.06 Programme enablers and systems strengthening	11,872,926	10,591,451	11,427,816	34.6%	34.4%	36.2%
ASC.06.01 Strategic planning, coordination and policy development	1,867,951	1,491,695	1,431,266	5.4%	4.8%	4.5%
ASC.06.02 Building meaningful engagement for representation in key governance, policy reform and development processes			20,700	0.0%	0.0%	0.1%
ASC.06.03 Programme administration and management costs (above service-delivery level)	4,720,406	4,298,936	4,357,375	13.8%	14.0%	13.8%
ASC.06.04 Strategic information	1,133,853	642,511	927,456	3.3%	2.1%	2.9%
ASC.06.05 Public Systems Strengthening	2,095,433	2,088,631	2,199,581	6.1%	6.8%	7.0%
ASC.06.06 Community system strengthening	129,563	181,840	432,284	0.4%	0.6%	1.4%
ASC.06.07 Human resources for health (above-site programmes)			5,875	0.0%	0.0%	0.0%
ASC.06.98 Programme enablers and systems strengthening not disagregated	1,925,720	1,887,838	2,053,278	5.6%	6.1%	6.5%
ASC.07 Development synergies	8,255	24,565	35,995	0.0%	0.1%	0.1%
ASC.07.01 Formative education to build-up an HIV workforce and other trainings not related to any specific activity		17,065	18,764	0.0%	0.1%	0.1%

ASC.07.98 Development synergies not disaggregated	8,255	7,500	17,231	0.0%	0.0%	0.1%
ASC.08 HIV-related research	180,371	50,000	39,623	0.5%	0.2%	0.1%
ASC.08.04 Socio-behavioural research	180,371	50,000	39,623	0.5%	0.2%	0.1%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Annex 7: Service Delivery Modalities (SDM), 2020-2022, US dollars and %

SDM	2020	2021	2022	% 2020	% 2021	% 2022
SDM.01 Facility-based service modalities	17,565,751	16,313,260	14,982,544	51.2%	53.0%	47.5%
SDM.01.01 Facility-based: Outpatient	1,762,435	1,778,741	2,389,051	5.1%	5.8%	7.6%
SDM.01.02 Facility-based: Inpatient	15,635	14,444	16,980	0.0%	0.0%	0.1%
SDM.01.98 Facility-based not disaggregated	15,787,681	14,520,076	12,576,513	46.0%	47.1%	39.8%
SDM.02 Home and community based service modalities	2,107,580	1,995,348	2,416,040	6.1%	6.5%	7.7%
SDM.02.01 Community-based: center	6,980	31,576	14,846	0.0%	0.1%	0.0%
SDM.02.04 Community-based: mobile unit	-	-	25,962	0.0%	0.0%	0.1%
SDM.02.05 Community-based: outreach	419,484	1,023,076	1,075,013	1.2%	3.3%	3.4%
SDM.02.07 HIV self-testing	-	31,153	54,445	0.0%	0.1%	0.2%
SDM.02.98 Home and community based not disaggregated	1,681,115	909,544	1,245,772	4.9%	3.0%	3.9%
SDM.03 Non applicable (ASC which does not have a specific SDM)	12,263,155	10,837,600	11,847,857	35.8%	35.2%	37.5%
SDM.03.01 Non applicable (ASC which does not have a specific SDM)	12,263,155	10,837,600	11,847,857	35.8%	35.2%	37.5%
SDM.98 Modalities not disaggregated	846,937	130,179	732,952	2.5%	0.4%	2.3%
SDM.98 Modalities not disaggregated	846,937	130,179	732,952	2.5%	0.4%	2.3%
SDM.99 Modalities n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
SDM.99 Modalities n.e.c.	1,515,675	1,527,000	1,586,300	4.4%	5.0%	5.0%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Annex 8: Beneficiary Population (BP), 2020-2022, US dollars and %

