



# **PUBLIC EXPENDITURE REVIEW, 2011 HIV AND AIDS**

TANZANIA MAINLAND



**TANZANIA COMMISSION FOR AIDS –TACAIDS**

**JULY 2012**



**Recommended Citation:** Tanzania Commission for AIDS. July 2012. *Public Expenditure Review, 2011 HIV/AIDS Tanzania Mainland*. Dar es Salaam, Tanzania and Health Systems 20/20 project, Abt Associates Inc.

# **PUBLIC EXPENDITURE REVIEW, 2011 HIV AND AIDS**

**TANZANIA MAINLAND**

# CONTENTS

<b>Contents</b> .....	<b>v</b>
<b>Acronyms</b> .....	<b>xi</b>
<b>Acknowledgments</b> .....	<b>xiii</b>
<b>Executive Summary</b> .....	<b>i</b>
<b>1. Introduction</b> .....	<b>vii</b>
1.1 Objective and Rationale of the HIV and AIDS Public Expenditure Review 2011 .....	vii
1.2 Methodology.....	vii
1.3 Limitations .....	vii
<b>2. Assessment of Recommendations from the HIV and AIDS Public Expenditure Review 2010</b> .....	<b>1</b>
<b>3. Performance Assessment</b> .....	<b>5</b>
3.1 The Magnitude of the HIV and AIDS Problem .....	5
3.2 Drivers of the HIV and AIDS Epidemic .....	5
3.3 Is the Money Spent on Combating HIV and AIDS Having Any Impact?.....	5
3.4 Achievements and Challenges in the HIV and AIDS National Response .....	6
3.5 Policy and Programmatic Response to the Challenges .....	8
<b>4. Development Partners' Support to Tanzania's HIV and AIDS National Response</b> .....	<b>9</b>
4.1 United States Government Funding through PEPFAR .....	9
4.1.1 Background.....	9
4.1.2 Funding Levels for the HIV and AIDS National Response.....	10
4.1.3 PEPFAR Implementing Partners.....	11
4.2 Global Fund to Fight AIDS, Tuberculosis, and Malaria.....	13
4.3 United Nations Agencies .....	14
4.4 Japan International Cooperation Agency.....	15
4.5 Canadian International Development Agency.....	15
4.6 Germany Development Cooperation .....	16
4.7 The World Bank.....	17
4.8 The Clinton Foundation .....	17
4.9 CIDA and the Danish International Development Agency .....	17
4.10 Other Sources.....	18

4.11	Summary of the Donor Financing of the HIV and AIDS Program .....	18
4.12	Summary of Actual Total Spending on HIV and AIDS, Projections, and Resource Gaps.....	19
<b>5.</b>	<b>Budget and Expenditures: National Level .....</b>	<b>21</b>
5.1	Introduction .....	21
5.2	MDA Spending: Budget versus Real Expenditure – National Level .....	21
5.3	Resource Allocation by Category– Aggregate from Selected Ministries .....	21
5.4	Analysis of HIV and AIDS Expenditure in the Selected Ministries.....	23
5.4.1	Ministry of Health and Social Welfare .....	23
5.4.2	Ministry of Education and Vocational Training.....	24
5.4.3	Ministry of Agriculture, Food, and Cooperatives.....	25
5.4.4	Ministry of Information, Culture, and Sports .....	26
5.4.5	Ministry of Labor, Employment, and Youth Development .....	28
5.4.6	Ministry of Community Development, Gender, and Children .....	28
5.5	Conclusion.....	28
<b>6.</b>	<b>Budget and Expenditures: Local Level.....</b>	<b>31</b>
6.1	Planning and Budgeting .....	31
6.2	HIV and AIDS Spending at the LGA Level.....	31
6.3	NMSF Expenditures and Execution in the Selected Councils .....	33
6.4	Audited Report of the NMSF Grant Fund .....	34
6.5	Resource Projections for Funding the NMSF Strategic Plan .....	35
6.6	Concluding Remarks and Implementation Challenges at LGAs .....	35
<b>7.</b>	<b>ASSESSMENT OF HIV AND AIDS ACTIVITIES IN THE PRIVATE SECTOR .....</b>	<b>37</b>
7.1	Introduction .....	37
7.2	General Information on Company HIV and AIDS Programs.....	37
7.3	Challenges and Conclusion.....	41
<b>8.</b>	<b>Assessment of the Coordination Framework of the National Response .....</b>	<b>43</b>
8.1	Achievements .....	43
8.2	Spending on Coordination.....	44
<b>9.</b>	<b>Tanzania AIDS Control Trust Fund .....</b>	<b>45</b>
9.1	Background.....	45
9.2	9.2 Proposed Funding Mechanisms.....	46

<b>10. Recommendations of the HIV and AIDS Public Expenditure Review 2011</b> .....	<b>49</b>
<b>Annex A: Tanzania HIV and AIDS Public Expenditure Review 2011: Scope of Work</b> .....	<b>52</b>
<b>Annex B: Members of the Finance and Audit Technical Working Committee and Public Expenditure Review Team</b> ..	<b>55</b>
<b>Annex C: PEPFAR Implementing Partners</b> .....	<b>57</b>
<b>Annex D: HIV Prevalence in Tanzania by Region</b> .....	<b>65</b>
<b>Annex E: Company Spending on HIV and AIDS Workplace Programs, 2009/10</b> .....	<b>67</b>
<b>Annex F: References</b> .....	<b>69</b>

## LIST OF TABLES

Table ES-1: Total Real Expenditure on HIV and AIDS (Bn TZS) .....	i
Table ES-2: Projected HIV and AIDS Resource Needs and Financing Gap .....	iii
Table 3.1: Tanzania Basic HIV and AIDS Statistics (2010) ...	5
Table 4.1: One UNJP on HIV/AIDS, Budget vs. Actual (Mn USD, %) .....	14
Table 4.2: Funds for HIV and AIDS by Donor, 2007–2010 and Forecast to 2014 (Mn USD) .....	18
Table 4.3: Total Real Expenditure on HIV and AIDS (BnTZS) .....	19
Table 4.4: Projected HIV and AIDS Resource Needs and Financing Gap (Bn TZS) .....	20
Table 5.1: Budgeted and Actual Spending in Selected MDAs (Mn TZS) .....	21
Table 5.2: Budgeted and Actual Spending on HIV and AIDS (Selected Ministries) (Mn TZS) .....	22
Table 5.3: Performance of HIV and AIDS Spending by Themes in Selected MDAs (Mn TZS) .....	23
Table 5.4: Ministry of Health and Social Welfare Real Spending by Intervention Area (Mn TZS) .....	23
Table 5.5: Ministry of Education Recurrent and Development HIV and AIDS Spending (Mn TZS) .....	24
Table 5.6: Source of Financing for the Ministry of Education HIV and AIDS Programs (Mn TZS) .....	25
Table 5.7: Ministry of Education HIV and AIDS Spending by Thematic Areas (Mn TZS) .....	25
Table 5.8: Ministry of Agriculture HIV and AIDS Recurrent Spending (Mn TZS) .....	26
Table 5.9: Ministry of Agriculture HIV and AIDS Spending by Thematic Areas (Mn TZS) .....	26
Table 5.10: Ministry of Information, Culture, and Sports HIV and AIDS Source of Financing (Mn TZS) .....	27

Table 5.11: Ministry of Information, Culture, and Sports HIV and AIDS Development and Recurrent Spending (Mn TZS).....	27
Table 5.12: Ministry of Information, Culture, and Sports HIV and AIDS Spending by Thematic Areas (Mn TZS) .....	27
Table 1: Sources of Financing for the Ministry of Community Development's HIV and AIDS Program (Mn TZS) .....	28
Table 6.1: NMSF Grant Budget and Actual Expenditure at LGAs and Regions (BnTZS) .....	32
Table 6.2: HIV and AIDS Spending in Selected Councils (Mn TZS) .....	33
Table 9.1: Proposed Funding Mechanisms .....	45
Table 9.2: Examples of Airline Levy Rates .....	46

## LIST OF FIGURES

Figure ES-1: Declining Development Partner Support (USD m) .....	i
Figure ES-2: HIV and AIDS Spending, 2008-2010 .....	ii
Figure 3.1: Actual HIV Prevalence Rate in Tanzania, Population Aged 15–49 Years .....	6
Figure 3.2: Estimated Annual AIDS Deaths.....	6
Figure 4.1: PEPFAR Support by Thematic Areas (Mn USD) 10	
Figure 1.2: PEPFAR Funding Projections.....	11
Figure 4.3: Regional Distribution of PEPFAR Partners in Tanzania.....	12
Figure 4.4: JICA Support (1,000 USD) .....	15
Figure 4.5: Increasing Canadian NMSF Support Since 2011/12.....	16
Figure 4.6: German Support Flattens Since 2011 .....	17
Figure 4.7: Development Partner's Support is Declining (Mn USD) .....	19
Figure 5.1: MDAs' HIV and AIDS Resource Spending Patterns .....	22
Figure 6.1: LGAs' and Regions' HIV and AIDS Expenditure (Bn TZS) .....	32
Figure 2: Per capita NMSF Grant Allocation to Selected Councils (TZS) .....	34
Figure 6.3: NMSF Grant Forecast (Mn USD) .....	35
Figure 7.1: Company Perception of HIV Prevalence.....	38
Figure 7.2: Company HIV and AIDS Policy.....	38
Figure 7.3: HIV and AIDS Services Provided by Companies .....	39
Figure 7.4: Company Sources of Funding HIV and AIDS Interventions .....	39
Figure 7.5: Company HIV and AIDS Actual Spending in 2009/10 (Mn TZS) .....	40

