# 2013/14 HIV AND AIDS PUBLIC EXPENDITURE REVIEW

## TANZANIA MAINLAND

August 2015

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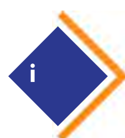

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# ACRONYMS

| | |
|---|---|
| **ART** | Antiretroviral Therapy |
| **ATE** | Association of Tanzania Employers |
| **ATF** | AIDS Trust Fund |
| **DPs** | Development Partners |
| **EA** | Expenditure Analysis |
| **HA** | Health Accounts |
| **HMIS** | Health Management Information System |
| **HPP** | Health Policy Project |
| **LGAs** | Local Government Authorities |
| **MDAs** | Ministries, Departments and Agencies |
| **MoF** | Ministry of Finance |
| **MoHSW** | Ministry of Health and Social Welfare |
| **MoU** | Memorandum of Understanding |
| **MS** | Member State |
| **MSM** | Men who have Sex with Men |
| **MTEF** | Medium Term Expenditure Framework |
| **MVC** | Most Vulnerable Children |
| **NACP** | National AIDS Control Program |
| **NGOs** | Nongovernmental Organizations |
| **NMSF** | National Multisectoral Strategic Framework |
| **PEPFAR** | President's Emergency Plan for AIDS Relief |
| **PER** | Public Expenditure Review |
| **PLHA** | People Living with HIV and AIDS |
| **PMO-RALG** | Prime Minister's Office, Regional Administration and Local Government |
| **PMTCT** | Prevention of Mother to Child Transmission |
| **SADC** | Southern Africa Development Community |
| **TACAIDS** | Tanzania Commission for AIDS |
| **TZS** | Tanzanian Shillings |
| **VMMC** | Voluntary Medical Male Circumcision |
| **WPP** | Workplace Program |

# ACKNOWLEDGMENTS

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Our deepest gratitude also goes to all who provided data and information. In particular we would like to acknowledge the support received from the donor community and Ministries, Departments, and Agencies. Dr. Gemini Mtei from the National Health Accounts team, Mr. Ubwa Mzee from the Ministry of Finance, and Mr. Elisa Rwamiago from the Prime Minister's Office, Regional Administration and Local Government deserve a special mention. They were all instrumental in providing data and experience.

We also wish to convey our appreciation for the support provided by the 10 councils included in the field study: Mbeya City Council, Ileje District Council, Tarime District Council, Rorya District Council, Shinyanga Munipal Council, Ushetu District Council, Njombe Town Council, Makete District Council, Bukoba Municipal Council, and Ngara District Council. We also recognize the contributions made by locally based nongovernmental organizations during the field survey.

We take this opportunity also to acknowledge the commitments made by development partners in continuing to support Tanzania's HIV and AIDS national response efforts, and to thank the Finance and Audit Technical Working Committee for providing strategic guidance to the study.

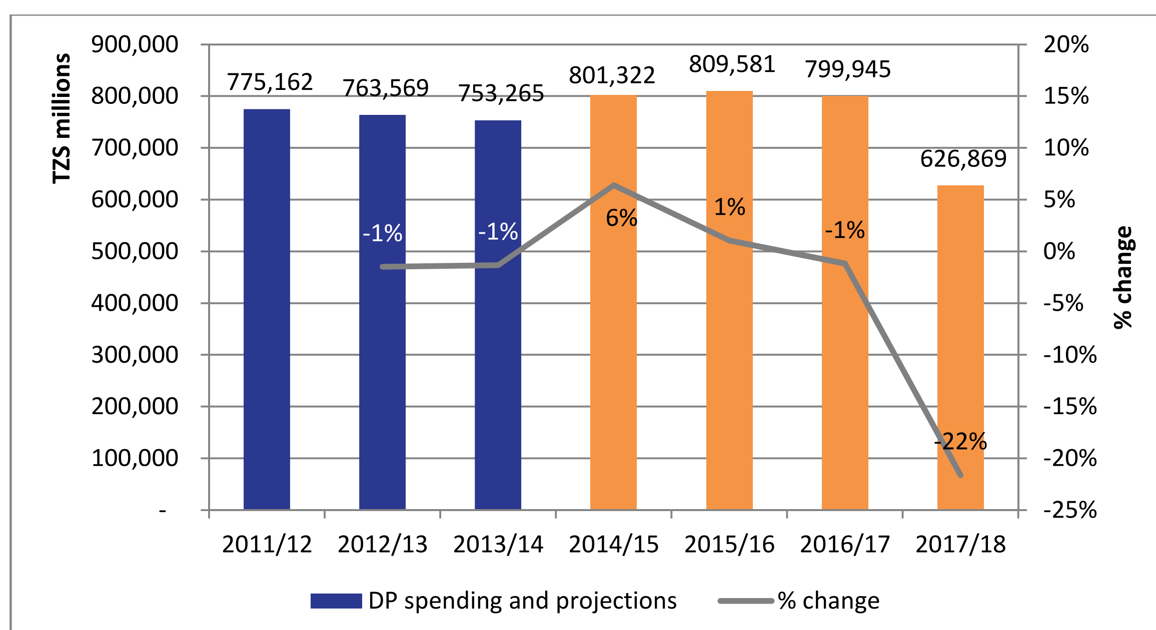
# Executive Summary

The 2013/14 HIV and AIDS Public Expenditure Review (PER) analyzes spending between 2011/12 and 2013/14, and projections until 2017/18. Data collection at the central and local level also permitted observations on challenges experienced in implementing HIV and AIDS activities. Spending has been analyzed according to the Second National Multi-sectoral Strategic Framework and by source of financing. For the first time, this PER has also analyzed spending by detailed HIV and AIDS program areas, through the use of distribution keys and Health Accounts data.

**Financing the National Response to HIV and AIDS through Domestic Resources Is Needed**

This report analyzes spending by development partners (DPs) and the government of Tanzania. Figure 1 highlights DP spending (blue columns), projections (yellow columns) and the annual change (line chart). The vast majority of spending on HIV and AIDS is financed by DPs—over 98 percent between 2011/12 and 2013/14. The U.S. government (President's Emergency Plan for AIDS Relief (PEPFAR)) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) account for 86 percent of the total donor support to the national response; this fell from 91 percent in the 2010/11 PER. Government and DP spending earmarked for HIV and AIDS fell between 2012/13 and 2013/14; this decrease is more pronounced after removing exchange rate changes. Decreases are also expected in 2016/17 and 2017/18. This potentially creates a significant financing gap and risks the implementation of the national HIV and AIDS response. More sustainable sources of financing should be found, particularly domestically. The private sector presents an exciting opportunity to contribute to the HIV and AIDS response.

**Figure 1: Development Partner Spending and Projections**



### HIV and AIDS Spending by the Second National Multi-sectoral Strategic Framework Themes

DP spending on care, treatment, and support increased to 55 percent of their HIV and AIDS spending in 2013/14. Prevention spending, which is prioritized in the Second National Multisectoral Strategic Framework (NMSF), remained at approximately one quarter of DP spending, followed by impact mitigation activities, which hovered around 11 percent. Spending on crosscutting issues fell from 16 percent in 2011/12 to 9 percent in 2013/14, driven largely by the Global Fund and the Danish International Development Agency. Government resources at Ministries, Departments, and Agency (MDA) level were spent mainly on care, treatment, and support (46 percent) and crosscutting activities (53 percent). At the Local Government Authority (LGA) level, the vast majority of government resources (73 percent) were spent on crosscutting activities.

### Budget Performance Assessments of Government Entities

Data collection at the central level showed strong budget performance for the sampled MDAs, at 95 percent during the three years. However, information collected at the MDA-level painted a different picture, with somewhat erratic execution rates among six MDAs sampled.

At the Local Government Authority level, execution of the NMSF grant spending improved from 74 percent in 2011/12 to 84 percent in 2013/14, due partly to extensive training and capacity-building undertaken with the Multi-sectoral AIDS committees at the council, ward, and village levels. Spending rates for Objective A were lower, but improved from 51 percent in 2012/13 to 63 percent in 2013/14.

Challenges reported in the previous PER still remain. The NMSF grant and Objective A disbursements are often delayed, which has a negative impact on implementation of HIV and AIDS activities at the local level. The PER team also heard from several MDAs and LGAs that the delay sometimes resulted in misallocation of funds so that the funds could be spent before the end of the fiscal year.

### Spending by Detailed Program Areas

Analysis of spending by detailed HIV and AIDS program areas was possible for government, PEPFAR, and Global Fund spending. In 2011/12, PEPFAR spent approximately half its funding on care, treatment, and support at the facility and community-based levels. Nearly one quarter of its spending was on prevention activities, such as Prevention of Mother to Child Transmission (PMTCT) (8 percent), testing and counselling (7 percent) and Voluntary Medical Male Circumcision (VMMC) (3 percent). In contrast, in 2011/12 the Global Fund spent the majority of its grants (85 percent) on crosscutting activities to strengthen national-level multi-sectoral coordination. It also funded some prevention work, particularly PMTCT (6 percent) and testing and counselling (3 percent). The government of Tanzania spent nearly all its resources on facility-based care, treatment, and support; the available data show predominantly antiretroviral therapy (ART) spending (97 percent), followed by treatment for opportunistic infections (1 percent). More detailed data on service utilization and cost of services will permit more detailed disaggregation of spending in the future. In Chapter 4, we propose a methodology that can be used to obtain this disaggregation.

## Recommendations

This review of HIV and AIDS public spending between 2011/12 and 2013/14 provides the following observations and recommendations:

1. Given the risk of declines in donor funding for HIV and AIDS activities over the next few years, it becomes more imperative that alternative, domestic sources of financing are explored and used. The central government should commit to timely disbursement of the budgeted funds.

Other options discussed in the previous PER and which still remain relevant include levies on tobacco, alcohol, cell phone airtime, and foreign transaction fees. Local governments should explore the feasibility of investing their own resources in prevention and treatment of HIV and AIDS. The private sector should be incentivized to contribute in a more systematic way via workplace programs, subsidies for health insurance, and social corporate responsibility initiatives. As the AIDS Trust Fund begins to tackle the challenge of resource mobilization, it should analyze these different initiatives for their feasibility and the revenues they can generate, in order to select the strategy most appropriate for Tanzania.

2. It is important that development partners and the government disburse funds for HIV and AIDS on a timely basis to avoid disruptions in implementation. This will not only help to provide the services planned for the population but will also help to prevent funds being misallocated to non-HIV and AIDS purposes.

3. Improved tracking of spending by thematic areas, and detailed intervention, will help programmers understand whether spending is aligned with priorities and whether reallocation of resources is needed. Detailed expenditure tracking can also help to demonstrate the impact achieved with the funds, which is a powerful tool when negotiating with potential funders. All of this will require coordination with other government units to ensure budgets and plans sufficiently accommodate the thematic areas in routine reports, and that Health Management Information System (HMIS) data are complete and accurate.

4. Finally, teams generating different expenditure analyses should aim to coordinate in a more effective manner, to provide decision makers with harmonized information and avoid duplication of effort. Decision makers will be more likely to use data when the data are clear and differences between reports are explained. Developing a harmonized data collection tool will not only improve the accuracy of responses by avoiding "survey fatigue," but will also facilitate consistency of analyses across different reporting mechanisms.

# 1. Introduction

## 1.1 Objectives and Rationale for 2013/14 HIV and AIDS PER

In the National Strategy for Growth and Reduction of Poverty (also known by its Swahili acronym "Mkukuta"), the Government of Tanzania aims to improve people's health by building stronger capacities to prevent and cure diseases. In line with Mkukuta and the National HIV and AIDS Policy of 2001, Tanzania has adopted a multi-sectoral approach in its response to the HIV and AIDS epidemic. This is reflected in the development of a series of multi-sectoral strategic frameworks to guide the response, the current one being the Tanzania Third National Multisectoral Strategic Framework for HIV and AIDS (2013/14–2017/18) (NMSF III).

NMSF III has established five strategic areas for primary investment, including comprehensive ART service delivery, which is viewed as the single most important investment, because it can reduce new infections and prolong the life of People Living with HIV and AIDS (PLHA). Other important strategic areas include HIV counseling and testing with effective linkages to facility- and community-based services; elimination of mother to child transmission, including adoption and implementation of Prevention of Mother to Child Transmission and Option B+ throughout the country; comprehensive sexuality, gender, and health education and services; and condom provision through programs that employ targeted and innovative strategies to increase access to both male and female condoms. The envisaged end result is zero new HIV infections, zero AIDS-related deaths, and zero stigma and discrimination.

Having established a multi-sectoral approach, there is a need to accurately budget for the resources required for HIV and AIDS, mobilize the necessary resources and to monitor spending. The latter will inform the government on how resources for HIV and AIDS are being used, to what extent they are in line with priorities, and help to anticipate potential funding gaps. As spending data are used more and more to inform decisions about resource allocation, this data will help to ensure continued future funding for the response to the epidemic. This report assesses HIV and AIDS activities of the public sector and of DPs in Tanzania, from both an implementation and financial perspective. It identifies implementation challenges, and recommends measures to ensure a more effective implementation of the National Multi-sectoral Strategy on HIV and AIDS.

The 2013/14 HIV and AIDS PER addresses the following policy questions:

- What has been the contribution of the government and DPs in the national HIV and AIDS response?
- What has been the trend in HIV and AIDS expenditure between 2011/12 and 2013/14, from DPs and the government?
- What was the performance of HIV and AIDS government spending against budgets during those years?
- What was the distribution of expenditure by NMSF thematic areas between 2011/12 and 2013/14?
- What is the projected funding from donors and government between 2014/15 and 2016/17?
- What was the distribution of spending by detailed program areas for government and DPs?

## 1.2 Methodology

In this PER, the focus has been on government and DP spending only. Government resources are sourced from general tax revenues.

DP spending includes funding via general budget support, contributions to the basket fund, spending via private implementing partners (e.g., nongovernmental organizations (NGOs) and other private contractors); and other contributions to government such as via Objective A. Objective A is a government program for workplace HIV and AIDS interventions at both MDAs and LGAs. Its main objectives are to sensitize employees at the workplace about HIV and AIDS; educate about the importance of knowing one's serostatus and disclosure; support employees who have disclosed their status; and, where necessary, provide protective gear at the workplace.