BP	2020	2021	2022	% 2020	% 2021	% 2022
BP.01 People living with HIV	18,373,953	16,158,510	12,743,222	53.6%	52.5%	40.4%
BP.01.98 People living with HIV not broken down by age or gender	18,373,953	16,158,510	12,743,222	53.6%	52.5%	40.4%
BP.02 Key populations	1,599,112	1,215,789	2,205,867	4.7%	3.9%	7.0%
BP.02.01 Persons who Inject drug users (PWID) and their sexual partners	238,191	176,034	237,110	0.7%	0.6%	0.8%
BP.02.02 Sex workers (SW) and their clients	616,743	339,420	415,075	1.8%	1.1%	1.3%
BP.02.03 Gay men and other men who have sex with men (MSM)	532,689	502,921	569,004	1.6%	1.6%	1.8%
BP.02.04 Transgender	27,774	99,850	116,104	0.1%	0.3%	0.4%
BP.02.05 nmates of correctional facilities (prisoners) and other institutionalized persons	5,219	-	-	0.0%	0.0%	0.0%
BP.02.98 “Key populations” not broken down by type	178,497	97,563	868,575	0.5%	0.3%	2.8%
BP.03 Vulnerable, accessible and other target populations	1,666,540	2,012,677	3,081,763	4.9%	6.5%	9.8%
BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns	104,870	599,922	1,033,961	0.3%	1.9%	3.3%
BP.03.06 Migrants/mobile populations	-	-	73,415	0.0%	0.0%	0.2%
BP.03.11 Children and youth out of school	-	7,200	-	0.0%	0.0%	0.0%
BP.03.14 Recipients of blood or blood products	1,338,274	1,314,898	1,553,912	3.9%	4.3%	4.9%
BP.03.98 Vulnerable, accessible and other target populations not broken down by type	223,396	90,657	420,476	0.7%	0.3%	1.3%
BP.04 General population	152,928	146,541	269,986	0.4%	0.5%	0.9%
BP.04.98 General population not broken down by age or gender.	152,928	146,541	269,986	0.4%	0.5%	0.9%
BP.05 Non-targeted interventions	12,236,893	10,720,593	11,750,628	35.7%	34.8%	37.2%

BP.05 Non-targeted interventions	12,236,893	10,720,593	11,750,628	35.7%	34.8%	37.2%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	269,672	549,278	1,514,227	0.8%	1.8%	4.8%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	269,672	549,278	1,514,227	0.8%	1.8%	4.8%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Annex 9: Production Factors (PF), 2020-2022, US dollars and %

PF	2020	2021	2022	% 2020	% 2021	% 2022
PF.01 Current direct and indirect expenditures	32,667,326	29,886,166	30,871,731	95.2%	97.0%	97.8%
PF.01.01 Personnel costs	11,455,644	11,543,605	11,532,878	33.4%	37.5%	36.5%
PF.01.02 Other operational and programme management current expenditures	4,357,125	3,496,978	3,524,752	12.7%	11.4%	11.2%
PF.01.03 Medical products and supplies	11,679,886	11,221,837	9,567,739	34.1%	36.4%	30.3%
PF.01.04 Contracted external services	1,330,195	890,223	999,983	3.9%	2.9%	3.2%
PF.01.05 Transportation related to beneficiaries	7,111	19,153	14,017	0.0%	0.1%	0.0%
PF.01.07 Financial support for beneficiaries	700,975	434,751	594,279	2.0%	1.4%	1.9%
PF.01.08 Training- Training related per diems/transport/other costs	1,346,857	770,362	1,307,043	3.9%	2.5%	4.1%
PF.01.09 Logistics of events, including catering services	611,138	348,584	1,055,121	1.8%	1.1%	3.3%
PF.01.10 Indirect costs	907,430	1,040,871	1,182,912	2.6%	3.4%	3.7%
PF.01.98 Current direct and indirect expenditures not disaggregated	270,963	119,801	1,093,004	0.8%	0.4%	3.5%
PF.02 Capital expenditures	550,733	444,312	537,928	1.6%	1.4%	1.7%
PF.02.01 Building	30,102	55,922	51,328	0.1%	0.2%	0.2%
PF.02.02 Vehicles	120,480	66,528	38,118	0.4%	0.2%	0.1%
PF.02.03 Other capital investment	379,699	290,874	381,306	1.1%	0.9%	1.2%
PF.02.98 Capital expenditure not disaggregated	20,451	30,987	67,176	0.1%	0.1%	0.2%
PF.98 Production factors not disaggregated	1,081,038	472,910	156,035	3.2%	1.5%	0.5%
PF.98 Production factors not disaggregated	1,081,038	472,910	156,035	3.2%	1.5%	0.5%
Grand Total	34,299,097	30,803,388	31,565,694	100.0%	100.0%	100.0%

Annex 10: Members of NASA 7 Steering Committee

No	Full name (en)	Gender	Position	Institution
1	OOP.E Tia Phalla	M	Deputy Chair of NAA	NAA
2	OOP.E Sim Sophay	M	Deputy of Secretary General	NAA
3	Dr. Chorn Samnang	M	Technical Assistant	NMCHC
4	Dr. Seng Por Sroun	M	Project Manager	KHANA
5	OOP.E Ros Seilavath	M	Deputy Chair of NAA	NAA
6	Dr. Ly Chanravuth	M	Deputy director of PMER	NAA
7	Dr. Mok Sankith	M	Deputy of finance	NCHADS
8	Dr. Tan Sokey	M	Technical Assistant	NAA
9	Dr. Khin Cho Win Htin	F	SI advisor	UNAIDS
10	Hannah Marqusee	F	Technical Assistant	USAID
11	Nichola Edward	M	COP	LHSS/Abt
12	Khieu Kimlee	M	Consultant	OPM
13	Sharapka Katerina	F	Consultant	OPM