Figure 7.6: Company Willingness to Support TACTF .....	41
Figure 8.1: TACAIDS Spending on Coordination (Mn TZS)	44
Figure 3: Tanzania Health Spending as Percentage of Total Budget .....	47
Figure A1.1: HIV Prevalence by Region .....	65



# ACRONYMS

ABCT	AIDS Business Coalition of Tanzania
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ART	Antiretroviral Therapy
ARV	Antiretroviral
Bn	Billion
CAD	Canadian Dollar
CBO	Community-Based Organization
CHAC	Council HIV and AIDS Coordinator
CIDA	Canadian International Development Agency
CMAC	Council Multisectoral AIDS Committee
CMTCT	Control of Mother-to-Child Transmission
COPTA	Community Planning Tool Against AIDS
CSO	Civil Society Organization
CSSC	Christian Social Support Commission
DACC	District AIDS Control Coordinator
eMTCT	Eliminate Mother-to-Child Transmission of HIV and AIDS
EUR	Euro
FATWC	Finance and Audit Technical Working Committee
FBO	Faith-Based Organization
GHI	Global Health Initiative
GIZ	German Agency for International Development
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
JICA	Japan International Cooperation Agency
JPY	Japanese Yen
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MDA	Ministry, Department, or Agency (of Government)
MDGs	Millennium Development Goals
MKUKUTA	National Strategy for Growth and Reduction of Poverty
Mn	Million
MoAFC	Ministry of Agriculture, Food, and Cooperatives
MoCDGC	Ministry of Community Development, Gender, and Children
MoEVT	Ministry of Education and Vocational Training
MoFEA	Ministry of Finance Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MoICS	Ministry of Information, Culture, and Sports
MoLEYD	Ministry of Labor, Employment, and Youth Development
MSD	Medical Stores Department

MTEF	Medium-Term Expenditure Framework
NACP	National AIDS Control Program
NGO	Nongovernmental Organization
NHA	National Health Accounts
NMSF	National Multisectoral Strategic Framework
O&OD	Obstacles and Opportunities for Development
OI	Opportunistic Infection
OVCs	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PLWHA	People Living With HIV and AIDS
PMO-RALG	President's Office, Regional Administration & Local Government
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
RACC	Regional AIDS Control Coordinator
RCBT	Regional Capacity Building Teams
RCT	Regional Coordinator of TACAIDS
RFE	Rapid Funding Envelope
SIDA	Swedish International Development Agency
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TACTF	Tanzania AIDS Control Trust Fund
TB	Tuberculosis
TMAP	Tanzania Multisectoral AIDS Program
TOMSHA	Tanzania Output Monitoring System for HIV and AIDS
TZS	Tanzanian Shilling
UN	United Nations
UNAIDS	UN Joint Program on HIV and AIDS
UNJP	UN Joint Program of Support to Tanzania on HIV and AIDS
URT	United Republic of Tanzania
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VMAC	Village Multisectoral HIV and AIDS Committee
WMAC	Ward Multisectoral HIV and AIDS Committee

# ACKNOWLEDGMENTS

---

The HIV and AIDS Public Expenditure Review 2011 Team wishes to acknowledge the help and timely contribution of various stakeholders toward the preparation and production of this report. In particular, we thank TACAIDS management and staff for their active engagement and guidance, Abt Associates through the Health Systems 20/20 Project for their oversight role, and USAID for financial support of this review.

Our deepest gratitude also goes to all who provided data and information, including responding to our questionnaire, from the donor community, private companies, civil society organizations, and ministries, departments, and agencies. Thank you for sharing your valuable time, information, and experience.

We also wish to convey our appreciation for the support provided by the 10 councils included in the field study: Same DC, Morogoro DC, Kilosa DC, Arusha MC, Arumeru DC, Korogwe DC, Muheza DC, and Moshi MC. In this regard, we also recognize the contributions made by village communities in focus group discussions 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 the Finance and Audit Technical Working Committee for providing strategic guidance to the study.

Thank you,  
The PER Team



# EXECUTIVE SUMMARY

## Status of the epidemic and progress in the national response

Tanzania's HIV and AIDS epidemic is still a major concern. Over 5.7 percent of adults were living with the virus in 2010. Deaths due to AIDS have begun to decline, but AIDS still claims over 50,000 adults each year, largely those in their most productive age. AIDS orphans have reached 1.3 million, and these need care and support. Only 50 percent of those in need of HIV and AIDS services are being reached. In short, much remains to be done to build an HIV-free society.

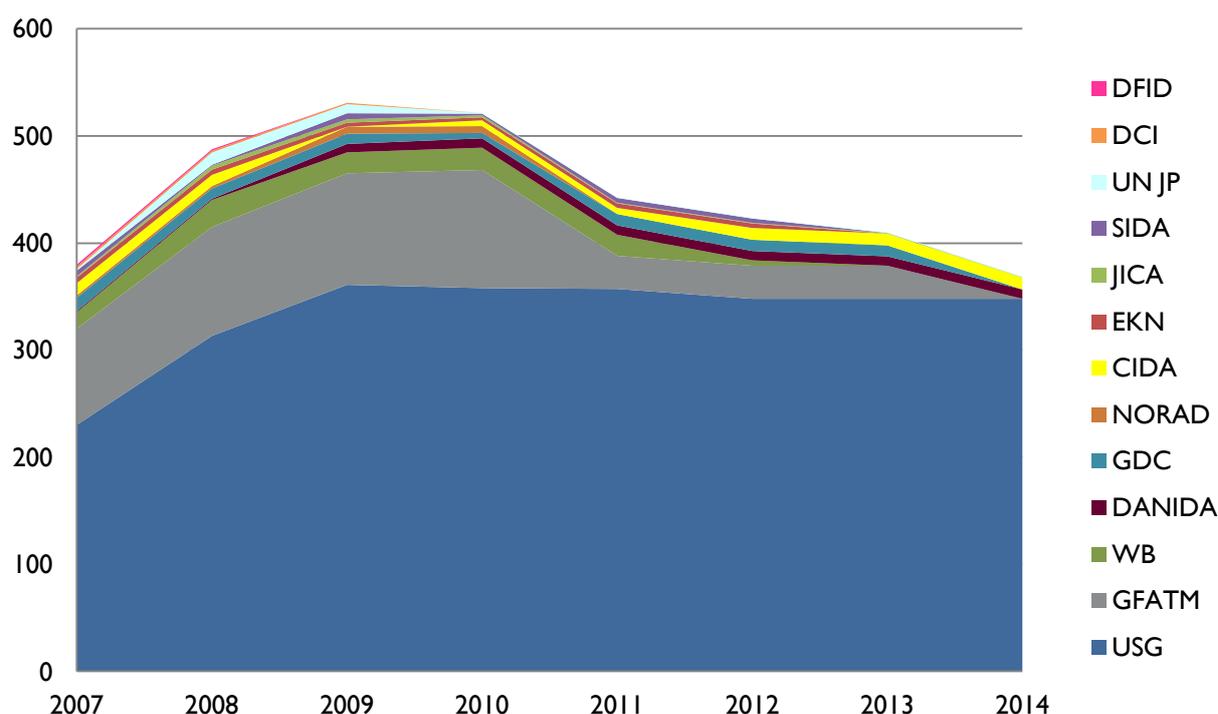
## Spending on HIV and AIDS

Actual spending on the HIV and AIDS national response is financed largely by development partners – over 97 percent in 2010/11. The U.S. government (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) account for 91 percent of the total donor support to the national response.