The data for the 2013/14 HIV and AIDS PER were sourced from a combination of primary and secondary sources. The main sources of secondary data were:

1. Ministry of Finance budget execution reports for MDAs via the EPICOR system
2. Tanzania Commission for AIDS data presented in various reports, e.g., Tanzania Commission for AIDS (TACAIDS) Annual Report (2013/14), NMSF III Costing Report, LGAs' NMSF Grant Expenditure Reports
3. Medium-Term Expenditure Frameworks, HIV and AIDS-related plans/activities, and financial reports of selected MDAs and LGAs for the financial years 2011/12, 2012/13, 2013/14, and 2014/15
4. LGA spending from the Prime Minister's Office, Regional Administration and Local Government (PMO-RALG), Dodoma

Primary data were collected, via a survey, from key DPs working in HIV and AIDS, as well as a sample of MDAs (six) and LGAs (10). The aim of data collection at the sub-national level was to obtain more-detailed spending information at the levels where spending is taking place, and which was not available from the Ministry of Finance. Where sub-national spending data were equally available at the national level, the primary data collection was used for triangulation.

MDAs of strategic importance were selected: either because they spend significantly on HIV and AIDS interventions, or because their sector specifically mandates them to have workplace programs. For example, the Ministry of Energy and Minerals was selected because of the latest developments in the gas and oil sector, which may necessitate more spending on their production sites going forward. The LGAs sampled were provided by TACAIDS, and include a sample from high- and low-burden regions. Data were collected from two districts from each region. For LGAs, the team was able to obtain a breakdown of HIV and AIDS spending by source of financing and by thematic area, as well as information on challenges faced in the implementation of HIV and AIDS activities. These samples are designed to give additional information on spending, but may not be representative of all regions.

Text Box 1: Primary Data Collection

*The MDAs and LGAs sampled for the PER were:*

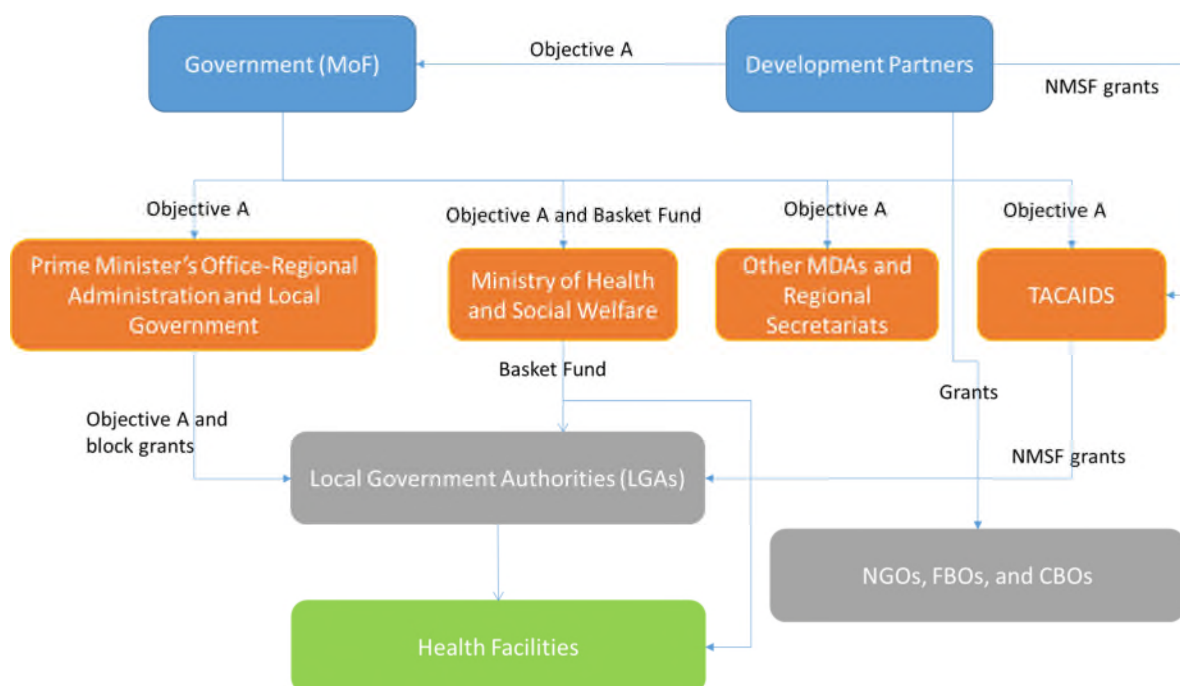
- Ministry of Community Development, Gender, and Children (MCDGC)
- Ministry of Energy and Minerals (MEM)
- Ministry of Agriculture, Food, and Cooperatives (MoAFS)
- Ministry of Education and Vocational Training (MoEVT)
- Ministry of Communication, Science and Technology (MoCST)
- Prime Minister's Office, Regional Administration and Local Government
- LGAs: Mara (Tarime District Council (DC) and Rorya DC), Kagera (Bukoba MC and Ngara DC), Shinyanga (Shinyanga MC and Ushetu DC), Mbeya (Mbeya City Council and Ileje DC), and Njombe (Njombe Town Council and Makete DC)

*Development partners who completed the PER survey were:*

- Bilateral partners: Canadian Department of Foreign Affairs, Trade and Development, Danish International Development Agency, Japan International Cooperation Agency, Government of Norway, and Government of USA (includes all PEPFAR funding to agencies such as USAID, CDC, State Department and Department of Defense)
- Multilateral partners: The European Union, the Global Fund, UNDP, UNFPA, UNICEF, and World Bank

Figure 2 shows the flow of major funds for HIV and AIDS activities in Tanzania. This figure was used to guide the data collection process, to ensure that data for all flows were captured. This PER concentrates on the flows from Ministry of Finance and foreign sources to MDA level; and from the central level to LGAs and other regional entities.

**Figure 2 Flow of Funds for HIV and AIDS Activities in Tanzania**



Government funds earmarked to HIV and AIDS are transferred to TACAIDS and the Ministry of Health and Social Welfare, in particular the Preventive Health Department, which hosts the National AIDS Control Program. The Ministry of Finance (MoF) also provides Objective A funds from both domestic and foreign sources, which are transferred directly to MDAs. Data on these flows were captured from the Ministry of Finance's EPICOR system. Information on Objective A funds in all LGAs was obtained from the Prime Minister's Office, Regional Administration and Local Government (Dodoma). Data on DPs' budget and expenditure were collected from the DPs themselves—those listed in the text box above. This information was triangulated with DP spending reported in the 2013/14 Health Accounts.

Unless otherwise specified, the analysis in this PER includes spending earmarked specifically to HIV and AIDS. Analysis of non-earmarked spending is typically conducted by the Health Accounts, where non-specific spending such as health workers' salaries and general medical supplies are disaggregated by different diseases through the use of distribution keys. An explanation of the differences between Health Accounts (HA) data and this PER is provided in Table 1.

**Table 1 Differences Between Health Accounts and PER Results in Chapters 3**

| Category | 2011/12 Health Accounts | 2011/12 Analysis from the 2013/14 HIV and AIDS PER |
|---|---|---|
| Sources of data | Includes spending from all sources, i.e., government, donors, households, insurance, and employers | Includes spending from government and donors only |
| Health/non-health spending | Includes health spending only | Includes health and non-health spending; e.g., Orphans and Vulnerable Children care and other impact mitigation activities are included |
| Earmarked/non-earmarked spending | Includes spending earmarked and non-earmarked to HIV and AIDS (e.g., a proportion of health workers' salaries are attributed to HIV and AIDS) | Spending earmarked for HIV and AIDS only |

## 1.3 Challenges

The exclusion of non-earmarked spending in this PER underestimates HIV and AIDS spending, particularly for the government, which pays for staff salaries, general medical supplies, and capital investments, and in this way contributes to HIV and AIDS services indirectly. Since the PER aimed to analyze expenditure and projections over time, only earmarked spending could be collected for the entire period of analysis, to maintain consistency. Using distribution keys to break down non-earmarked spending for the entire period of analysis was not possible, due to lack of data[1]. This PER also focused on collecting data not already covered by the Health Accounts, e.g., non-health data, projections data.

[1] Information on non-earmarked spending were only available for years in which Health Accounts were conducted

Government data is also underestimated for 2011/12 since government spending for LGA (via Objective A) was unavailable from PMO-RALG for this year. The government spending for this year therefore includes its contribution to MDAs only.

During data collection, data disaggregated to the desired level (e.g., by thematic areas) was not always available. We understand that spending by thematic areas is often tracked, but not always consolidated, such that at the time the request was made, staff at MDAs and the PMO-RALG had to compile this data for us. This is particularly in relation to NMSF grants and Objective A spending at the MDA and LGA level. Similarly, utilization data for detailed HIV services—e.g., VMMC, treatment of opportunistic infections or STIs—was sometimes unavailable or insufficiently complete to facilitate spending breakdowns by these interventions.

The team noticed inconsistencies for both government and donor spending from different sources. For example, donor disbursement data from donors submitted to the Health Accounts team and the PER team differed; in these cases data from TACAIDS was used. In some cases, budget and expenditure data obtained from the MoF differed from the same obtained from our sample of MDAs.

## 1.4 Organization of the PER

This PER report is organized in five chapters. After the introduction in Chapter 1, the second chapter presents a review of recommendations from the previous PER (2010/11). Chapter 3 summarizes overall trends in HIV and AIDS budget and spending, followed by analysis of DP and government spending in more detail. Chapter 4 provides more-detailed analysis of funds spent by the government by program area, level of implementation, and implementing entity. Chapter 5 highlights key observations and findings, with potential recommendations for the way forward.

# 2. 2010/11 PER Recommendations and Review of Progress

The main recommendations from the PER for financial year 2010/11 are presented in Table 2 below, together with progress during financial years 2011/12 to 2013/14. Green highlights good progress or shows that the recommendations have been successfully followed; yellow highlights some progress; and red highlights little progress and the need for additional action.

**Table 2 Progress Status of implementation of Recommendations from 2011 PER**

| | Recommendations | Status of Implementation |
|---|---|---|
| | ***(A) Increase local financing.*** | |
| 1. | Progress in the establishment of AIDS Trust Fund (ATF) to ensure sustainability of the HIV and AIDS national response<br>• Establishment of the Trust Fund.<br>• Appointment of a team of technical experts to recommend an appropriate institutional, administrative, and management structure, operational modalities, and related financial accountability systems | • The Supplementary Bill of TACAIDS Act, which establishes the ATF, was passed by the Parliament on March 25, 2015. The Bill was accented by the President of The United Republic of Tanzania early in May 2015.<br>• The team of experts was formed. The team recommended an appropriate institutional, administrative, and management structure for the ATF. The recommendations were submitted to the Cabinet in a form of a Cabinet Paper and approved in November 2014.<br>• The development of the appropriate operational modalities and related financial accountability is in progress, with the support (financially and technically) of USAID through Futures Group. |
| 2. | Review the already recommended sources and mechanisms for funding the AIDS Trust Fund and map out their implementation strategy. | The recommended sources and mechanisms for funding were reviewed by the government, HIV and AIDS Parliamentary Committee, and the stakeholders, through consultative meetings organized by the Parliamentary Committee. |
| 3. | Mobilize funds through (1) a levy on airline traffic, (2) a small levy on large domestic and international businesses operating in Tanzania, and (3) mapping out fundraising campaign strategies at the national level, targeting the general public and external partner organizations. | • The agreed sources of funding as per ATF law are:<br>a) Such sums of money as may be appropriated by the Parliament<br>b) Revenue by or payable to TACAIDS<br>c) Money raised by way of loans, donations, grants, or bequests<br>d) Other income generated by way of investment<br>• Development of Resource Mobilization Strategy is in progress. Fund-raising event will be launched after the completion of this process. |

| | | |
|---|---|---|
| | ***(B) Enhance the involvement of the private sector.*** | |
| 4. | Develop guidelines and reporting mechanisms for the private sector for implementation of HIV and AIDS activities in the workplace. | • The ***Manual on HIV and AIDS and Health Promotion at the Workplace*** was developed**.** The purpose is:<br>1. To equip and strengthen workplace program (WPP) facilitators and coordinators with skills and knowledge to design, develop, and implement a workplace HIV and AIDS and health promotion intervention<br>2. To orient the facilitators and coordinators step by step on how to use the manual as a reference tool<br>3. To inform the team of facilitators and WPP coordinators on updates and new areas incorporated in the WPP manual |
| 5. | Provide support to the Association of Tanzania Employers (ATE) and AIDS Business Coalition of Tanzania to enable these organizations to play a more effective role in coordinating the private sector's response. | • ATE was elected as the private sector focal point, replacing AIDS Business Coalition of Tanzania.<br>• GIZ and ILO provided technical and financial support to ATE through the recruitment of ATE's private sector focal person.<br>• TACAIDS in collaboration with ATE, ILO, and Tanzania Private Sector Foundation conducted oversight visits to regions for the purpose of strengthening WPP facilitators and coordinators with skills and knowledge to design, develop, and implement a workplace HIV and AIDS and health promotion intervention.<br>However, private sector contributions to ATF have not yet been secured. |
| | ***(C) Strengthen coordination for efficient implementation of the NMSF.*** | |
| 6. | Scale up the execution of HIV and AIDS interventions in MDAs, by addressing factors contributing to low budget execution, such as late release or non-release of funds, lengthy procurement procedures, and low absorption capacity, especially at the LGA level. | • TACAIDS in collaboration with the President's Office of Public Service Management has revised the existing National HIV and AIDS Workplace Program Guideline, whereby currently Technical AIDS Committees at all levels are chaired by their respective Authorizing Officers, i.e. Permanent Secretaries, Head of Institutions, etc. This was intended to ensure that all planned HIV and AIDS-related activities are allocated enough resources and implemented as scheduled.<br>• Regular supportive supervisory visits have been conducted by the national to regional level, and regional level to council level, towards HIV and AIDS- related implemented activities, followed by provision of feedback. This has dramatically assisted in addressing unnecessary existing bureaucracies at each level.<br>• There have been delays in allocating resources for regular capacity-building activities for administrators within MDAs to produce an annual capacity building plan for their employees |
| 7. | Release the NMSF grant in full and on time, to allow LGAs the flexibility to decide how to use the resources within the scope of the NMSF and the guidelines provided for the use of the funds. | • In order to release the NMSF grant in full and on time, TACAIDS in collaboration with the Ministry of Finance and PMO-RALG ensured that both financial and implementation reports were submitted in time to allow early disbursement of funds to LGAs for implementation, based on the agreed standards and procedures. |