Annex 11: list of participants who attended in the NASA 7 training

NGO and development partners

No	Full name	Gender	Position	Institution
1	Ly Chanravuth	M	Deputy of PMER	NAA
2	Tep Navuth	M	Director of PMER	NAA
3	Chhim Monin	F	Deputy of Fin. Office	NAA
4	Tep Romaing	M	SI Technical Advisor	FHI360
6	Sreng Por Srun	M	Program Manger	KHANA
7	Chek Srey Pech	F	Staff of NAA	NAA
8	Hor Many	F	Staff of AHF	AHF
9	Yeh Actchara	F	Staff of AHF	AHF
10	Veth Sreng	M	Program Manger	RHAC
11	Mo Mai	M	Health Financing	WHO
12	Khieu Kimlee	M	Consultant	OPM
13	Sharaptka Katerina	F	Consultant	OPM
14	Khin Cho WinHtin	F	SI Prog. Officer	UNAIDS
15	Sim Sophay	M	Deputy of Sec. Gen.	NAA
16	Dy Sengrong Kea	M	Health Specialist	WHO
17	Sem Sithat	M	Program Manager	FI
18	Phan Sokphons	M	Assoc Prog. Officer	CHAI
19	Srey Mony	M	Principal Advisor	LHSS/Abt
20	Lim Sophom	M	Program Manger	HACC
21	Sem Somaly	M	Program Manager	HACC
22	Keo Vimeanratana	F	Coordinator	CRS
23	Sum Sopheak	F	FAO officer	LHSS/Abt

Government counterparts

No	Full name	Gender	Position	Institution
1	Seng Dara	M	Dep. Of Department	Min. of Social Affair
2	Om Vutharo	M	CD office	CRC
3	Pich Sokunthea	F	Office Manager	MOEYS
4	Te Phanith	M	Accountant officer	NMCHC
5	Lay Oun Ry	F	Deputy of MoI	MoI
6	Sing San Panlina	F	Staff of MOI	MoI
7	Chum Piseth	F	Staff of CRC	CRC
8	Porn Kim Hoeung	F	Deputy of office	Min Of Social Affair
9	Horn Sokunthea	F	Staff of MoI	MoI
10	Rim Chanra	M	Deputy of office	Min. of Wo. Affair
11	San Sochetra	F	Finance officer	NMCHC
12	Chamroeun Bora	M	Technical staff	NCHADS
13	Khieu Kimlee	M	Consultant	OPM
14	Noy Nita	F	DPHI officer	MOH
15	Choun Samnang	F	DPHI officer	MoH
16	Leng Monipheap	F	Chief of officer	Min. of Wo. Affair
17	Tat Vuthoeun	M	Deputy of admin office	Min. of Wo. affair
18	Tren Maren	F	Deputy of office	MOI
19	Mok Sankith	M	Deputy of finance	NCHADS
20	Chan Dany	F	Finance officer	DMHSA/MOH
21	Ly Chanravuth	M	Deputy of PMER	NAA
22	Seng Srey Pov	F	Deputy of office	NAA
23	Chak Srey Pech	F	Staff of NAA	NAA

24	Ma Chandaly	M	Communication Consultant	UNAIDS
25	Sharapka Katerina	F	Consultant	OPM
26	Sim Sophay	M	Deputy of SG	NAA
27	Patricia OngPin	F	Country Director	UNAIDS
28	Khin Cho Win Htin	F	SI advisor	UNAIDS
29	Kong Sathin	F	Chief of office	MoLVT
30	Heng Soy Kanika	F	Staff of DOSH	MoLVT
31	Sun Pileap	F	Deputy of office	MoEYS
32	Pech Samet	F	Admin officer	AUA
33	Nou Chanly	M	Chief of technical office	CENAT
34	Chhuon Naom	F	Prov Coordinator	AUA
35	Maun SreyPich	F	Officer	DMHSA/MoH
36	Um Vireak	M	Chief office	MoWA
37	Sum Sopheak	F	FAO office	LHSS/Abt
38	Phy Searatha	F	Officer	NAA
39	Cham Pisey	F	Deputy of FAO office	NAA