**TABLE ES-1: TOTAL REAL EXPENDITURE ON HIV AND AIDS (BN TZS)**

	2006/07	2007/08	2008/09	2009/10	2010/11
Government	22.0	23.0	14.0	12.5	11.0
Development partners	282.0	383.3	566.9	566.3	431.8
Total	304.0	406.3	580.9	578.8	442.8
%of total from donors	92.8%	94.3%	97.6%	97.8%	97.5%

**FIGURE ES-1: DECLINING DEVELOPMENT PARTNER SUPPORT (USD MN)**

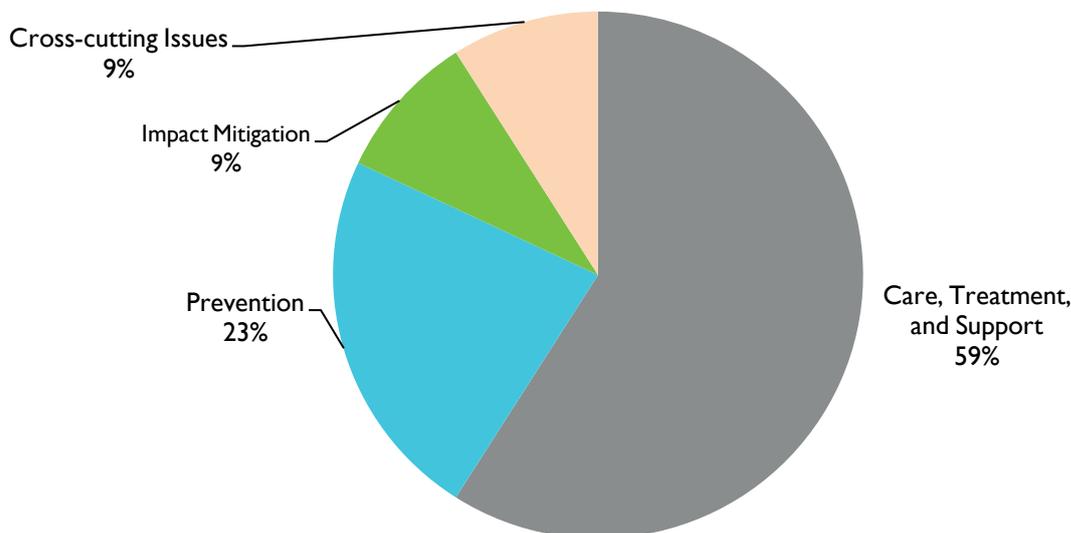


Most of the donor spending is off-budget – over 85 percent in 2010/11 – meaning the funds are not subjected to oversight control by government systems and scrutiny by the controller and auditor general. The share of government spending is low, typically less than 3 percent of the resources in recent years, putting the sustainability of the HIV and AIDS national response in jeopardy.

### Resource availability projections

The Public Expenditure Review (PER) survey observed declining support to the country’s HIV and AIDS national response by almost all major financiers of the program, particularly after 2011.

**FIGURE ES-2: HIV AND AIDS SPENDING, 2008-2010**



Source: TACAIDS (2011a)

This is a signal for the government to fast-track establishment of the proposed Tanzania AIDS Control Trust Fund (TACTF), if the national response is to be sustainable.

### HIV and AIDS spending by National Multisectoral Strategic Framework themes

Over 59 percent of HIV and AIDS spending is on care, treatment, and support, followed by prevention interventions at 23 percent of the resources. Crosscutting issues (which includes program management) uses 9 percent of the funds, while the remaining 9 percent is used to defray costs of impact mitigation. The National Multisectoral Strategic Framework (NMSF) 2008–2012 prioritizes prevention, but implementation of this resolve has not been achieved because most funding is off-budget and largely out of control by the government.

### Going forward, what is the financing gap?

The financing gap beyond 2012/13 is huge, above 90 percent. This is partly because there are no assurances that once the U.S. government agreement to support Tanzania’s HIV and AIDS response ends in 2013, it will be renewed at current levels. Secondly, the second-largest funder (the Global Fund) has announced it will not solicit further HIV and AIDS proposals until 2014; although as Section 4.2 shows, there is USD120 million in the pipeline for the Global Fund’s Round 8 until 2015/16. Further, some of the development partners have scaled down their support substantially beyond 2012/13.

**TABLE ES-2: PROJECTED HIV AND AIDS RESOURCE NEEDS AND FINANCING GAP**

	2011/12	2012/13	2013/14	2014/15
Resource needs	1,076.8	1,130.6	1,187.2	1,246.5
Projected available funding	658.6	582.0	114.9	107.4
Unmet gap	418.2	548.6	1,072.3	1,139.1
Gap as % of requirements	38.8%	48.5%	90.3%	91.4%

### **Sustaining the response through the Tanzania AIDS Control Trust Fund**

Tanzania's HIV and AIDS epidemic is still a big threat to the lives of many people, given the HIV prevalence rate averaging 5.7 percent or more. Funding of the national response is in serious jeopardy. Over 97 percent of the HIV and AIDS national response is funded by donors, but their support is declining. The resource needs for the national response is over TZS1 trillion (USD670 million) per year, but currently only TZS550 billion (USD67 million) per year are made available from all sources, which is about 50 percent of the requirements. This means the national HIV and AIDS response is not sustainable the way it is currently being funded. Because of this, there is an urgent need to fast-track approval and implementation of the proposed TACTF as a key way of reducing donor dependency and enhancing sustainability of the response. In this regard, the PER 2011 Team recommends the following:

1. Charging a small levy on all passenger and freight traffic (excluding flights in transit) of USD2.50 per passenger and USD0.05 per ton of cargo. This levy will be applied in a similar fashion to the airport tax and deposited to the trust fund account. The expected revenue for 2012/13–2015/16 would be about USD80 million, or TZS120 billion.
2. Authorizing all large domestic and international businesses operating in Tanzania to contribute 0.5 percent of their annual gross earnings to the TACTF. This corporate social responsibility levy will be collected by Tanzania Revenue Authority and deposited to the fund account. It is expected such a levy will yield TZS17 billion for the trust fund between 2012/13 and 2014/15.
3. Allocating 5 percent of government total domestic revenue to the TACTF. The expected revenue for 2013/14–2015/16 will be TZS1.44 trillion, bringing the country to within 3 percentage points short of the Abuja African Governments' commitment to allocate 15 percent of total government expenditure to the health sector.
4. Urging the Tanzania Union for Government Health Employees to consider donating 30 percent of the 2 percent employee levy it collects monthly as its contribution to the AIDS trust fund. It is estimated that this contribution will add TZS4 billion to the fund between 2012/13 and 2014/15.
5. Carrying out fundraising campaigns at the national level, targeting the general public and external partner organizations.
6. Adopting best practices in the administration and management of the AIDS fund, including making use of existing proven planning, budgeting, financial management, and reporting tools that are already in use at national and local levels.

### **Performance assessment**

Budget execution at the national level for the selected ministries, departments, and agencies (MDAs) was relatively good, but sometimes erratic. For example, in 2009/10 the average performance for development spending was close to 100 percent, while real recurrent spending was 76.5 percent of what was planned/budgeted. However, in the following fiscal year (2010/11), performance declined to 66 percent for development spending and 34.9 percent for recurrent expenditure. Part of the reason for these large variations is late or non-disbursement of committed funds by both the government and development partners.

At the Local Government Authority (LGA) level, performance of the NMSF grant spending has improved from 48.8 percent in 2008/09 to 86.5 percent in 2010/11, due partly to extensive training and capacity building undertaken with the multisectoral AIDS committees at the council, ward, and village levels.

Several challenges persist in the efforts to improve execution performance, including:

- Inadequate capacity at the village/ward and district levels to plan, budget, and report on HIV and AIDS interventions/activities, despite ongoing capacity building. All systems for sound planning, budgeting, financial management, and reporting have been developed and are operational, but still there are observed delays in reporting and some councils still have weak plans.
- The NMSF grant disbursements are often delayed, impacting negatively on implementation of HIV and AIDS activities at the local level. The delays are often related to poor communication between the implementers of the grant, inconsistent guidelines, and weak instructions on how to use the funds.
- Sometimes guidelines and budget ceilings are presented late and disbursements are delayed and often lower than those approved. This derails councils' action plans which are frequently not fully implemented, resulting into poor performance.

### **Private sector involvement in the HIV and AIDS national response**

The PER Team observed that substantial resources are used by private businesses to fund workplace interventions. The 29 businesses that were surveyed which have HIV and AIDS programs invested TZS4,317 million in 2009/10. Over 80 percent of the business firms supplied free condoms to their workers, 55 percent provided Voluntary Counseling and Testing (VCT) services, while 40 percent defrayed costs of antiretroviral drugs.

Private businesses have the potential to forge a private-public linkage in the fight against the HIV and AIDS epidemic. However, these businesses face a number of challenges, including:

- Inadequate involvement of top management of the private companies in HIV and AIDS workplace interventions, relegating this task to junior staff who in most cases cannot make binding decisions.
- Lack of HIV and AIDS workplace policies, which hinders effective and efficient implementation of HIV and AIDS workplace interventions.
- Inadequate financial resources within the AIDS Business Coalition of Tanzania (ABCT) to play an effective role of coordinating the private sector's HIV and AIDS response.