| | | |
|---|---|---|
| | | • The NMSF grant was released in full in the last two financial years (2012/2013 and 2013/2014). However, there was a delay in release of funds of up to 4 months in 2013/14 (the first tranche was released in November 2014). The delay is caused by both donors (disbursement delay) and implementers (delay in submitting reports). |
| 8. | Develop NMSF Grant exit strategy and test it before ending or winding down NMSF HIV and AIDS support, in order to avoid the risk of losing the gains that have already been achieved through investments in physical, human, and financial resources. An exit strategy will enable the government to find ways of filling the gaps, and hopefully sustain the gains achieved by the program. | • Although no exit strategy has been developed, LGAs have been sensitized to set aside funds from their own sources in order to fund activities on socio-economic impact mitigation and prevention (the main mandate of NMSF Grant).<br>• A mini evaluation of the NMSF Grant was conducted in 2013/2014, to learn gains already achieved. It is important to note that during the inception of NMSF Grant, performance indicators were not developed specifically for measuring the achievement of this Grant. That has made it difficult to tease out achievements of NMSF Grant in terms of specific indicators. |
| 9. | Strengthen the coordination of the HIV and AIDS NMSF by ensuring that MDAs' HIV and AIDS focal persons and all Multisectoral AIDS Committees have appropriate resources, and sufficient recognition to enable them to carry out their task of coordination of HIV and AIDS activities at the national, sector, regional, district, and ward/village levels. | As of 2011/12, the NMSF grant set aside a budget for TACAIDS and PMO-RALG aimed at strengthening HIV and AIDS coordination and capacity-building at the national and sub-national levels. This support improved the capacity of HIV and AIDS focal persons and the committees to coordinate HIV and AIDS activities at all levels. For instance, project reporting and implementation by LGAs improved from below 50 percent to 96 percent, as shown in the PMO-RALG reporting inventory of 2012. |
| 10. | Roll out the Community Participatory Planning Tool Against AIDS | Rolling out of the COPTA has been implemented by LGAs through the support of the Regional Coordinators for TACAIDS, though at a very low pace and on a small scale. The exercise requires substantial resources and consumes a lot of time in one station (village level). |
| | ***(D) Review the resource allocation formula.*** | |
| 11. | Hold Finance and Audit Technical Working Committee meeting to discuss the NMSF grant allocation formula and ensure the formula is consistently applied across all LGAs. | The Finance and Audit Technical Working Committee meeting was held on July 3, 2014. The basis of the current budget funds allocation formula for LGAs has been strongly debated by the LGAs and other partners. The committee was oriented on the new formula that was proposed by the health sector, which is as follows: population (60 percent); vehicle route (20 percent); poverty (10 percent), and under-5 mortality (10 percent). The committee decided that more information should be sought regarding the usefulness of the health sector formula, in order to see the appropriateness of its application for the NMSF program. The proposed resource allocation formula for HIV and AIDS that is being discussed is composed of the following elements: population (70 percent); number of poor residents (10 percent); district medical vehicle route (10 percent); and the council's estimated HIV and AIDS prevalence rate—normally regional prevalence rate (10 percent). |

| | | |
|---|---|---|
| ***(E) Focus on preventive interventions which are tailored to gender and to regions.*** | | |
| 12. | Follow up with LGAs on the implementation of the Gender Operational Plan that was disseminated in 2012. Based on the Operational Plans, ccouncils are expected to design work plans that are gender-integrated, so that harmful norms such as patriarchy can be appropriately addressed. | TACAIDS is keen to oversee the process of engendering Council's HIV and AIDS work plans but it is yet unclear whether any action has been taken. |

# 3. HIV and AIDS Spending and Projections: Summary Results

This chapter presents an assessment of HIV and AIDS budget and expenditure trends during the 2011/12–2013/14 financial years, and projections between 2014/15 to 2017/18. Further breakdowns by source of finance and thematic areas are also provided.

## 3.1 Trends in HIV and AIDS Spending

Table 3 provides a summary of HIV and AIDS spending between 2011/12 and 2013/14. Total HIV and AIDS expenditure declined from Tanzanian Shillings (TZS) 779 billion in 2011/12 to TZS 762 billion in 2013/14.[2] This is the equivalent to a 0.1 percent decline in 2012/13 and 2.1 percent in 2013/14. The same analysis was also conducted using constant exchange rates, to remove the effect of changing annual exchange rates. At constant 2012 exchange rates, spending fell by 2.4 percent in 2012/13 and 5.0 percent in 2013/14 (Figure 3), driven by decreases in spending from both government and DPs. Figures in the remainder of the report use average annual exchange rates.

The national HIV and AIDS response is predominantly financed by DPs, who accounted for over 98 percent of financing between 2011/12 and 2013/14. Of the DPs, PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) are the two largest, together accounting for more than 86 percent of DP funding. DP spending fell from TZS 775 billion in 2011/12 to TZS 753 billion in 2013/14. Government spending earmarked for HIV and AIDS also fell from TZS 15 billion to TZS 9 billion between 2012/13 and 2013/14. Comparisons for government spending from 2011/12 have not been made due to the unavailability of government funding for LGA for this year. The government's earmarked contribution to HIV and AIDS also fell as a percentage of its total government budget, from 0.20 percent to 0.10 percent during the period of analysis.

In this analysis, government expenditures include the money transferred from domestic revenues to MDAs, regions, LGAs, and HIV and AIDS-based institutions such as TACAIDS and the National AIDS Control Program. Spending by DPs includes funds distributed both to government and to other implementing partners, such as NGOs.

[2] Using average annual exchange rates.

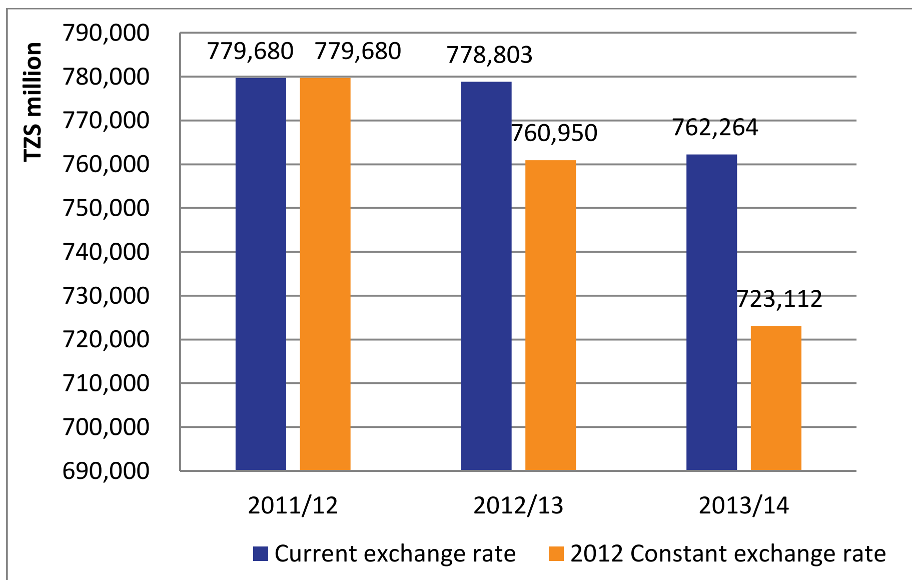
### Table 3 Summary of HIV and AIDS Spending[3]

| Sources | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Government (domestic financing) | 4,518[4] | 15,234 | 8,999 |
| Development partners | 775,162 | 763,569 | 753,265 |
| **Total[5], current exchange rate (TZS million)** | **779,860** | **778,803** | **762,264** |
| **Total, current exchange rate (U.S. dollars million)** | **501** | **489** | **464** |
| % of total from development partners | 99.4% | 98.0% | 98.8% |
| % of total from government | 0.6% | 2.0% | 1.2% |
| | | | |
| **Total, 2011/12 constant exchange rate (TZS million)** | **779,680** | **760,950** | **723,112** |
| **Total, 2011/12 constant exchange rate (U.S. dollars million)** | **501** | **489** | **465** |
| | | | |
| Government contribution to HIV/AIDS as % of total government budget (earmarked spending only) | 0.7% | 0.20% | 0.10% |

### Figure 3: Trend in HIV and AIDS Spending from Government and Donors

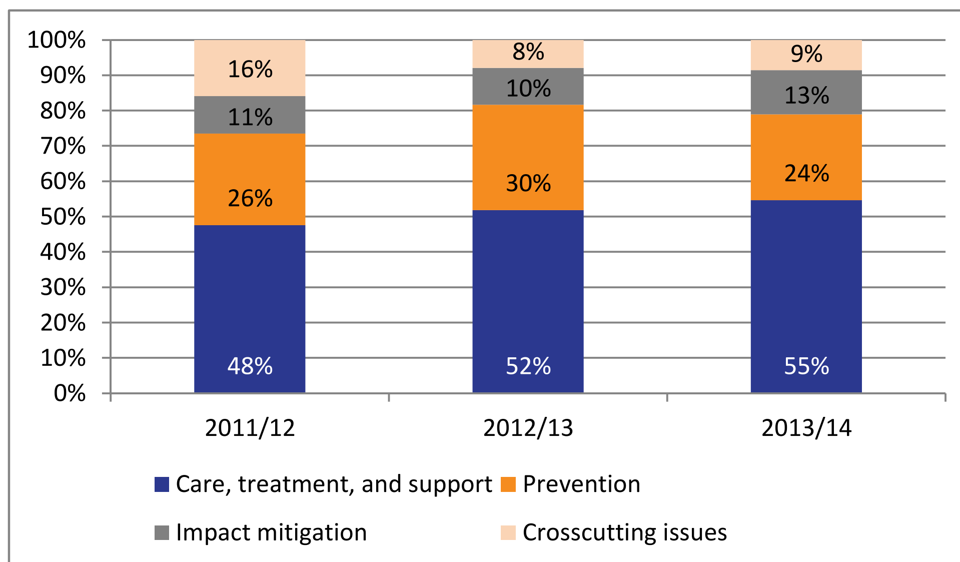
[3] As explained in Table 1, these figures will differ from total spending in the 2011/12 Health Accounts, because the HA include other sources of HIV and AIDS financing, e.g., payments via social and private health insurance, as well as direct out-of-pocket payments, and also include non-earmarked spending.
4 Includes MDA funding only. Government funding for LGAs for HIV and AIDS were unavailable for 2011/12

5 Current exchange rates uses the average exchange rate for each fiscal year




All DP spending for HIV and AIDS was combined and analyzed by NMSF II thematic areas, in order to understand the types of activities that donors are funding and the thematic areas that may encounter a financial gap if donor funding decreases in the future. As Figure 4 highlights, the majority of funding was spent on care, treatment, and support, for which funding increased to 55 percent in 2013/14. Prevention spending increased to 30 percent in 2012/13 but fell to 24 percent in 2013/14. Spending on crosscutting activities (e.g. stigma reduction, advocacy, mainstreaming HIV and AIDS) approximately halved, to 9 percent in 2013/14. Impact mitigation activities (e.g. OVC, social and economic support for PLHA) remained around the 11 percent mark. These proportions and their trends are driven largely by the two largest DPs, i.e., PEPFAR and the Global Fund.

**Figure 4: Development Partner Spending by NMSF II Thematic Area**[6]

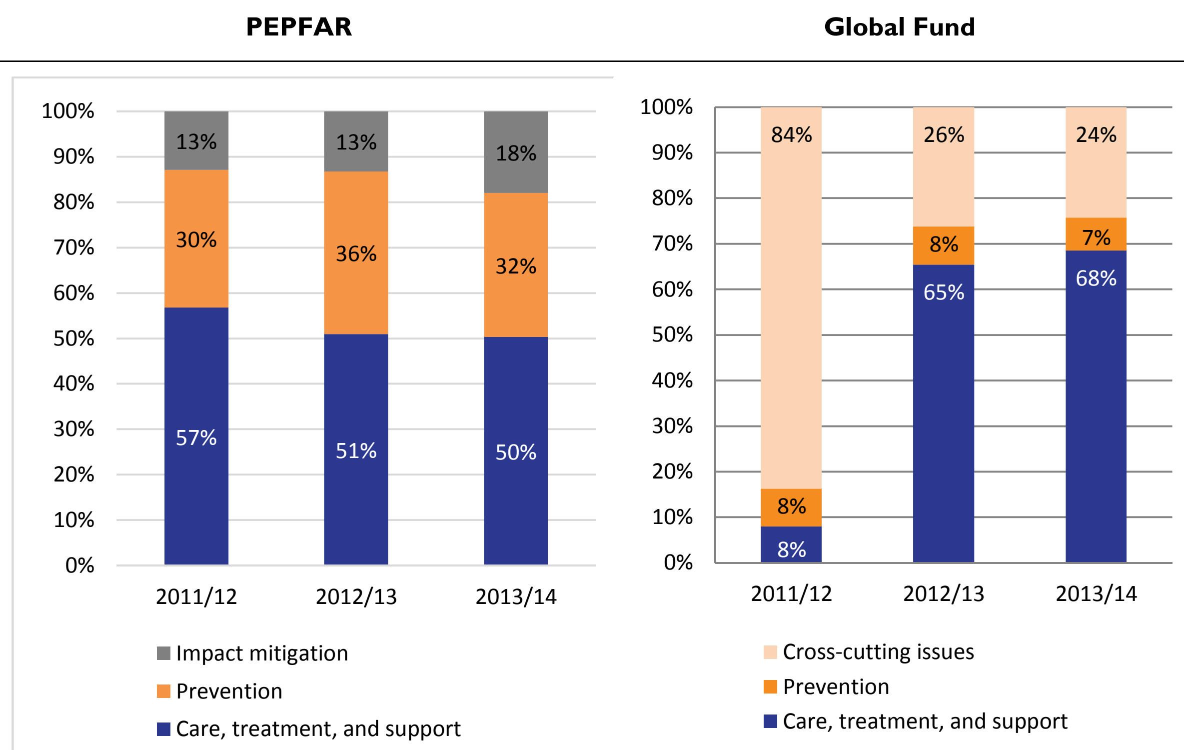



[6] Figures may not sum to 100 due to rounding

Figure 5 shows spending by the two major donors, by the NMSF II thematic areas. The majority of PEPFAR spending during this period was for care, treatment, and support. However, the proportion of spending for this category fell from 57 percent to 50 percent over the period of analysis. Prevention and impact mitigation spending saw an increase in terms of proportion to 32 percent and 18 percent respectively. Approximately one third of PEPFAR spending is for prevention.