### **Coordination of the HIV and AIDS national response**

The Tanzania Commission for AIDS (TACAIDS) has put in place a credible national HIV and AIDS monitoring and evaluation (M&E) system. The institutional framework for M&E is in place and functional. During the review period, efforts were placed on building capacity of LGAs through training, mentorship, and supportive supervision. Most LGAs are now more effective in reporting on nonmedical HIV and AIDS interventions through the Tanzania Output Monitoring System for Nonmedical HIV and AIDS (TOMSHA). However, several challenges persist, including:

- Weak coordination and oversight system at regional and LGA levels which needs further strengthening.
- Weak planning, budgeting, and M&E and reporting in some MDAs, regions, and LGAs, coupled with low reporting compliance, all of which require greater efforts to improve system-wide performance.
- Weak linkage between TACAIDS and the private sector, especially in M&E, with regard to the latter's support of the HIV and AIDS national response. In this regard, TACAIDS should encourage all private companies, nongovernmental organizations, community-based organizations, and faith-based organizations to report their HIV and AIDS activities to TACAIDS.

## RECOMMENDATIONS

This review of HIV and AIDS public spending for the period 2009/10–2010/11 provides the following observations and recommendations:

1. The government is urged to fast-track the establishment of the TACTF to ensure sustainability of the HIV and AIDS national response. This is urgent because, as observed by the PER Team, donor financing of the response is progressively declining. The Global Fund has declared that no new proposals will be solicited until 2014. The United States government support agreement is coming to an end in 2013 and there is no assurance of continuation of the program at the current levels of support. Other donors have also scaled down their support. Therefore, the government needs to increase its commitment by allocating greater budgetary resources to the HIV and AIDS national response.
2. TACAIDS is urged to appoint a team of technical experts to deliberate and recommend an appropriate institutional, administrative, and management structure, operational modalities, and related financial accountability systems. The team will also review already-recommended sources and mechanisms for funding the AIDS trust fund and map out their implementation strategy. The PER Team proposes additional possible sources of financing for the TACTF: (1) a levy on airline traffic, (2) a small levy on large domestic and international businesses operating in Tanzania, and (3) map out fundraising campaign strategies at the national level, targeting the general public and external partner organizations.
3. TACAIDS should develop a guidelines tool for the private sector for implementation of HIV and AIDS activities in the workplace. In this regard, TACAIDS (in collaboration with other stakeholders) should ensure that the private sector has a reporting mechanism and effective workplace HIV and AIDS programs.
4. Execution of HIV and AIDS interventions in MDAs and LGAs should be scaled up in order to realize the objectives and goals of the national response. The challenges contributing to low budget execution should be addressed— in particular, late or non-release of funds, lengthy procurement procedures, and low absorption capacity, especially at the LGA level where capacity building is most needed. In addition, the release of the NMSF grant in full and on time will 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.
5. TACAIDS (in collaboration with relevant stakeholders) should work with development partners to develop an exit strategy for their programs and test it before ending or winding down their HIV and AIDS support. Often, ending a program that has many beneficiaries risks losing the gains already achieved through huge 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.
6. The coordination of the HIV and AIDS NMSF should be strengthened to improve the effectiveness and efficiency of the national response at all levels. In particular, there is a need to ensure 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. In addition, TACAIDS should facilitate achievement of greater private-public partnership in the HIV and AIDS national response by providing appropriate guidance to private businesses. This may also entail providing support to the Tanzania Association of Employees and ABCT to enable these organizations to play a more effective role in coordinating the private sector's response.



# I. INTRODUCTION

---

## I.1 OBJECTIVE AND RATIONALE OF THE HIV AND AIDS PUBLIC EXPENDITURE REVIEW 2011

The main objective of the HIV and AIDS Public Expenditure Review (PER) 2011 is to assess expenditures on HIV and AIDS activities by the public and private sectors in Tanzania (Annex A). This includes an identification of gaps and recommendations on measures for ensuring a more effective contribution to the National Multisectoral Strategic Framework 2008–2012 (NMSF) and ways to enhance and explore public and private sector contributions to the HIV and AIDS response.

The Tanzania Commission for AIDS (TACAIDS) conducted an HIV and AIDS PER in 2010 covering the years 2007/08–2008/09. The PER 2010 found that the total of all expenditures on HIV and AIDS interventions by the government and development partners rose from TZS596 billion in 2007/08 to TZS643 billion in 2008/09. The share of foreign-funded interventions for the 2008/09 PER period was 97 percent of the total funding, rising from 95 percent in 2006/07. Funds from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which are off-budget, accounted for almost TZS463 billion (72 percent of the total) in 2009. The HIV and AIDS PER 2011 provides an update of these findings in order to accurately ascertain HIV and AIDS expenditure trends, which will inform the government on how to better ensure continued future funding for the response to the epidemic.

## I.2 METHODOLOGY

The PER 2011 review was conducted under the guidance of the Director of Finance and Administration, TACAIDS. Two consultants were contracted to lead the PER Team consisting of five staff members from TACAIDS.

The Finance and Audit Technical Working Committee (FATWC) served as a reference group for this activity. The FATWC is chaired by TACAIDS and is composed of representatives from United Nations (UN) institutions, the World Bank, civil society organizations (CSOs), ministries, the private sector, and bilateral donors. Members of the FATWC and members of the PER Team are shown in Annex B.

The Terms of Reference required the PER Team to assess the HIV and AIDS activities of seven ministries, departments, and agencies (MDAs), 10 Local Government Authorities (LGAs), donors, 10 private companies, and umbrella organizations (Annex C). The review from the sample presents a clear picture on trends in financing and spending to combat the HIV and AIDS epidemic.

The PER 2011 is an analysis of the current plan for HIV and AIDS-related activities and budget and expenditures for 2009/10 and 2010/11, with projections to 2014/15. The PER Team used both questionnaires and interviews with the sampled organizations to obtain data. Calculations are based on an extraction of all recorded government expenditures on Objective A, including regions, LGAs, and the whole budget of TACAIDS. The review is also based on interviews with national and local government officials, development partners, and representatives of CSOs and community-based organizations (CBOs). The review also used supplementary documents and data from a number of sources as listed in the reference list (Annex F).

## I.3 LIMITATIONS

The PER Team faced a number of difficulties that affected the interview process, data collection, and compilation of the PER. The first challenge related to untimely receipt or displacement of the questionnaires by MDAs. Three weeks before the field interviews, TACAIDS sent out in advance a "Letter of Introduction" and a questionnaire to MDAs, councils, donors, companies, and umbrella

organizations. The organizations had ample time to prepare before the PER Team visited them for data collection. Unfortunately, many of the letters never reached concerned partners, such as the Council's HIV and AIDS Coordinator (CHAC), the District's AIDS Control Coordinator (DACC), or the HIV coordinators in the ministries, and therefore they had not compiled the data in advance of the team's visit.

The second challenge related to the timing of the interviews. MDAs were busy completing their 2012/13 Medium-Term Expenditure Framework (MTEF) budgets. As a result, it was difficult to secure appointments with people at the selected ministries, and even when appointments were firm, these were cancelled without notification, delaying the data collection exercise.

## 2. ASSESSMENT OF RECOMMENDATIONS FROM THE HIV AND AIDS PUBLIC EXPENDITURE REVIEW 2010

The HIV and AIDS PER 2010 provided several recommendations to improve the functionality of the HIV and AIDS national response. The status of implementation to date is as follows:

Recommendations	Status of Implementation
<b>A) Strengthen coordination for efficient implementation of the NMSF</b>	
<p>1. Advocate for HIV and AIDS integration into all clusters in the revision of the National Strategy for Growth and Reduction of Poverty (MKUKUTA).</p>	<p>Several HIV and AIDS advocacy meetings were conducted during the preparation of MKUKUTA-II. The Ministry of Finance and Economic Affairs (MoFEA) prepared a concept note that was used as a guide for MKUKUTA secretariat. An independent consultant was recruited to promote inclusion of HIV and AIDS into MKUKUTA clusters. TACAIDS attended all cluster meetings. The outcome of the advocacy meetings are as follows:</p> <ul style="list-style-type: none"> <li>• HIV and AIDS is currently mainstreamed in two clusters of MKUKUTA, Clusters 1 and 2.</li> <li>• Under Cluster 1, the cluster strategy is to address HIV and AIDS issues through mainstreaming them into the core activities of key economic sectors.</li> <li>• Under Cluster 2, HIV and AIDS is found under Goal 3: improving survival, health, nutrition, and wellbeing, especially for children, women, and vulnerable groups. The implementation of the NMSF aims at attaining this goal by 2015.</li> </ul> <p><i>Further action needed:</i> Continue to advocate for HIV and AIDS integration into Cluster 3: Governance and Accountability – partly because HIV and AIDS erodes human capital, removing the trained and most-productive age groups from the workforce and diverting resources to care for the ill.</p>
<p>2. Ensure that HIV and AIDS coordinators at all levels (TACAIDS, focal persons at MDAs, Regional aids control coordinators (RACCs) at the regional level, and CHACs/DACCs at the local level) 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, and district levels. Closely link the HIV and AIDS coordinators to the Departments of Planning and Finance at Ministries, Regional Administrative Secretariats and Councils, for the needed oversight of available resources and the insight to be able to provide the management with strategic advice.</p>	<p><b>At the MDAs level:</b> TACAIDS staff were trained for two weeks in various institutions inside and outside the country in 2010/11 with the aim to improve their coordination skills and knowledge.</p> <p><b>At the regional level:</b></p> <ul style="list-style-type: none"> <li>• The Regional Coordinator of TACAIDS (RCTs)' capacity has been strengthened through various orientation workshops.</li> <li>• The roles and functions of the Regional administration (RA), Regional facilitation persons (RFPs), RACCs, and the RCTs have been better defined.</li> <li>• Regional Capacity Building Teams (RCBTs) have been formed and trained.</li> <li>• The NMSF Fund has been operationalized at the LGA and regional levels.</li> </ul> <p><i>Further action needed:</i> Continue to ensure the regional, council, and</p>