In contrast, Global Fund spending for care, treatment, and support increased significantly between 2011/12 and 2013/14, from 8 percent to 68 percent. This has been at the expense of enabling environment activities such as advocacy, stigma-reduction, and mainstreaming HIV and AIDS in policies and programs. The Global Fund's prevention spending represented less than 10 percent of its spending during this period. (See Annex A for details of the NMSF II thematic classifications.)

**Figure 5: Spending by PEPFAR and Global Fund by Thematic Area**[7]




## 3.2 Financial Gap Analysis

In 2015 TACAIDS and the Health Policy Project (HPP) completed a costing study of the NMSF III, including a financial gap analysis.[8] The financial gap analysis calculated the resources that would be required to implement the NMSF III, after accounting for resources already committed by the government of Tanzania and DPs. Using updated information obtained from donors about their projected commitments for HIV and AIDS, the PER team updated the financial gap analysis conducted by TACAIDS and HPP. Assumptions for government funding remain the same as in the TACAIDS/HPP report. The updated analysis, and that from the NMSF III costing, is provided in Figure 6.

The projected financial gap for NMSF III is projected to fall to TZS 137 billion 2016/17, after which it is expected to more than double. However, the financial gap analysis is heavily dependent on the accuracy with which donors are able to predict their funding. The projected financial gap for NMSF III is projected to fall to TZS 137 billion in 2016/17, after which it is expected to more than double. However, the financial gap analysis is heavily dependent on the accuracy with which donors are able to predict their funding. Note that this financial gap is overestimated because it does not include

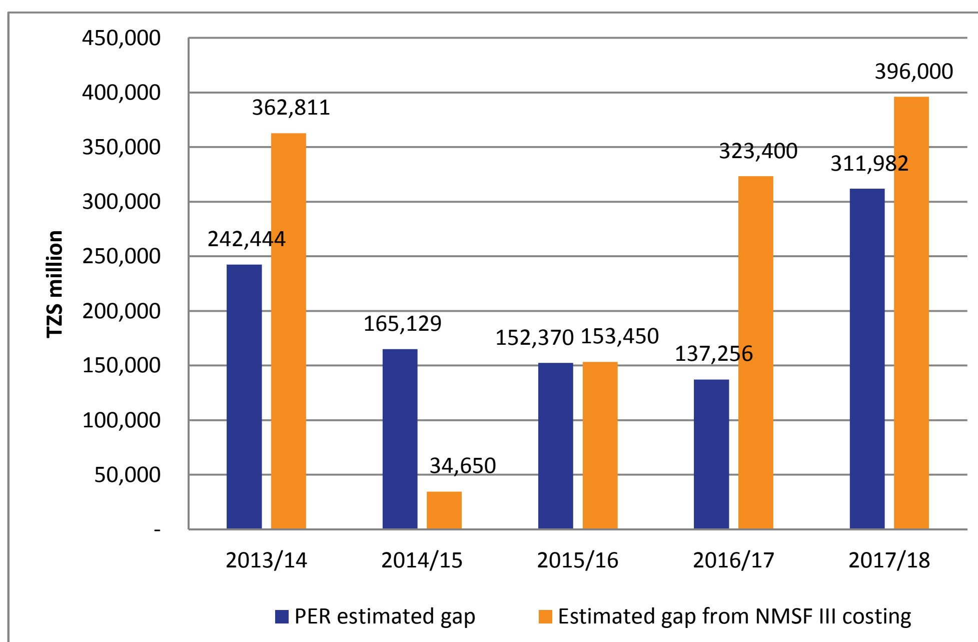
[7] idem

[8] TACAIDS and HPP. 2015. Brief Report on Financial Resources Required for the Third National Multi-Sectoral Strategic Framework (NMSF) on HIV and AIDS 2013/14–2017/18, 2015.

other types of organizations who provide funding for HIV and AIDS, such as NGOs' own funds and employers.

The projected financial gap for NMSF III is projected to fall to TZS 137 billion 2016/17, after which it is expected to more than double. However, the financial gap analysis is heavily dependent on the accuracy with which donors are able to predict their funding.

**Figure 6 Financial Gap Analysis for NMSF III**




## 3.3 Analysis of Government Spending

This section reviews spending on HIV and AIDS, first by MDAs and then by LGAs. MDAs and LGAs receive funds earmarked to HIV and AIDS via the "Objective A" mechanism. LGAs receive additional funding for HIV and AIDS through the NMSF grant allocations. The NMSF grant is a funding mechanism created in 2009 to support the implementation of the Tanzania National Multisectoral Strategic Framework on HIV and AIDS. The grant is supported by the governments of Canada (via the Department of Foreign Affairs, Trade and Development) and Denmark (via the Danish International Development Agency). The NMSF grant was a result of a former HIV Fund.

Analyses of six MDAs and 10 LGAs that were sampled are also presented.

### 3.3.1 Ministries, Departments and Agencies—Objective A Spending

The total MDA budget and expenditure for Objective A are shown in

Figure 7 for 2011/12 to 2013/14. During this period, Objective A was primarily funded by DPs (over 90 percent). Budget allocations and spending for Objective A by MDAs more than doubled in 2012/13 and 2013/14. On average, the execution of MDAs' budget is above 95 percent for the three years.

**Figure 7: MDAs' Objective A Budget and Expenditure (TZS Million)**

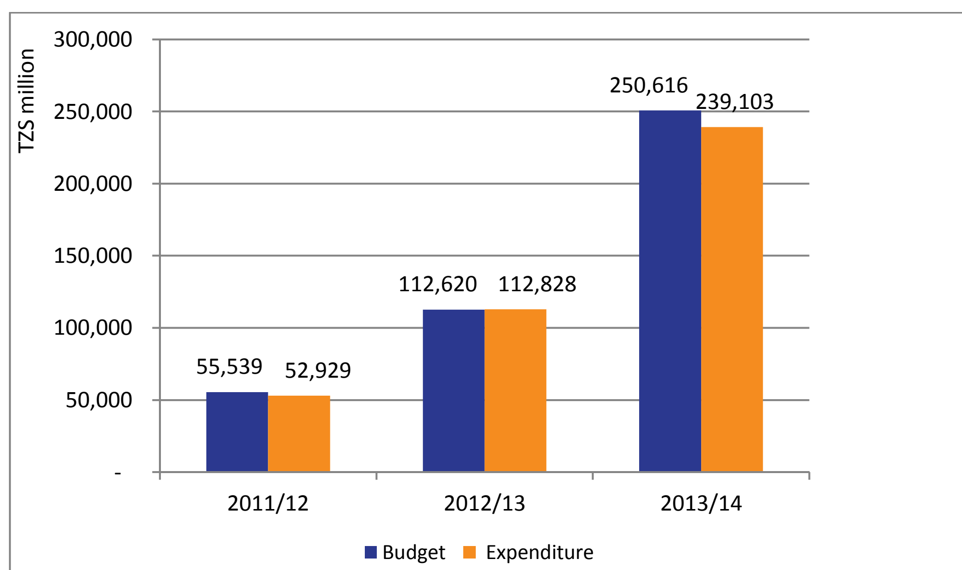
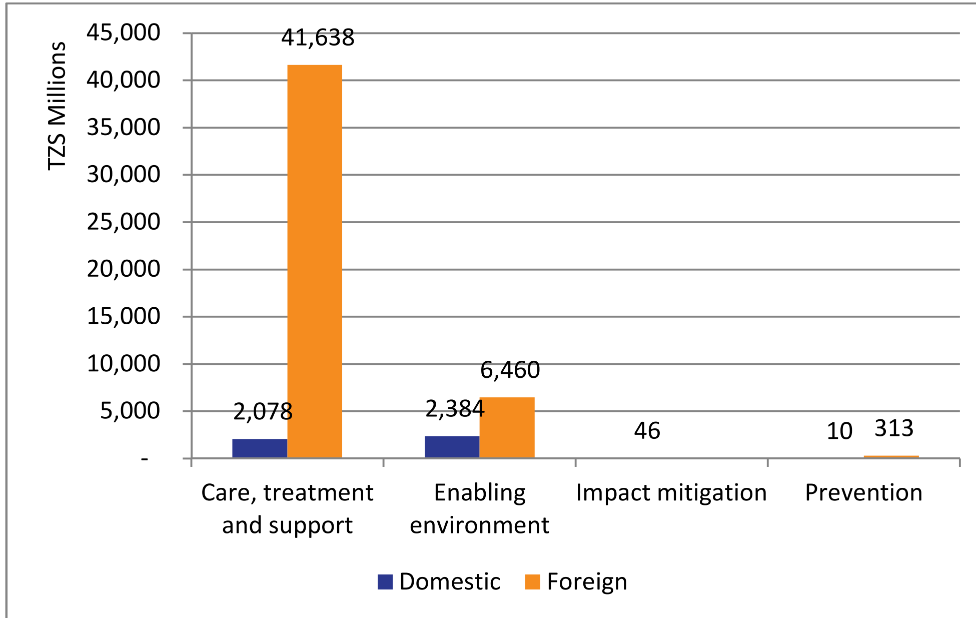



Figure 8 provides a breakdown of MDAs' Objective A spending by source and by NMSF II's thematic areas in 2011/12. It is important to monitor spending by thematic areas in order to ensure that funds are spent as planned in the NMSF II costing. It should be noted that NMSF II ended in 2012, and NMSF III is now being implemented. However, spending is still being reporting by NMSF II thematic areas.

The vast majority of Objective A spending (83 percent) was for care, treatment, and support. Interventions for care, treatment and support, and enabling environment, are heavily DP-dependent. In contrast, impact mitigation activities (TZS 46 million in 2011/12) were solely financed by domestic resources in 2011/12, although this represented a very small proportion of Objective A spending.

**Figure 8: MDAs' Objective A Spending by Source and Thematic Area, 2011/12**



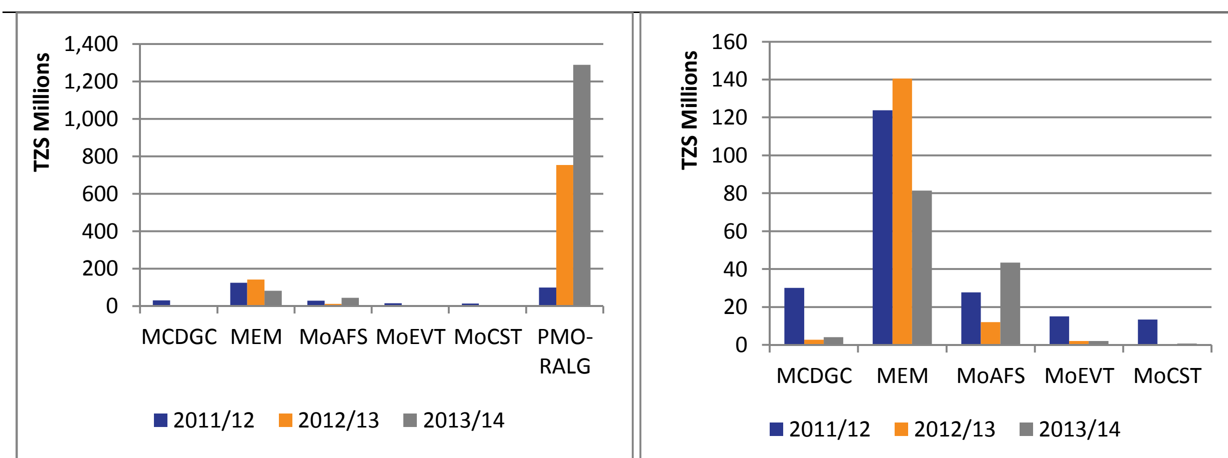

## *Analysis of Objective A Spending in Sampled MDAs*

Total spending by the selected MDAs increased significantly, from TZS 308 million in 2011/12 to 1,420 million in 2012/13. Figure 9 shows the level of Objective A spending by MDAs that were sampled by the PER team. Of the MDAs selected, the PMO-RALG is the biggest recipient of Objective A funds. We understand that the tripling of spending between 2011/12 and 2013/14 is mainly due to the accumulation of funds by the PMO-RALG over this period. In contrast to the increasing trend in total Objective A spending in MDAs (

Figure 7), the trend in spending across the sampled MDAs varied significantly.

**Figure 9: Objective A Spending by Sampled MDAs**

| **Sampled MDAs' Objective A Spending** | **Sampled MDAs' Objective A Spending, Excluding PMO-RALG** |
|---|---|




The budget performance of selected MDAs is shown in

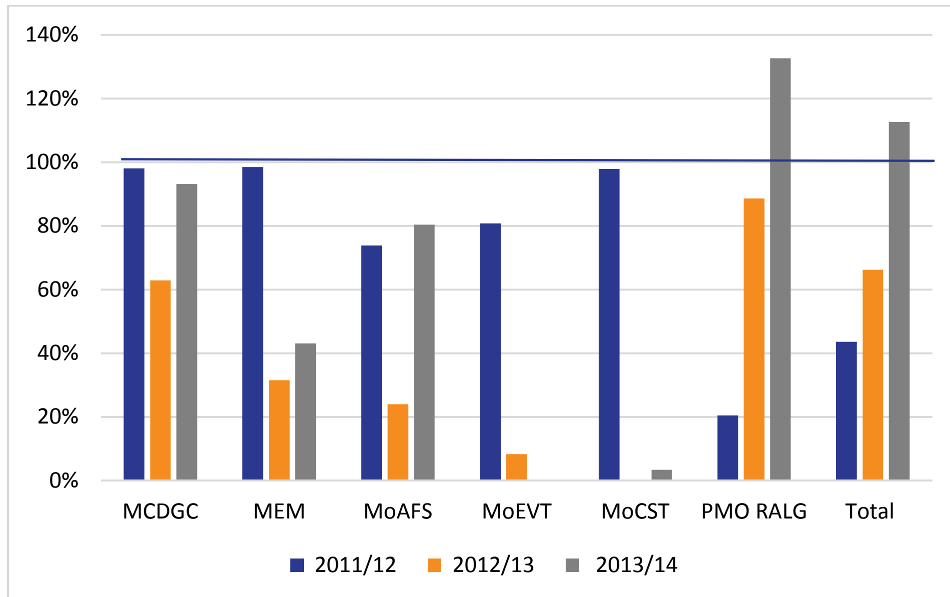
Figure 10. The team observed differences in performance rates according to MoF data and according to data obtained at the MDA level. This is likely due to the fact that the MoF reports an expenditure when funds have been disbursed to the MDAs, while from the MDAs' perspective all the funds received may not be spent, and may be accumulated over more than one fiscal year. The data show that budget execution rates across MDAs and across time are variable. Possible reasons for the low budget execution rates observed at the MDA level include:

- the unavailability of funds from the MoF to allocate to Objective A
- the late disbursement of funds from central government and DPs
- the misallocation of funds to non-HIV and AIDS interventions

The last reason poses a serious challenge to implementing the Objective A activities. If funds are being misallocated to a different purpose than originally planned, the government risks not meeting Objective A targets and government staff are not receiving the workplace programs they are entitled to. This raises questions about how Objective A funding can be protected, or at a minimum monitored, to ensure that the funds are spent for their original purpose.

According to the MDAs, the main reason for execution rates above 100 percent is the accumulation of funds over several financial years.

**Figure 10: Budget Performance Across Sampled MDAs**



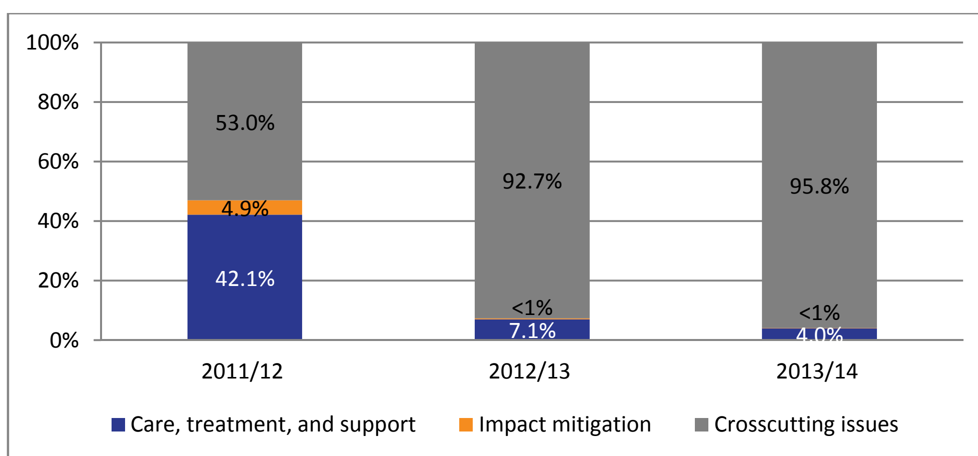

Data at the MDA level were sought from the HIV and AIDS focal person in each MDA. However, this proved to be a challenge because of the lack of data made available by the sampled MDAs to the PER team. Since this data would form part of the standard expenditure reporting to the MoF, it is not clear why this information was not available. It may also raise concern that information is not being shared between the HIV and AIDS focal person and the policy and planning unit within the MDAs. This observation echoes the need to reexamine the mandate and capacity of HIV and AIDS focal persons not only in the planning, budgeting, and monitoring of HIV and AIDS activities, but also in participating in decision making organs of MDAs. In most cases, HIV and AIDS focal persons are the middle cadre in the Human Resource Department; they are not involved in major resource allocation decisions, and may not have access to financial information.

From the MDAs we spoke with, there was the sentiment that there is little demand for care, treatment, and support at the workplace because most employees do not know their sero status, and those who know they are HIV-positive do not disclose it due to stigma. This perceived lack of demand causes laxity in planning, budgeting, and allocation of resources to workplace HIV and AIDS interventions. It also poses the question about the effectiveness of stigma-reduction and other programs designed to increase the demand for care, treatment and support services.

As noted in the 2010/11 HIV and AIDS PER, most MDAs have already established an HIV and AIDS Strategic Plan, and an Implementation Plan, and some have even costed the program. But the level of actual implementation of activities is very low. Given the need to protect those who are not infected and support those who are infected, the MDAs need a renewed impetus on budgeting for HIV and AIDS through Objective A in their Medium-Term Expenditure Frameworks, and funds must be used for their intended purposes.

Figure 11 shows the sampled MDAs' spending for Objective A by thematic areas. The proportion of Objective A spending allocated to crosscutting issues grew significantly, and in 2013/14 accounted for 96 percent of Objective A spending. This echoes MDAs' experience; they confirmed that where workplace programs are organized, they are mainly focused on advocacy. In contrast, the proportion allocated to care, treatment, and support has decreased, from 42 percent in 2011/12 to 4 percent in 2013/14, for the reason explained above.

**Figure 11: Selected MDAs' Expenditure by Thematic Areas**




### 3.3.2 Local Government Authorities' Spending

This section analyzes local government HIV and AIDS spending based on data compiled from the PMO-RALG (for Objective A), TACAIDS reports (for NMSF grant spending), Comprehensive Council Health Plans, and Technical and Financial Implementation Reports in 10 sampled councils. For all LGAs, the team was able to collect data for Objective A spending and NMSF grant spending. In the sampled LGAs, the team was able to collect data for HIV and AIDS from additional sources, such as the proportion of basket fund resources allocated to HIV and AIDS and LGA's own resources. It would appear that this data are not compiled at the central level and are available at the LGA level only.

At LGA level, the NMSF grant supports activities mainly in two thematic areas: prevention (e.g., sensitization, condom distribution) and impact mitigation,e.g., support to PLHA and Most Vulnerable Children, income-generation activities, strengthening coordination with the national level (PMO-RALG and TACAIDS), and support to Civil Society Organizations.

Figure 12 shows spending by all LGAs for the financial years 2011/12–2013/14. 2011/12 includes NMSF grant spending only, since Objective A spending data were unavailable from the PMO-RALG for this year. There was an increasing trend in Objective A and NMSF grant funds for LGAs during this period. Total spending from NMSF grants and Objective A increased from TZS 38.2 billion in 2012/13 to TZS 46.7 billion in 2013/14 (a 22 percent increase). However, the Danish International Development Agency has since stopped supporting the NMSF grant, and the Canadian International Development Agency support is due to end in 2016. Therefore, spending for HIV and AIDS activities such as prevention and cross-cutting issues at LGA level will experience a gap if alternative sources of funding are not found. (NMSF grants accounted for 40 percent of LGA spending during the period of analysis).

Approximately 70 percent of funds were disbursed in 2011/12 and 2012/13, and this improved to 84 percent in 2013/14. In the two years for which there is complete data, NMSF grants as a source of funding accounted for approximately 40 percent of spending from DANIDA and CIDA. The end of DP contributions to the NMSF grant will produce a financing gap in the future, particularly for prevention and crosscutting activities at the LGA level.

**Figure 12: LGA Spending (Objective A and NMSF Grant)**

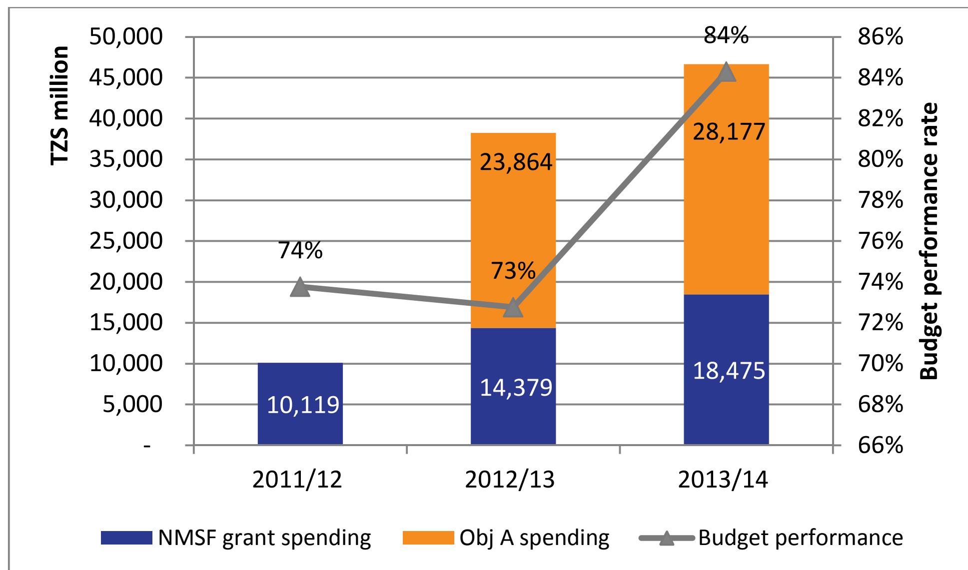



Figure 13 provides the breakdown of LGAs' Objective A spending by source and by NMSF II thematic areas in 2013/14. As with MDAs, the vast majority (79 percent) of LGAs' Objective A spending is sourced from DPs. The vast majority of spending is for cross-cutting activities (87 percent), followed by impact mitigation (10 percent).

**Figure 13: LGA Objective A Spending by Source of Funding, 2013/14**

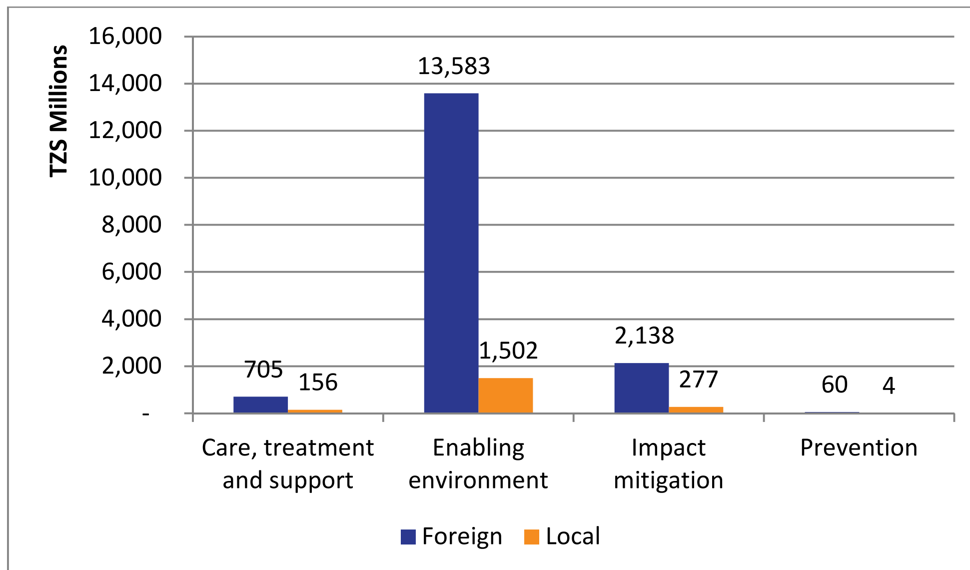
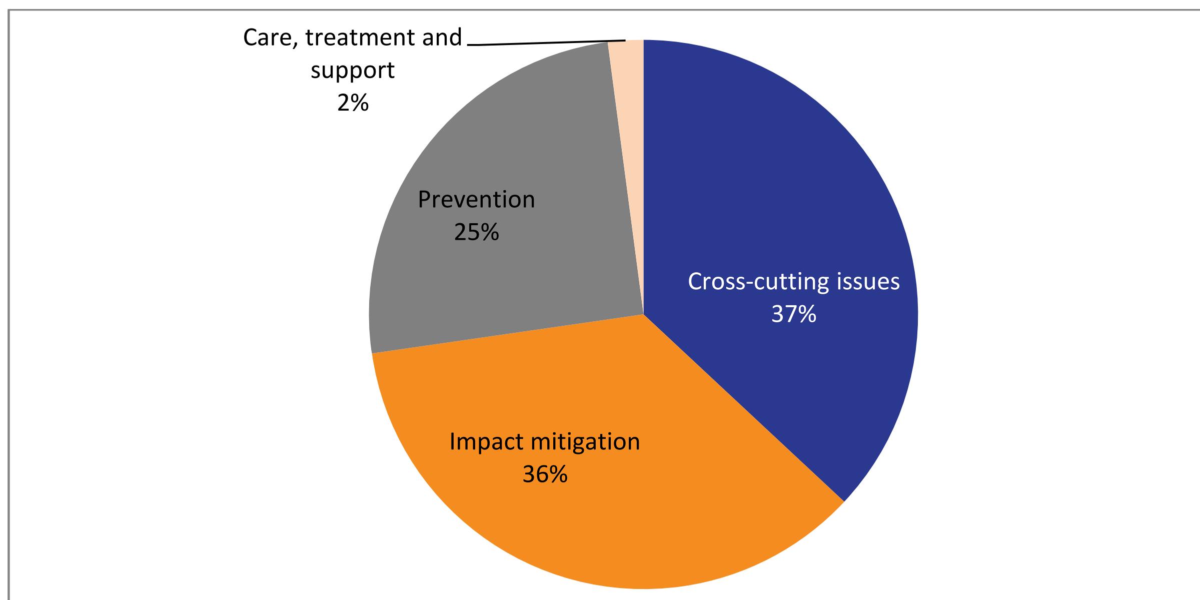



Figure 14 provides a breakdown of LGAs' NMSF grant disbursements by thematic area. NMSF grants are fully funded by donors. This was available for the July to December 2014 period only. This

period showed that impact mitigation and cross-cutting activities represented approximately 36 percent each. A quarter of spending was for prevention activities and the remainder for care, treatment, and support.

**Figure 14 NMSF Spending by Thematic Area**




## *Analysis of Spending in Sampled LGAs*

The total budget and expenditure by the sampled LGAs is provided in Figure 15. This captures spending for HIV and AIDS from all sources, including Objective A, NMSF grants, LGAs' own resources, and funding through implementing partners. Expenditures increased from TZS 1.5 billion in 2011/12 to TZS 2.2 billion in 2012/13 (increase of 52 percent), but decreased by 25 percent to TZS 1.7 billion in 2013/14. The budget execution rate for LGAs fell from 92 percent in 2011/12 to 80 percent in 2013/14, due partly to late disbursement of funding.