Recommendations	Status of Implementation
	ward/village levels have adequate financial resources to enhance their coordination tasks.
3. Provide the LGAs, Regional administrative secretaries and MDAs with comprehensive guidance to facilitate planning and implementation and enable better follow-up and monitoring of Objective A; disseminate the NMSF, the Community Planning Tool Against AIDS (COPTA) attached to the Obstacles and Opportunities for Development (O&OD), the minimum package, the assessment tool of CSOs, the prevention strategy, etc.	TACAIDS has been developing strategies and guidelines to facilitate LGA, Regional secretariat and MDA plans and implement and monitor implementation of the NMSF. In this regard, TACAIDS has: <ul style="list-style-type: none"> <li>• Revised mainstreaming Guidelines, training manuals, and planning tools.</li> <li>• Mainstreamed COPTA in O&amp;OD and is now ready to roll it out in the LGAs.</li> <li>• Developed a mapping tool for data collection from CSOs and distributed it to RCTs for CSO assessment.</li> </ul> <p><i>Further action needed:</i> Roll out COPTA in all LGAs.</p>
4. Release the NMSF grant in full and on time and allow LGAs the flexibility to decide how to use the funds within the scope of the NMSF and the attached guidelines. Enforce that the NMSF priorities are taken into consideration in planning, budgeting, and reporting at LGAs, regions, and MDAs.	The NMSF grant was released in full in the financial years 2009/10 and 2010/11 (100 percent of the budget). Flexibility on the use of funds by LGAs has been granted, as all LGAs are budgeting using the Essential Minimum Package (the national budget guidelines that are issued to be used by the LGAs), which does not prescribe how they should use the funds.
5. Map and assess strengths and weaknesses of CSOs at local, regional, and national levels. Assess the councils' comparative advantage in relation to CSOs operating in the district. Evaluate the overall impact of the councils' efforts to coordinate, prevent, care or mitigate the impact of the disease in their respective areas.	A mapping tool for data collection from CSOs has been developed and distributed to RCTs for CSO assessment. To date, more than 2,500 CSOs have been assessed in 21 regions. <p><i>Further action needed:</i> Continue efforts to reach more CSOs in the regions.</p>

## B) Enhance the involvement of civil society

1. Encourage the CSOs to work with committees (e.g., Council Multisectoral AIDS Committees [CMACs], Ward Multisectoral AIDS Committees [WMACs], and Village Multisectoral AIDS Committees [VMACs]), regional administrative secretariats, and ministries, including TACAIDS; influence these bodies to become more accountable to Tanzanians citizens and to development partners. Train CSOs on how to demand involvement, how to scrutinize the budget, and how to track expenditures. Recognize the CSOs' role as service provider but also as an accounting control mechanism and important for advocacy, capacity building, and communication.	<ul style="list-style-type: none"> <li>• At the council level, CSOs are represented in CMACs. At the regional level, CSOs are represented in RCBTs, and at the national level, CSOs are developing a mechanism called the National Steering Committee. Through the Rapid Funding Envelope (RFE) program called BOCAR, about 90 nongovernmental organizations (NGOs) including umbrella organizations are earmarked for capacity building training.</li> <li>• The development of expenditure performance profiles (EPP) encourages the involvement of CSOs, but in practice it is not implemented due to limited funds at the LGA level and inadequate skills among CHACs.</li> </ul> <p><i>Further action needed:</i> Undertake capacity building and training for CHACs.</p>
2. Pool the financial support for CSOs through existing channels such as the RFE or FSC and analyze and identify longer-term financing for CSO (e.g., basket funding or general budget support).	TACAIDS is advocating for increased support to the NMSF Grant Fund and RFE. For example, the UN Joint Program of support to Tanzania on HIV and AIDS (UNJP)-3 supported CSOs' capacity building through RFE in 2011/12.

	Recommendations	Status of Implementation
<b>C) Increase local financing</b>		
1.	Bring the high-level national political leaders' attention to the share of government budget and expenditures on HIV and AIDS and the implications of current expenditure levels and trends in relation to estimated needs. Improve public expenditure management and enforce budget classifications at all levels. Increase domestic revenue for sustainable financing of expenditures, e.g., in service delivery. Share best practices and provide guidance to the LGAs on income-generating activities.	<ul style="list-style-type: none"> <li>• The Cabinet Paper for the establishment of TACTF was discussed with the Secretariat of the Cabinet and will soon be discussed by the Permanent Secretaries.</li> <li>• The Parliamentarian HIV and AIDS Standing Committee was oriented in HIV and AIDS funding, gaps, and current efforts for establishing TACTF.</li> <li>• The whole Parliament was oriented on the funding for HIV and AIDS responses in Tanzania. The governance structures established at the decentralized level (such as CMACs) were part of the discussion, and the Members of Parliament recommended a way forward for improvement.</li> </ul> <p><i>Further action needed:</i> Follow up with relevant authorities to ensure fast-tracking of approval of TACTF.</p>
<b>D) Increase transparency, predictability, and alignment of funding</b>		
1.	Strive for maximum transparency and openness of information of current support to CSOs, LGAs, or MDAs.	<ul style="list-style-type: none"> <li>• Recipients of funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) for HIV and AIDS activities are currently found through the mechanism of advertising in the newspapers, and selection is done by a committee.</li> <li>• Transfer of funds under the NMSF grant to the LGAs and regions is advertised in the newspapers.</li> <li>• LGAs will be advised to consider more transparency for the funds transferred to CSOs.</li> </ul>
2.	Refuse money off-budget (or ensure that the off-budget support is captured by the government's system of exchequer dummies).	Discussion with the MoFEA was carried out. It was realized that it is difficult to capture funding in the government budgeting system if the actual funding is not implemented or passing through the government system.
3.	Request implementing partner to continuously inform and communicate with the concerned governmental body where the partner operates on what and how much is planned to be injected in respective geographic and thematic areas.	Sixty-one percent of implementing partners comply with the Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) for monitoring and evaluation (M&E). TACAIDS is making good progress in the implementation of TOMSHA and the National Database. <i>Further action needed:</i> Continue to make progress on this issue in subsequent fiscal years.
4.	Aim to commit support as long as possible for increased predictability of HIV/AIDS resources and use the government's own system for planning, control, auditing, and reporting.	TACAIDS commitment so far is to increase support by stakeholders using government systems. Establishment of TACTF will help to increase commitment.
<b>E) Focus on preventive interventions which are tailored to gender and to regions</b>		
1.	Reconsider the NMSF grant formula and create financial incentives for stronger attention to preventive interventions.	<ul style="list-style-type: none"> <li>• TACAIDS is planning a meeting with the Prime Minister's Office, Regional Administration and Local Government (PMO-RALG) to discuss how to improve guidelines for strengthening interventions at the LGA level.</li> <li>• Review of the NMSF grant allocation formula will be discussed in the FATWC.</li> </ul> <p><i>Further action needed:</i> Hold FATWC meeting to discuss the NMSF grant allocation formula and ensure the formula is consistently applied across all LGAs.</p>

	<b>Recommendations</b>	<b>Status of Implementation</b>
2.	Focus on population groups with disproportionately higher HIV incidence rates and focus on areas where there is the greatest potential for impact regarding HIV transmission. Divert resources to where they make the most impact and focus on synergies; aim to assess the impact and results.	<ul style="list-style-type: none"> <li>• A Gender Operational Plan has been developed to ensure that the focus on reducing impact among the groups with higher incidence is supported accordingly by designing appropriate programs based on their needs.</li> <li>• A Monitoring and Evaluation Plan for the Gender Operational Plan has been developed. Seventeen indicators have been established to track changes and measure results.</li> <li>• Funds have been allocated to undertake a Capacity Needs Assessment for Women Living with HIV networks and groups. The results will guide further resource allocation to address identified capacity gaps.</li> </ul>
3.	Address the societal norms, like gender-promoting values of masculinity and femininity, gender-based violence, and the widespread acceptance of multiple sexual partnerships.	The Gender Operational Plan is expected to be disseminated at all levels before the end of 2012, and councils will have to design work plans that are engendered, which means that the harmful norms such as patriarchy will be appropriately addressed.
4.	Tailor preventive interventions to gender differences and regional variations, in accordance with the drivers of the epidemic.	A Training of Trainers was conducted for the purpose of building capacity on gender-related interventions among the RCBTs, which in turn will support councils to ensure that gender-related issues are integrated into their MTEF. Funds have been allocated for gender training for RCBTs to be able to facilitate interventions at the regional level. Further, Shinyanga Region has been selected as a pilot region to implement comprehensive gender-related HIV interventions from which lessons and best practices will be drawn to scale up the interventions country-wide.
5.	Address the institutional weaknesses or systematic causes of women's and children's vulnerability to HIV.	During supportive visits, TACAIDS through the Monitoring and Evaluation Directorate has been assessing institutional and systemic weaknesses of women's and children's vulnerability to HIV. The focus has included employment and job advertisements that are not genuine (like those that say "women are encouraged to apply," but in actual fact a woman cannot apply for that job), and higher learning institutions (where there are more male dormitories compared to those of women). Addressing the institutional and systemic gender issues requires collective efforts from all sectors.