**Figure 15: Budget and Expenditure in Sampled LGAs**

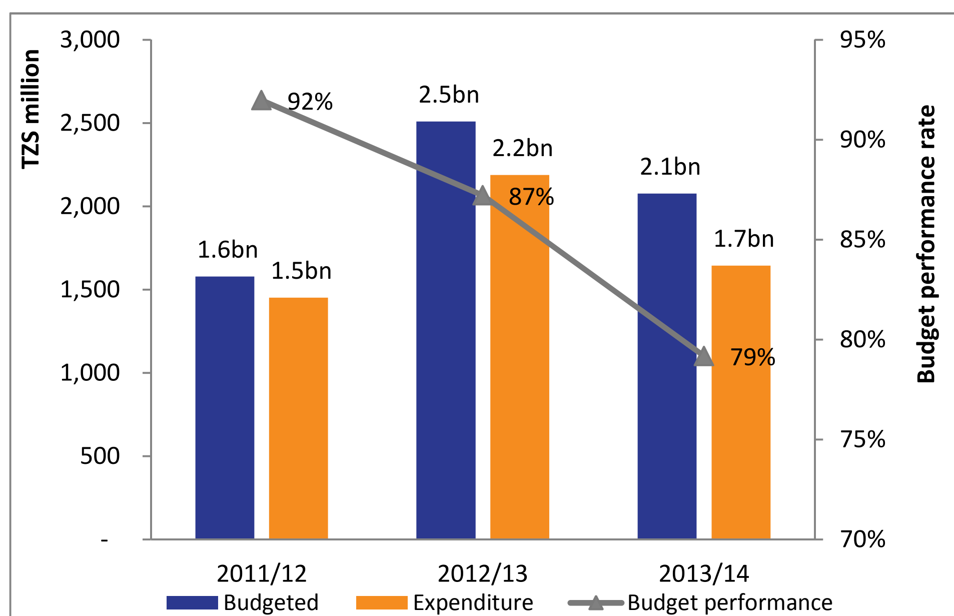
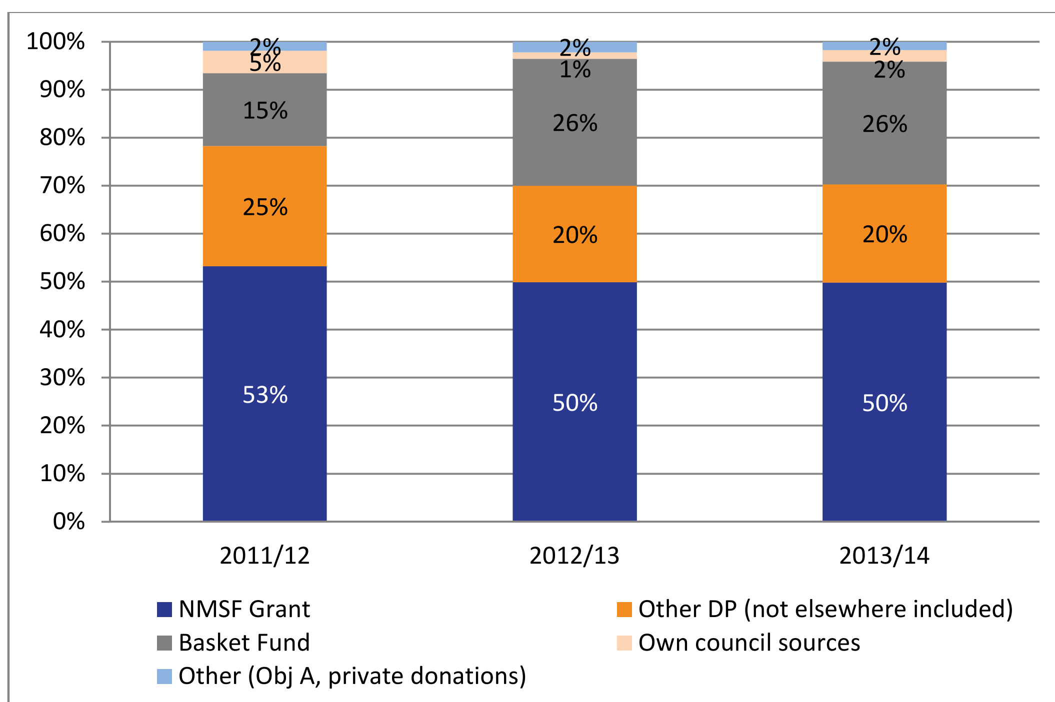


Figure 16 highlights the sources of funding for sampled LGAs for HIV and AIDS activities. The majority of funding was through NMSF grants, although this funding landscape will change going forward, as both funders of the NMSF grants are removing their funding in this area. The second biggest source of funding in 2011/12 was from DPs (predominantly PEPFAR), and implemented via local and international NGOs working in collaboration with the LGAs. This source decreased in importance to 20 percent by 2013/14. The team collected HIV and AIDS spending from the basket fund, which has increased to become an important source of funding in 2013/14 (26 percent). Other, minimal, sources include LGAs' own resources, block grants, and Objective A funds. As some LGAs develop economically (e.g., from natural resources), there may be scope to increase their own contributions to the health sector, and specifically HIV and AIDS.

**Figure 16: HIV and AIDS Interventions in sampled LGAs by source of funding**[9]



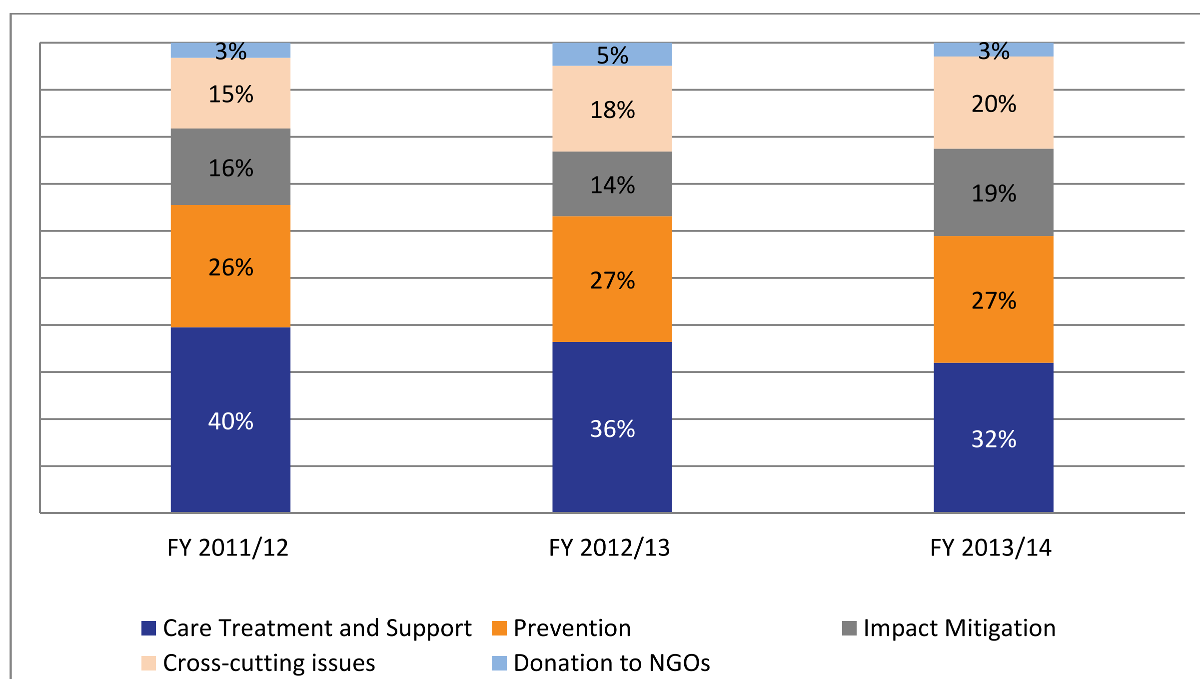

Spending by thematic area is partly influenced by the funding sources, since some funding is tied to certain activities. For example, NMSF grants are predominantly for non-medical costs such as income-generating activities and support for Orphans and Vulnerable Children. While the spending on prevention is rather constant in the three-year period, there is a decline in financing for care, treatment, and support (from 40 percent in 2011/12 to 32 percent in 2013/13) which reflects the total spending trend from DPs in Figure 1. Care, treatment, and support spending by LGAs includes primarily home-based care, training for health workers, and allowances for health workers.

[9] Figures may not sum to 100 due to rounding

Expenditures on cross-cutting issues and impact mitigation have exhibited an upward trend (

Figure 17). The reported impact mitigation activities include support for school fees, nutrition support, seed money in the form of loans to groups of PLHA, support to disabled persons, and training for income-generating activities. The NMSF II prioritized care, treatment, and support, and prevention interventions. While overall spending for these two areas still represents the majority of spending at the LGA level, spending for care, treatment, and support fell and remained fairly constant for prevention.

**Figure 17: Spending in sampled LGAs by thematic area[10]**




## 3.4 Spending by the Private Sector

Traditionally, analysis of HIV and AIDS financing has focused mainly on expenditures from the government and DPs. Although the current contributions from the private sector appear minimal, there is significant potential to increase these. Results from a study commissioned by TACAIDS on HIV and AIDS expenditures by companies show that the sampled 16 companies spent a total of TZS 3,982 million to support HIV and AIDS costs for employees in 2011–2013.[11] Further study into the contribution of the entire private sector will better help to understand their current role.

Initiatives such as the Kilimanjaro Challenge against HIV and AIDS have also been initiated by the private sector and demonstrate their commitment to join the national response. This annual joint program, introduced by Geita Gold Mining and hosted jointly with TACAIDS, aims to mobilize resources from various local and international companies through climbing Mount Kilimanjaro. In the 2013 event, a total of TZS 700 million was mobilized, which was awarded to beneficiaries in May 2014. However, more resources could be mobilized with better engagement and sensitization of

[10] Figures may not sum to 100 due to rounding

[11] TACAIDS. 2014. *Private Sector Expenditure Review 2014*. Dar es Salaam.

organizations in this sector. Catalyzing the private sector through its umbrella organizations such as the Tanzania Private Sector Foundation, Tanzania Chamber of Commerce Industry and Agriculture, and Association of Tanzania Employers is imperative, so that private companies can sustainably contribute to the AIDS Trust Fund.

Civil society organizations also raise a significant amount of funds for HIV and AIDS, through their own sources, fund-raising events, and private contributions. Another innovation in managing the pandemic at the local level is the formation of groups by PLHA and those affected by HIV and AIDS, such as widows, so that they can respond with collective voice and efforts. Some of the groups have been registered as Savings and Credit Cooperative Societies, and they can access loans for investment as a way of addressing the economic impact of the scourge.

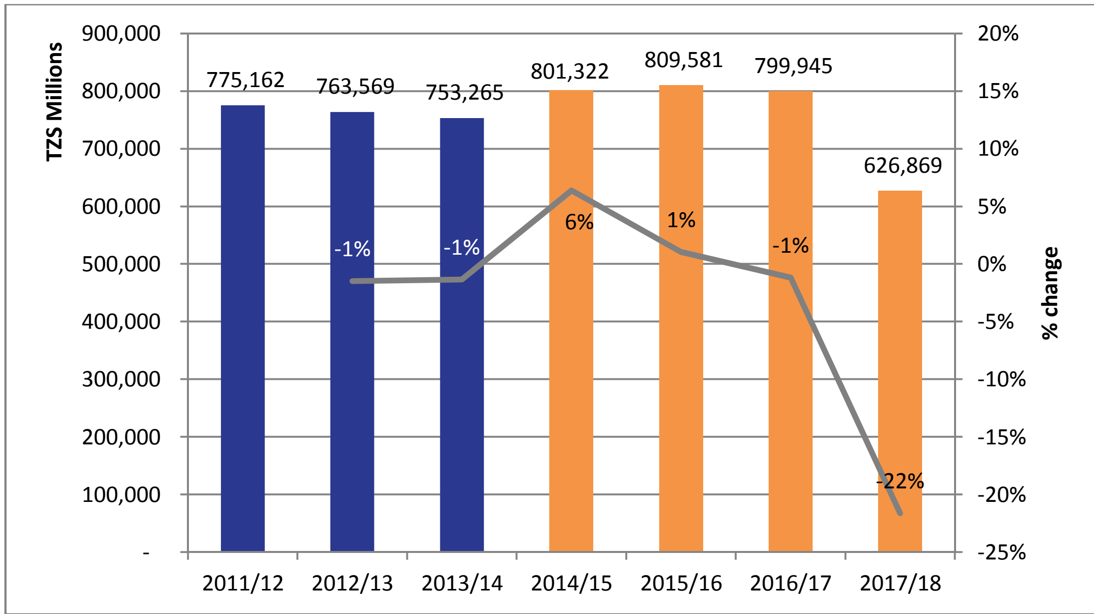
The Southern Africa Development Community (SADC), of which Tanzania is a member state, established a Regional Fund to support the HIV and AIDS response among its member states. Over $1.5 million have been assigned for activities such as the following:

- Promoting the inclusion of the 50+ population group in the fight Against HIV and AIDS, which will be implemented by Help Age International in Tanzania, Zimbabwe, and South Africa
- Strengthening the capacity of SADC Member States' National Parliaments to facilitate the implementation of regional, continental, and international commitments on HIV and AIDS, to be implemented by SADC Member States' National Parliaments through SADC Parliamentary Forum in four SADC Member States including Tanzania
- Research and clinical validation of Tashak herbal remedy used singly or concurrently with ART by PLHA in Tanzania, to be implemented by Tanga AIDS Working Group.

## 3.5 Projected Spending for HIV and AIDS

Data on projected spending until 2017/18 was collected from DPs. Figure 18 shows the trend in DP spending between 2011/12 and 2013/14 (blue columns), and projections between 2014/15 and 2017/18 (orange columns). An increase in DP funding is expected between 2013/14 until 2015/16, followed by decreases in 2016/17 and 2017/18. Note that the quality of data in projections is dependent upon how well DPs can estimate their future funding. Going forward, the U.S. government remains the largest donor each year, contributing well over half of the projected resources for the national HIV response. The projected fall from 2016/17 highlights the need to plan for greater financial sustainability of the national HIV and AIDS response.

**Figure 18: Estimated Projected Funding for HIV and AIDS from DPs**


TZS Millions
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
-
775,162
763,569
753,265
801,322
809,581
799,945
626,869
-1%
-1%
6%
1%
-1%
-22%
20%
15%
10%
5%
0%
-5%
-10%
-15%
-20%
-25%
% change
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18

# 4. SPENDING ANALYSIS BY DETAILED PROGRAM AREAS FOR 2011/12

This chapter provides further breakdowns of HIV and AIDS spending by the government of Tanzania and DPs. This is a new analysis not previously included in past HIV and AIDS PERs. The purpose of this addition is to provide more detail on the way HIV and AIDS funding has been spent, by looking at expenditures by program areas. Note that only spending sourced from the government, PEPFAR, and the Global Fund were used for this analysis due to limitations in data availability.