## 3. PERFORMANCE ASSESSMENT

### 3.1 THE MAGNITUDE OF THE HIV AND AIDS PROBLEM

The AIDS epidemic in Tanzania is generalized and severe, meaning it affects all sectors of the population. The economy has been adversely affected by the premature death of women and men in their prime years of productivity. This also affects the development of institutional capacity, which requires skilled workers and leaders. For example, professionals in medical care, education, agriculture, and engineering are not easily replaced. The demographic consequences of the epidemic are reflected in the country's quality of life indicators, including the increasing level of infant mortality and the decreasing life expectancy. The numbers are saddening (Table 3.1).

**TABLE 3.1: TANZANIA BASIC HIV AND AIDS STATISTICS (2010)**

Number of people living with HIV	2.3 million
of which HIV+ women	730,000
Children aged 0 to 14 living with HIV	160,000
Newly infected with HIV in 2009	100,000
Orphans due to AIDS aged 0 to 17	1.3 million
Deaths due to AIDS in 2009	86,000
HIV prevalence (2010)	5.7%

Source: UNGASS (2010); TACAIDS (2012); TACAIDS (2011b)

The epidemic's severity differs widely from region to region, with some regions reporting an HIV prevalence of less than 2 percent (Arusha, Manyara, Kilimanjaro, Kigoma, and Zanzibar) and others higher than 7 percent (Iringa, Dar es Salaam, Mbeya, Mara, and Shinyanga) (TACAIDS 2010).

### 3.2 DRIVERS OF THE HIV AND AIDS EPIDEMIC

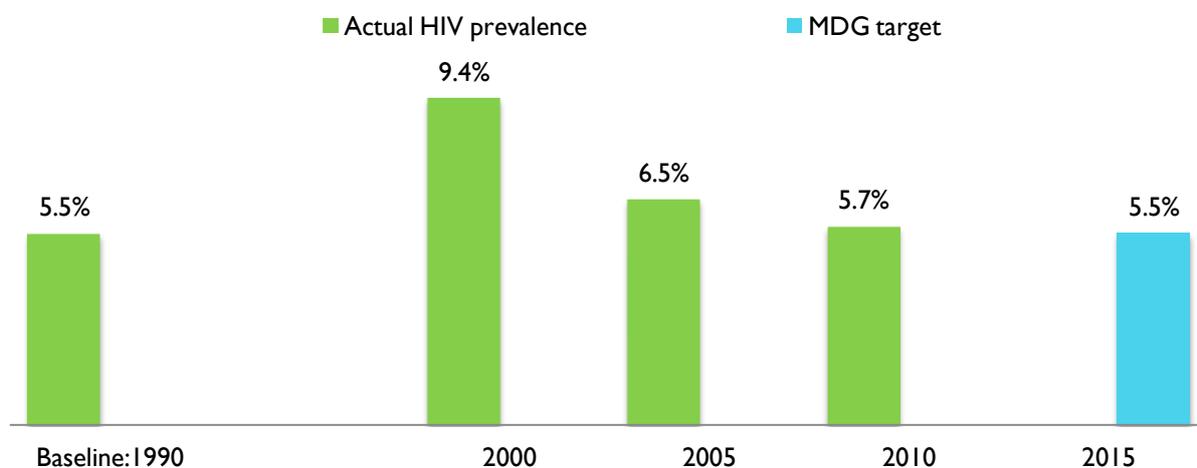
The main drivers of the epidemic are multiple concurrent sexual partnerships, early sexual debut, transactional and cross-generational sex, low and inconsistent use of condoms, low level of male circumcision, low levels of testing and disclosure of HIV status, mobility, mother-to-child HIV transmission, gender inequities, sexual violence, harmful sociocultural norms, and drug abusers (TACAIDS 2010). The primary underlying factors fuelling the epidemic are unsafe sexual behavior by males, on the one hand, and female subordination and lack of economic independence on the other. The most vulnerable group in Tanzania has been shown to be married women, who are the least likely to have protected sex and the most likely to be exposed to infection. Also exacerbating the spread of the epidemic are substance abuse such as alcohol consumption and local cultural practices such as widow "cleansing."

### 3.3 IS THE MONEY SPENT ON COMBATING HIV AND AIDS HAVING ANY IMPACT?

Although the epidemic is still severe, there are discernible successes. Progress has been made in reducing HIV prevalence in adults from 9.4 percent in 2000 to 5.7 percent in 2010, getting closer to the Millennium Development Goals (MDG) target of 5.5 percent (Figure 3.1). The prevalence rate among women declined from 7.7 percent in 2003 to 6.3 percent in 2007, while that among men dropped from 6.8 percent to 4.7 percent in the same period. HIV prevalence rates among youth

have dropped quite substantially; from 4.0 percent to 3.0 percent among young women in the 15–24 years age group and from 3.6 percent to 1.1 percent among young men in the same age group.

**FIGURE 3.1: ACTUAL HIV PREVALENCE RATE IN TANZANIA, POPULATION AGED 15–49 YEARS**

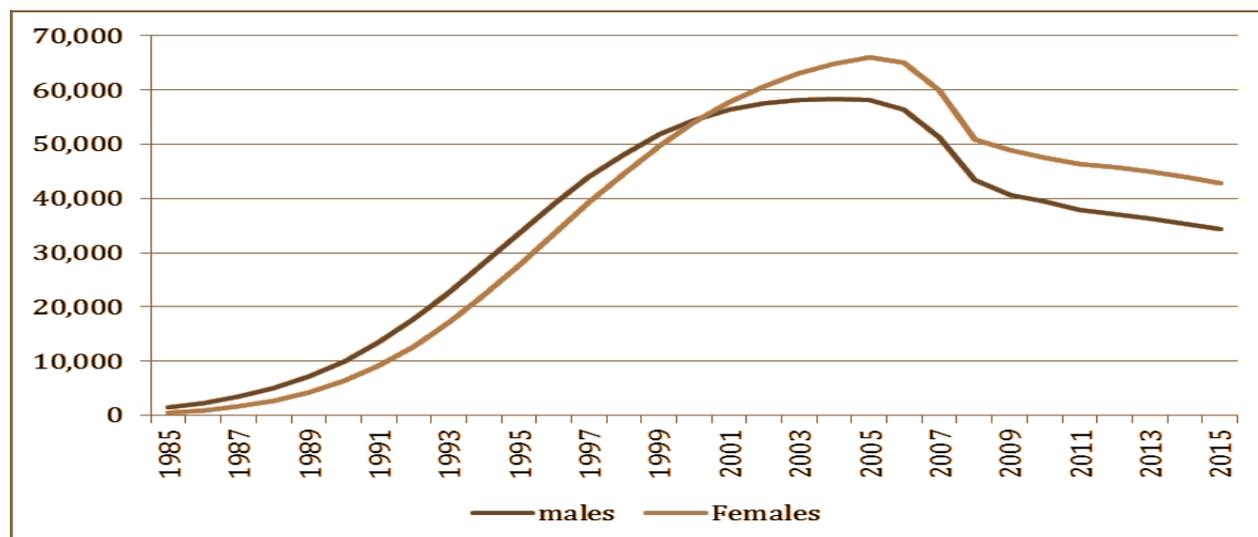


### 3.4 ACHIEVEMENTS AND CHALLENGES IN THE HIV AND AIDS NATIONAL RESPONSE

The main achievements are:

- Annual AIDS deaths have begun to decline (Figure 3.2).

**FIGURE 3.2: ESTIMATED ANNUAL AIDS DEATHS**



- By the end of 2012 it is planned that 60 percent of males and females aged 15–49 will be receiving home-based care and treatment services (HBC), and will know their HIV status through making the services available in 3,039 health facilities and introducing home-based counseling and testing in 30 percent of the districts. In 2010 there were 1,035 sites providing voluntary counseling and testing (VCT) and 15 percent of the adult population (women and men 15–49 years) knew their HIV status. This level is still low, but gradually increasing.
- The access to HIV and AIDS counseling, treatment, and care is strongly related to the health

care system in general, and care and treatment for HIV has shown significant performance improvement. Antiretroviral therapy (ART) is currently provided in 700 health facilities. As of March 2010, 219,800 people living with HIV and AIDS (PLWHA) have been enrolled for ART, which accounts for 55 percent of the people in need of treatment. Scaling up access toward universal coverage is the principle aim of the government.