For government spending, health spending data from the Health Accounts and non-health data from the PER exercise were used. Analysis for 2011/12 only is presented here since this is the year for which published Health Accounts data was available. The Health Accounts distributes total health spending by disease; the proportion of government resources allocated to HIV and AIDS was used for this analysis. These government resources include funds earmarked and not earmarked for HIV and AIDS. Non-health spending for HIV and AIDS was taken from the PER data collection exercise, and includes care for Orphans and Vulnerable Children, stigma reduction activities, and other activities that seek to create an enabling environment for the fight against HIV and AIDS. For government data, distribution keys were used to break down spending to the program areas. However, utilization data were not available to the level of the program areas presented here, so analysis of government data is limited to a select few categories.

Detailed data were available for PEPFAR via its Expenditure Analysis, which assesses spending by implementing partners. Relatively detailed data were available for the Global Fund via its Program Grant Agreements.

The program areas were chosen based on common categories of spending that are of interest to stakeholders and that are commonly reported on. The data presented here are therefore consistent with Health Accounts (for government resources), PEPFAR's Expenditure Analysis reporting, and Global Fund Enhanced Financial Reporting.

## 4.1 Methodology

The analysis presented here demonstrates the detailed breakdowns of spending that is possible using existing data. We present the methodology for reproducing this analysis in the future, both in the case where Health Accounts data are or are not available.

### 4.1.1 When Health Accounts Data Are Available: Approach 1

Spending data were disaggregated to the most detailed category level possible. In some cases, spending was clearly earmarked to a category, and where it was not, distribution keys were used. Distribution keys apportion spending to different categories using an appropriate weighting factor. Distribution keys were applied to government resources only. PEPFAR and Global Fund data were sufficiently disaggregated for this analysis.

Care and treatment spending and prevention spending are two areas that required distribution keys. Here, a combination of utilization data and unit costs were used to disaggregate spending, on the

assumption that spending is in line with utilization after adjusting for the intensity of use of resources (i.e., cost). Utilization data were sourced from the HMIS report[12] and unit costs data from the Oxford Policy Management costing study.[13]

Table 4 explains how HA data for government resources were mapped to the program areas of the PER.

**Table 4: Crosswalk between Health Accounts categories and 2013/14 PER Program Areas**

| Health Accounts Category (Function Classification) | PER Program Category | Comments |
|---|---|---|
| **HC 1 – Curative care** | Use distribution key to allocate between ART treatment, PMTCT, sexually transmitted infections management, and opportunistic infections | Source of data: utilization and unit cost data per program area |
| **HC 6.1 – Prevention: Information, Education and Communication** | Prevention – Behavior Change Communication | An attempt was made to further break down behavior change communication spending between mass media and community outreach, but data were unavailable at this level of detail. |
| **HC 6.2 – Immunization Programs** | Not applicable | |
| **HC categories HC 6.3 to HC 6.nec** | Government spending in the Health Accounts had no spending attributed to HC 6.3 ("Early Disease Detection Programs") nor HC 6.4 ("Healthy Condition Monitoring").<br>HC 6.nec ("Prevention Spending Not Elsewhere Classified") was therefore disaggregated to condom distribution and HIV Testing and Counseling, using a distribution key. | An attempt was made to also disaggregate for VMMC, but reliable utilization data were not available. |
| **HC 7 – Governance and financing and administration of the health system** | Supportive environment: Policy development including workplace policy | |

[12]Ministry of Health and Social Welfare. 2015. Health Management Information System. Dar es Salaam.
[13] Oxford Policy Management. 2013. The Costs of Delivering Health Services in Tanzania: Findings from a Comprehensive Costing Analysis.

### 4.1.2 When Health Accounts Data Are Unavailable: Approach 2

If Health Accounts data are unavailable, the PER team will need to conduct a full data collection for HIV and AIDS health *and* non-health spending. This will require collection of (i) spending data earmarked to HIV and AIDS, e.g., ART, PMTCT services, and HIV-specific prevention programs; and (ii) non-earmarked spending. In the non-earmarked arena, spending such as health worker salaries will need to be disaggregated to capture the estimated proportion for HIV and AIDS, as will general operating costs of health facilities. Text Box 1 outlines the methodology for disaggregating non-earmarked spending to HIV and AIDS in the case where Health Accounts data are unavailable.

**Text Box 2: Calculating Distribution Keys for Care and Treatment Without Health Accounts Data**

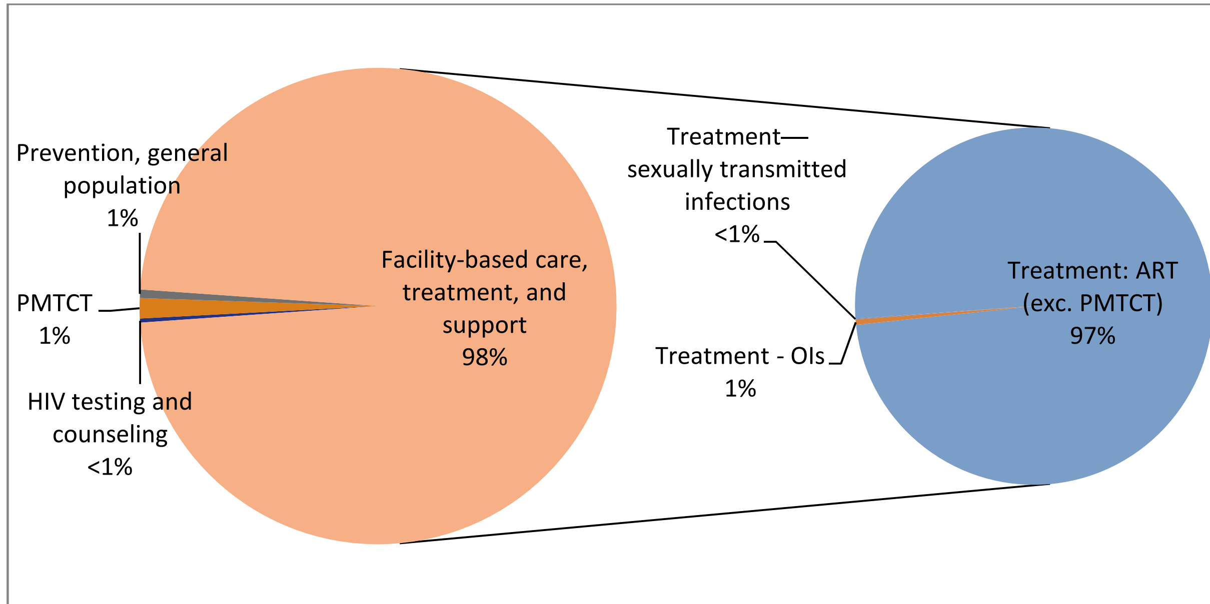
1. *Utilization data should be compiled by all services reported in the HMIS, and covering the broadest range of diseases or conditions. Each service should be assigned to a disease or condition, to the greatest extent possible. They should be separated between inpatient and outpatient care e.g. number of cases of malaria treated (outpatient) and number of bed-days for malaria treated (inpatient).*
2. *The inpatient/outpatient ratio should be calculated in order to convert all utilization data into a comparable unit. For example, all inpatient admissions should be converted to their outpatient equivalent or vice versa. This ensures that there is a common unit of measurement e.g if one inpatient visits equals 3 outpatient visits, then all inpatient visits should be multiplied by 3 or all outpatient visits should be divided by 3.*
3. *Unit costs, or another proxy for costs, for each service should be multiplied by its respective utilization number. The unit cost must match the utilization to which it is being applied; e.g., if inpatient utilization is measured by number of bed days, the unit costs should also be per bed day .*
4. *Using the total estimated spending for each service, apply the proportions obtained from the utilization × unit cost calculations to the total non-earmarked health spending figure that was collected.*

## 4.2 Results

The vast majority of government resources are spent on facility-based treatment (Figure 19).This is to be expected, since the government pays the salaries of staff who provide HIV and AIDS counselling, treatment, and other services, and pays for the drugs used to treat HIV and AIDS patients as well as laboratory costs for tests. Data to further disaggregate the "ART treatment" category was not available. It is likely that this category is overestimated since utilization data for Treatment of Sexually Transmitted Infections and for Treatment of Opportunistic Infections were not complete and may be part of the "ART treatment" utilization category.

Utilization data for prevention spending did not permit a further detailed breakdown of spending by type of prevention activity. Therefore, spending on some specific prevention categories is underestimated, as it is included in the general prevention category. This category is also underestimated, because some prevention spending may be included in the care, treatment, and support category, where integrated services are provided at the facility level.

**Figure 19: Government Spending by Program Area, 2011/12**




In contrast with government spending, the majority of Global Fund spending in 2011/12 was on crosscutting activities such as "Strengthening Government" and "Supporting National Level Multisectoral Coordination"[14] (

Figure 20). Nine percent of funds were used on prevention spending, namely PMTCT and testing and counselling. Only 3 percent was spent on facility-based care, treatment, and support, and 4 percent was spent on impact mitigation activities. However, as Figure 5 shows, this breakdown changed the following year.

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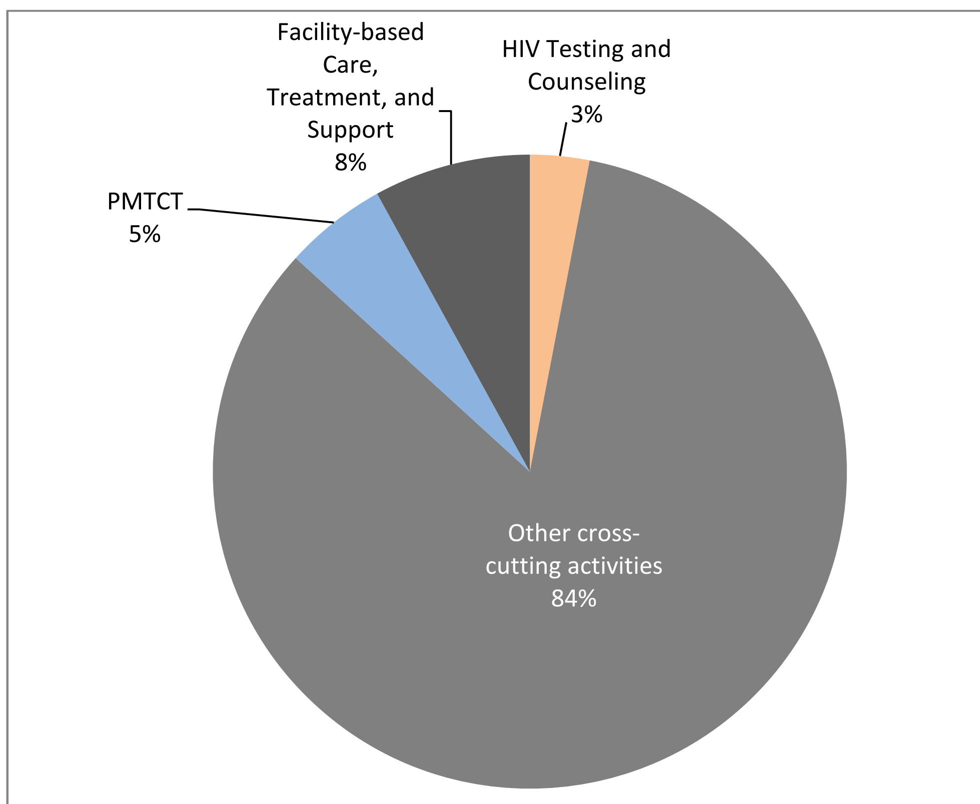
[14] The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2009. Program Grant Agreement for Grant No. TNZ-809-G13-H.

**Figure 20: Global Fund Spending by Program Area, 2011/12**[15]

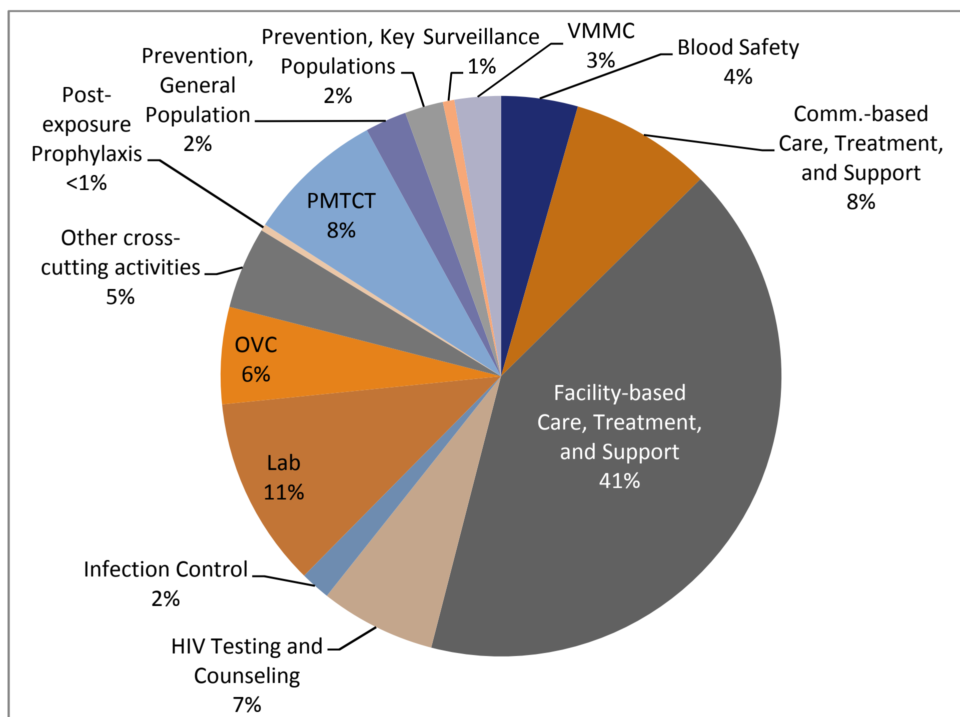



Finally, PEPFAR spending was analyzed by program area, as shown in

[15] Ratios for Global Fund are taken from budget information in the Program Agreements. Detailed information on spending by program areas was not available at the time of the PER; it is therefore assumed that spending is line with budget.

Figure 21[16]. PEPFAR has been collecting detailed spending data through the Expenditure Analysis in Tanzania since 2009. In 2011/12, almost half of spending was used for care, treatment, and support at the facility and community level. Over one-fifth of spending was used for prevention activities, including PMTCT, testing and counselling, VMMC, and general population prevention.

**Figure 21: PEPFAR Spending by Program Area, 2011/12**




[16] PEPFAR dashboards: http://www.pepfar.gov/funding/c63793.htm. 2015. Accessed July 2015.

# 5. Conclusions and Recommendations

The 2013/14 HIV and AIDS PER has analyzed budget and expenditure trends for HIV and AIDS. For the first time, it also analyzed HIV and AIDS spending by detailed program areas. This will provide stakeholders with much-needed evidence to decide how to best finance the response to the epidemic in a sustainable manner. It will also inform resource allocation decisions in a way that responds to the NMSF III objectives.

Key observations noted in relation to the 2013/14 HIV and AIDS PER:

1. High dependence on donors for HIV and AIDS financing poses a risk to the NMSF III and coverage of services.
2. A potential decline in funding for HIV and AIDS interventions is coupled with misallocation of funds, especially for Objective A, and this hinders effective implementation of workplace programs.
3. The potential of the private sector and other complementary sources to address the HIV and AIDS resources gap remains underexplored.
4. Expenditure tracking does not yet appear to be systematic for HIV and AIDS. In addition, data at a disaggregated level are not yet fully available. Such data would enable organizations such as TACAIDS and the ATF to make informed decisions about resource allocations, and to monitor spending against priorities.
5. Tanzania benefits from a wealth of data, analyses, and reports on health spending and general HIV and AIDS spending. However, lack of consistency between these sources renders them less useful than they otherwise would be.

***The need to identify new, more sustainable financing for the national HIV and AIDS response***

Implementing the NMSF III will require a significant amount of resources ($2.96 billion over the NMSF III period). This is in the context of a financial position in which there is high dependence on external financing, and that financing stream is showing a declining trend from 2016/17. This situation increases the need to find more stable sources of financing domestically, in order to continue providing goods and services for tackling the national HIV and AIDS response. Financing from the central government, local governments, community health funds, and the private sector are potential sources of domestic financing, which could be further developed. This is precisely the objective of the newly established AIDS Trust Fund. The threat of decreased financing from DPs not only affects the total resources available for HIV and AIDS, but may also threaten specific interventions to which DPs significantly contribute. Those include the provision of ART, and prevention activities such as VMMC and PMTCT. It is important to note that all the resource mobilization strategies discussed here are as relevant to the entire health sector as they are to HIV and AIDS. Resources for HIV and AIDS will need to compete with other health and non-health priorities. Therefore, HIV and AIDS spending must be closely tracked in order to demonstrate the impact of HIV and AIDS spending.

Maintaining, if not increasing, the proportion of the government budget is important to demonstrate the government's commitment to the national response for HIV and AIDS. Stronger assurances to disburse government funds allocated to HIV and AIDS are necessary to support the MDAs and LGAs. However, reliance on government spending is threatened by increased competition for its resources. Local government resources are similarly under increasing competition, and are currently a small proportion of the total funding pie; the average expenditure from councils' own resources accounted for 2.4 percent of councils' HIV and AIDS funding in 2013/14, and that has been falling.

However, as some regions grow economically, LGAs may want to allocate more of their resources to HIV and AIDS. Greater sensitization at the local level about the economic impact of HIV and AIDS is important so LGAs have the incentive to invest.

The private sector, which is very active in Tanzania, presents a significant opportunity to mobilize additional domestic resources. Strategies to mobilize domestic resources used in other countries have included:

1. "Sin taxes" or other levies. A proportion of taxes on tobacco and alcohol could be used to support health services. This is a relatively stable source of financing, since tobacco and alcohol spending tend to be inelastic to changes in income. Alternatively, a proportion of cell phone airtime, foreign transaction fees, tourism fees, or airline taxes could also be allocated. Currently, more than 28 countries use alcohol taxes to fund health care. In some countries such as Pakistan and Vietnam, this can contribute a significant proportion (approximately one third) of government health spending.[17,18]
2. Encourage greater health spending by corporations through Corporate Social Responsibility programs, or as a way of contributing to greater productivity of their work force and the local community. The private sector can be used to provide workplace programs, offer their own health providers, and subsidize health insurance for their workers (including the costs of HIV services). They can also be an important contributor to local fund-raising campaigns, such as the Kilimanjaro Challenge. This will involve catalyzing the private sector through its umbrella organizations such as the Tanzania Private Sector Foundation, Tanzania Chamber of Commerce, Industry and Agriculture, Association of Tanzania Employers, and the Tanzania Informal Economy Network Initiative for AIDS, so that private organizations can see the benefits of funding HIV and AIDS activities and commit to funding the ATF over the long term.
3. Civil Society Organizations Funds: A major innovation in managing the pandemic at the local level is the formation of groups by PLHA and those affected by HIV and AIDS such as widows, so that they can respond with collective voice and efforts. Some of the groups have been registered as Savings and Credit Cooperative Societies. These groups could be offered expanded financial services, such as subsidized loans, to access health services and pay for other resources needed to address the impact of the pandemic. Being in a group, they not only have a stronger bargaining voice with authorities such as LGAs in order to access a certain service, they also contribute to addressing stigma and discrimination.

*Recommendation*

**Explore alternative domestic sources of financing,** including greater commitment from central and local government, the private sector, and community-level schemes. Private sector contributions provide innovative options that have not been fully exploited, through workplace programs, the expansion of low-cost health insurance, and fund-raising campaigns.

**Produce financial scenarios showing the potential for revenue generation from these different options** and their implementation costs, in order to assess the most viable option for Tanzania.

[17] WHO – Regional Office for South East Asia. *Tobacco taxation and innovative health care financing.* New Delhi: WHO. 2012.

[18] Doetinchem, Ole. *Hypothecation of tax revenue for health.* World Health Organization. 2010.

***Weak implementation of HIV and AIDS activities at MDA and LGA levels***

Inconsistent and sometimes very low execution of Objective A activities in MDAs and LGAs reflects the weak implementation of workplace HIV and AIDS interventions. Given that most employees do not know their serostatus, and those who know they are HIV-positive do not disclose it due to stigma, demand for workplace interventions has been low, at least from the point of view of care and treatment. This may have caused laxity in using the funds allocated through Objective A for workplace HIV and AIDS intervention, and it could be a cause of the observed misallocation of HIV and AIDS resources. Given the need to protect those who are not infected and support those who are infected, there is a need for renewed impetus on implementing planned HIV and AIDS activities, particularly advocacy programs to reduce stigma and know one's sero status as an end in itself, and to increase demand for care, treatment and support services. TACAIDS in collaboration with the MoF should emphasize the importance of using funds for their original purpose, and find mechanisms to better monitor and protect Objective A spending.

Sampled MDAs and LGAs reported late or non-disbursements for Objective A and the NMSF grants. Although the grant has been released in full in the past three financial years, late disbursements by DPs have caused delays, and so has the late submission of reports on the part of MDAs and LGAs, which delays government disbursements. Delays result in the reallocation of funds for other non-HIV and AIDS activities. This is especially so when the funds are released in the last quarter and there is a pressure to spend.

*Recommendation*

Central and local government should **commit to disburse funds that are budgeted for HIV and AIDS**, and on a timely basis.

**Better protection and monitoring of Objective A funds** will help to ensure HIV and AIDS activities are implemented as intended.

***Review Resource Allocations to Ensure They Address Priorities of NMSF III***

A decline in expenditure on care, treatment, and support has been observed in spending by NMSF II thematic areas. Given that treatment is the single most important investment for the NMSF III, and given the costs of providing HIV and AIDS treatment, this decreasing trend is surprising. It is important that resource allocation decisions are tracked to ensure that they are consistent with the priorities laid out in the NMSF III. Tracking spending by key priorities begins with planning and budgeting according to the NMSF III priorities. For some MDAs and LGAs, available data could not show how funding earmarked to HIV and AIDS was used, and how they addressed the NMSF II thematic areas.

*Recommendation*

The PER highlights the changing patterns of spending by thematic area, particularly the fall in the proportion of spending allocated to care, treatment, and support. **Better tracking of resources by thematic areas is needed**, so that programmers understand how spending is aligned with priorities and to demonstrate the impact of spending.

### *Improving Data Collection to Facilitate Regular Tracking of HIV and AIDS Spending*

Capturing data from MDAs and LGAs was a challenge. In MDAs, there does not appear to be a systematic way of tracking HIV and AIDS expenditure information, despite having an HIV and AIDS focal person in each MDA. This observation echoes the need to re-examine the mandate and capacity of HIV and AIDS focal persons in planning and budgeting of HIV and AIDS activities and implementing and reporting the same. For LGAs a consortium of people, led by the Regional Coordinator for TACAIDS and the Council HIV and AIDS Coordinator, provided data. However, understanding the total resources provided to HIV and AIDS was not possible. For example, apportioning the basket fund spending to HIV and AIDS was challenging.

The analysis of spending by program area in Chapter 4 used data that is currently available from donor websites, the HMIS and costing studies. The disaggregation produced will help stakeholders understand what interventions are being funded and whether reallocations are necessary. However, in order to continue producing this analysis going forward, and to further refine its accuracy, it is imperative that HMIS data becomes more complete and accurate. As stakeholders better understand the need for this analysis, and how it can improve HIV and AIDS programming, the incentive for reporting complete and accurate data will hopefully increase. The results of the PER should be shared with health care workers so that they can understand the importance of the data that they compile, and provide their perspectives on the challenges highlighted in this report.

*Recommendation*

Continue to **ensure complete and accurate reporting of services through the HMIS** to facilitate detailed analysis of spending going forward and to help improve programming.

It is important to **share the results of the PER widely** so all stakeholders understand the importance of data in decision making and to incentivize them to report complete and accurate data.

### *Develop Opportunities to Coordinate Data Collection Exercises and Share Analysis*

The diverse range of expenditure tracking exercises in Tanzania, e.g., health PER, HIV and AIDS PER, Health Accounts, and PEPFAR Expenditure Analysis, provides an opportunity to harmonize data collection. This will not only help to save time and resources, but will also help to ensure consistency of data. Decision makers will only use analysis that is easy to digest, clear, and accurate; multiple reports with seemingly inconsistent figures may prevent programmers from using otherwise useful pieces of analysis. While figures may legitimately differ between these analyses due to differences in scope and methodology, it is important that these differences are explained. If the raw data could be made consistent, through the use of a harmonized data collection tool, these differences would become easier to reconcile, and that would encourage greater use of the various analyses. A harmonized tool will also ensure higher-quality data, by preventing “survey fatigue.” The PER team was fortunate to coordinate closely with the HPP and HA team for triangulation purposes, and to help ensure consistency between the difference analyses. Such opportunities to share data and discuss methodologies should be continued.

*Recommendation*

Explore the possibility of using a **harmonized data collection tool for expenditure tracking,** e.g., Health Accounts, health PER, HIV and AIDS PER and PEPFAR EA. Continue to share analysis from these exercises.

# ANNEX A: NMSF II AND III THEMATIC AREAS

The NMSF II (2008–2012) defines thematic areas for HIV and AIDS interventions (Table A1). Four main areas have been defined. Using disaggregated data from TACAIDS reports, analysis of expenditures was conducted according to these NMSF thematic areas.

**Table A1: NMSF II HIV and AIDS Key Intervention Areas**[19]

**Thematic Area 1: Crosscutting Issues Related to the Entire National Response (Enabling Environment)**

- Advocacy
- Fighting stigma, denial, and discrimination
- Regional, district, and community response
- Mainstreaming HIV and AIDS
- HIV and AIDS and development and poverty reduction policies

**Thematic Area 2: Prevention**

- Sexually transmitted infections control and case management
- Condom promotion and distribution
- Voluntary Counseling and Testing
- Prevention of mother to child transmission
- Health promotion for specific population groups, notably children and youth, girls and women, men, and disabled people
- School-based prevention for primary and secondary school levels
- Health promotion for vulnerable population groups
- Workplace interventions (public, private, and informal sectors)
- Safety of blood and blood products, and universal precautions in health care and non-health care settings including waste management

**Thematic Area 3: HIV and AIDS Care and Support**

- Provision of ART
- Treatment of common opportunistic infections
- Home- and community-based care and support

**Thematic Area 4: Social and Economic Impact Mitigation**

- Economic and social support for persons, families, and communities affected by AIDS
- Support for orphans and vulnerable children

[19] United Republic of Tanzania (URT). 2007. The Second National Multi-Sectoral Strategic Framework for HIV and AIDS (2008 – 2012), Dar es Salaam, Prime Minister's Office.

NMSF III categories are provided in Table A2. The implementation period for NMSF III is 2013–2017; however, reporting is still to NMSF II themes.

**Table A2: NMSF III Strategic Areas of Primary Investment**[20]

| |
|---|
| 1. **Comprehensive ART service delivery**: This is the single most important investment in the NMSF III. Scaling up and sustaining access to and retention in treatment, care, and support interventions, along with investments in infrastructure, procurement, and supply chain management, require exceptional program management to ensure the continuous availability of ART for all HIV-positive Tanzanians. |
| 2. **HIV counseling and testing with effective linkages to facility- and community-based services:** These envisaged services are those that respect human rights and provide informed consent, and focus on high-disease-burden areas, as well as mobile, hard-to-reach, and key populations. These key populations include discordant couples, sex workers, men who have sex with men, women who have anal sex, people who inject drugs, and others at highest risk. |
| 3. **Elimination of mother-to-child transmission:** The services include adoption and implementation of PMTCT option B+ throughout the country, providing testing and counseling to all prospective mothers, and placing all HIV-positive mothers on life-saving ART. |
| 4. **Comprehensive sexuality, gender, and health education and services:** This includes all necessary investments in curricula and training for the provision of facility and community-based interventions that deliver a comprehensive package of education and services relating to sexuality, gender, and health for the HIV national response. |
| 5. **Condom provision and programming**: Targeted and innovative strategies to increase availability of and access to male and female condoms and water-based lubricants should be employed, through both the private and public sectors. |

[20] United Republic of Tanzania (URT). 2013. Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013/14–2017/18), Dar es Salaam, Prime Minister's Office.

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