- The program to Eliminate Mother-to-Child Transmission of HIV and AIDS (eMTCT) has increased since 2005, but coverage remains fairly low despite a rapid increase in the number of sites. For example, in 2011 there were 3,029 health facilities providing eMTCT. Among the 127,920 estimated HIV-positive pregnant women in 2009, 70,944 received antiretroviral (ARV) prophylaxis (55 percent coverage). Forty percent of infants born to those HIV-tested pregnant women received ARV prophylaxis and among infants born to mothers who tested positive, less than 50 percent received post-natal prophylaxis.
- Condom procurement and use is increasing. Plans are to raise the annual number of male condoms distributed from 150 million in 2007 to 250 million by the end of 2012, and substantially increase the number of female condoms distributed. Condom procurement, promotion, and distribution are implemented on the Tanzania mainland and in Zanzibar by the government, Population Services International (PSI), and the Tanzania Marketing and Communications Company Ltd. Other CSOs are also involved in condom promotion and distribution. There has been a progressive increase in the number of male and female condoms distributed in the commercial and public sectors, as well as through the 32,000 social marketing outlets across the country.
- All public hospitals and health centers provide sexually transmitted infection (STI) services. About 67.2 percent of the service providers have been reported to be able to provide appropriate STI treatment to their clients. In rural areas, 66 percent of dispensaries offer quality STI services.
- The overall goal of the blood safety program in Tanzania is to ensure that 100 percent of blood units donated are screened for HIV. The government continues to ensure all the units in the national blood supply bank are HIV-free.
- School HIV prevention programs have been scaled up. In 2009/10, it was estimated that 58 percent of secondary schools and 73 percent of primary schools provided life skills-based HIV education, based on the number of primary and secondary school teachers trained. The Ministry of Education and Vocational Training (MoEVT) trained 22,410 primary school teachers and 4,295 secondary school teachers up to 2010, which accounted for 72 percent and 58 percent of teachers targeted for training, respectively.
- The government continues to care for orphans and vulnerable children (OVCs). Projected number of OVCs in the country for 2007 and 2010 were 946,615 and 1.04 million, respectively. Service coverage to the OVCs is low, about 42 percent, and only 98 councils provide assistance to OVCs. All local governments should endeavor to ensure protection and care of the OVCs in their jurisdiction.

- One of the biggest challenges facing the HIV and AIDS national response is inadequate numbers, skills, and retention of human resources for health, especially in rural areas. Overall, the health system requires 55,404 staff, but it is now operating with only 21,424 (38 percent of the required human resources for the sector). This affects efforts directed at rapid acceleration of the ART roll-out, the achievement of the set targets in the NMSF grant and national plans, and also has an impact on the quality of services provided, especially in rural health centers and clinics.

### 3.5 POLICY AND PROGRAMMATIC RESPONSE TO THE CHALLENGES

Tanzania has taken two important measures to strengthen policy implementation that have direct implications for the HIV and AIDS national response. The first is the development of the Global Health Initiative Strategy 2010–2015 and the second is the eMTCT Strategic Plan. These two national responses are aligned to the Tanzania mainland policy and programmatic responses currently being implemented, which includes the third Health Sector Strategic Plan (HSSP-III, 2009–2015), which was developed in line with the goals of MKUKUTA-II (2010/11–2014/15), the National Health Policy 2007, and the MDGs.

Under TACAIDS coordination and leadership, costing of the NMSF has been completed. An average cost of USD852 million (TZS1.2 trillion) per year will be required to implement the NMSF. This translates to TZS42,000 per capita or TZS1.5 million per PLWHA. These are substantial amounts of resources that need to be mobilized.

A big challenge facing Tanzania is that over 97 percent of the HIV and AIDS national response is funded by donors. Given the adverse effects of economic hardship in Tanzania, budget cuts by donors could affect the provision of ARVs and other medical supplies in the future and worsen health worker shortages. Moreover, capping of PEPFAR funding in 2010, and reduced funds available from the Global Fund, will likely make it difficult for Tanzania to expand treatment and care services unless the domestic budget for HIV and AIDS is increased. Worse, the current funding decline may result in an increase in new infections, due both to downturns in effective prevention programming and a stagnation or decline in treatment access. An increase in new infections and decrease in treatment access would have grave implications for maternal and child mortality, which could increase and potentially wipe out the gains achieved in the last decade through massive injections of donor financing for the national response.

## 4. DEVELOPMENT PARTNERS' SUPPORT TO TANZANIA'S HIV AND AIDS NATIONAL RESPONSE

Tanzania's HIV and AIDS national response is over 97 percent dependent on foreign financing. Two sources account for 86 percent of the donor financing: PEPFAR (67 percent) and the Global Fund (19 percent). In 2011, the Global Fund cancelled its next round of new funding proposals until 2014 due to financial constraints arising largely from the failure of donors to meet their financial commitments to the Global Fund.

Over 80 percent of the foreign funding does not appear in Tanzania's government budget and is instead managed by the donor governments or their implementing partners. This means that it is not always necessarily aligned with the goals set out in Tanzania's National Policy on AIDS or priorities determined by the country's NMSF. For example, less than a quarter of PEPFAR and Global Fund money in Tanzania is spent on prevention despite the government inclusion of prevention as the key focus of the NMSF (TACAIDS 2007).<sup>1</sup> This has implications for country ownership of the national response, including its stewardship. This section reviews the main external sources of funding for the HIV and AIDS response in Tanzania.

### 4.1 UNITED STATES GOVERNMENT FUNDING THROUGH PEPFAR

#### 4.1.1 BACKGROUND

PEPFAR was initiated in 2006. Since then, Tanzania has received more than USD1.0 billion to combat the HIV and AIDS epidemic. In Tanzania PEPFAR is managed by five U.S. agencies and implemented by a large number of partners and subpartners. In 2006, a regional division of ART implementing partners was adopted in order to simplify coordination of PEPFAR programs as well as to reduce the risk of overlap and duplication. The management and staffing costs for the PEPFAR program are currently around 4 percent of the overall budget, but these costs do not include implementing partners' actual cost for management and overhead costs.

The PEPFAR support to Tanzania by thematic area shows that the largest support goes to treatment, about 63.5 percent or an average of USD200 million in the past three years (but declining). Support to prevention activities is increasing, with its share being about 22.6 percent of the resources. Funding channeled to crosscutting issues such as gender and program management is increasing, averaging 14.9 percent of the total support.

The PEPFAR treatment component supports purchasing of ARVs for the national program. In particular, the package of care and treatment services that the U.S. government supports includes: support for retention in care/treatment and adherence, management and prevention of opportunistic infections (OIs), and support for nutritional assessment and supplementation. Interventions to reduce the risk of HIV transmission are incorporated into programming. PLWHA benefit from

---

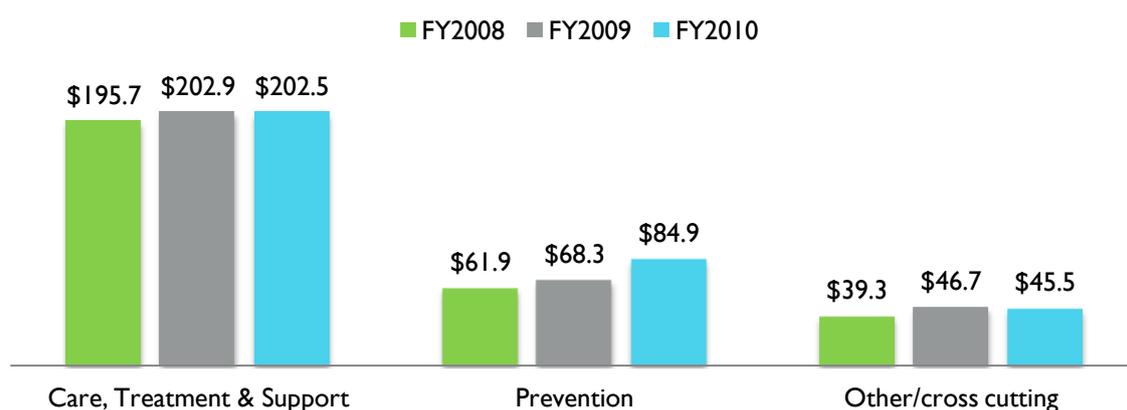
<sup>1</sup> According to a PEPFAR official, PEPFAR programs are fully aligned with the government of Tanzania's NMSF through the Tanzania Partnership Framework Agreement. PEPFAR broadly supports all six thematic areas. PEPFAR funding is *off-budget* and is not reflected in the government's exchequer system, although the funding is reported to the Aid Management Platform in the MoFEA.

programs focused on economic strengthening. Care interventions have consistently maintained around 24 percent of the budget allocation during the last three years. The components of the U.S. government's care program are HBC, pediatric care and support, care for OVCs, and tuberculosis (TB) and HIV. Counseling and testing is included under the category of care services.<sup>2</sup> During 2009/10, PEPFAR introduced specific budget codes for male circumcision, intravenous and non-intravenous drug use, and pediatric care, support, and treatment in order to better capture existing program resources being used in these areas.

#### 4.1.2 FUNDING LEVELS FOR THE HIV AND AIDS NATIONAL RESPONSE

The U.S. government through PEPFAR is the largest financier of the Tanzania HIV and AIDS program, disbursing an average of USD315.5 million per year or over 67 percent of external resources between 2008/09 and 2010/11. The NMSF thematic areas support are shown in Figure 4.1.

**FIGURE 4.1: PEPFAR SUPPORT BY THEMATIC AREAS (MN USD)**



Source: Authors' calculations based on PEPFAR reports

Treatment and care is allocated the largest share, about 63.5 percent of the resources, followed by prevention 22.6 percent. The remaining funding is allocated to crosscutting issues, including leadership support (3.5 percent), procurement support (4.5 percent), human resources improvement (3.5 percent), and evidence-based research/assessments (1.5 percent) and others (1.9 percent).

The number of PEPFAR-supported care and treatment clinics has grown from 15 in 2004 to 605 in 2009. During 2009/10 alone, the U.S. government directly supported 473,533 PLWHA with care and support services, including 427,731 PLWHA who received care in facilities, 136,221 PLWHA who received services through HBC programs, and a growing proportion of persons who received both. In addition, the U.S. government directly supported 197,412 people on ARVs in Tanzania.

Government of Tanzania-approved second-line and alternative first-line treatment regimens lack drugs that are both U.S. Food and Drug Administration (FDA) - and Tanzania Food and Drugs Authority (TFDA)-approved. As a result, U.S. government procurement of generic ARVs in 2009 was only 11 percent of the total national ARV procurement. Now that there are generic antiretroviral drugs such as Tenofovir Disoproxil Fumarate (TDF)-based products tentatively approved by the FDA and registered with TFDA, it is expected that the U.S. government's generic procurements will increase significantly.

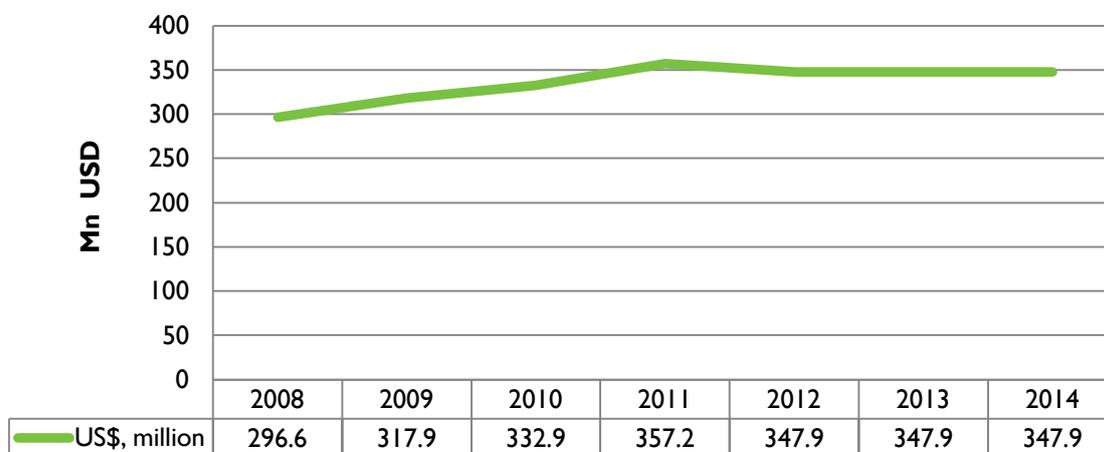
HIV test kit procurements are to a large extent supported through the Global Fund and Japan International Cooperation Agency (JICA), while U.S. government support focuses on technical

<sup>2</sup>Counseling and testing is defined by the NMSF as a "prevention" activity.

assistance to the Ministry of Health and Social Welfare (MoHSW) for planning and forecasting as well as small emergency procurements.

Resource projections show the U.S. government will continue to support the HIV and AIDS national response at about USD347.9 million per year, a 9.3 percent decrease from the 2010/11 level (Figure 4.2)

**FIGURE 4.2: PEPFAR FUNDING PROJECTIONS**



Source: Authors' calculations based on PEPFAR reports

### 4.1.3 PEPFAR IMPLEMENTING PARTNERS

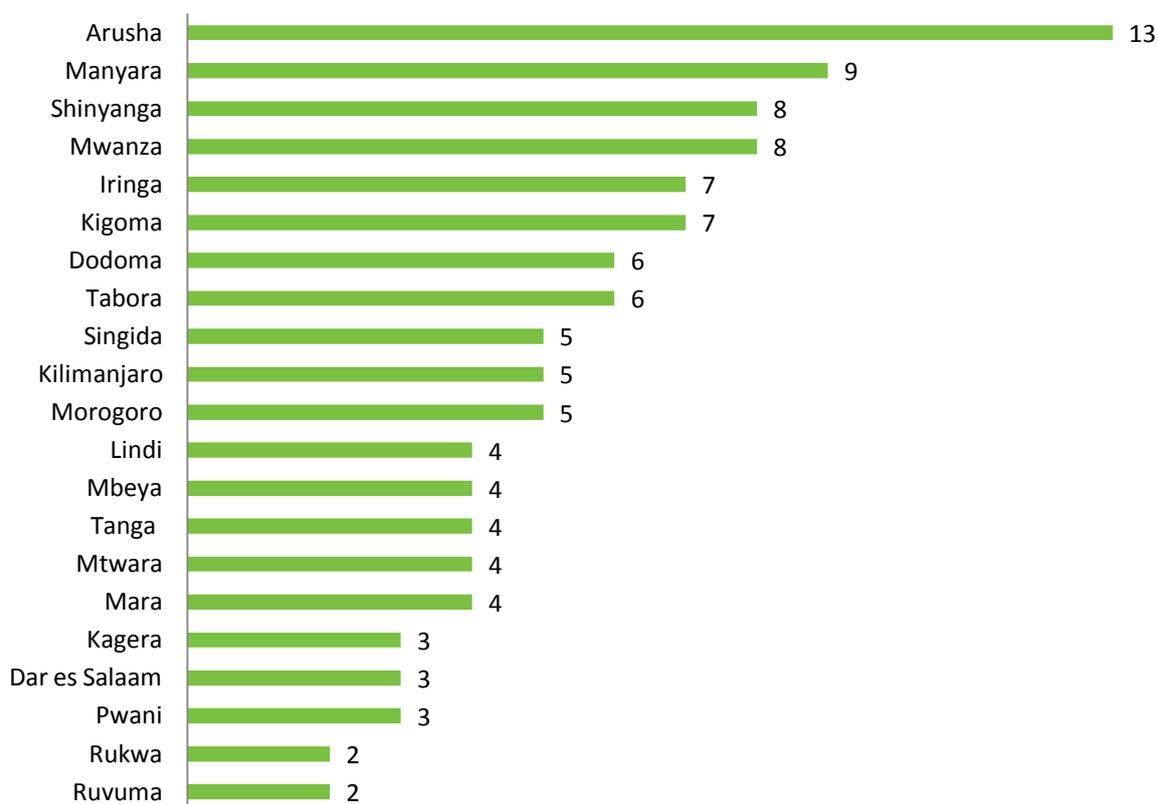
All U.S. government support to Tanzania is off-budget. U.S. government support is implemented through a large number of PEPFAR implementing partners, some of which are based in the United States, and which provide essential logistics and guidance. There are two categories of PEPFAR partners operating in Tanzania – the first category provides services at local level, and the second at both the local and national levels. A brief summary of these two categories is attempted below with the help of data from the PEPFAR office and the National Health Accounts (NHA) (NHA 2012).

#### PEPFAR implementing partners at the local level (regions/districts)

There are over 22 PEPFAR implementing partners in the regions/districts. Some of these partners provide services to more than 10 regions (Pharm Access, JHPIEGO, Engender Health, and Elizabeth Glaser). Others provide services to 4–10 regions (Africare, PACT, Intra Health, Family Health International, Savannas Forever, Deloitte, Baylor College of Medicine, and Johns Hopkins University). The remaining partners provide services to less than 4 regions (African Wildlife Foundation, Pediatric AIDS, Jane Goodall Institute, University of Rhode Island, World Education, and ZTC).

The PEPFAR implementing partners are not uniformly distributed to the regions/districts in Tanzania. Some districts have more than 6 partners and as many as 13 (Arusha) while others have less than 3 partners (Rukwa and Ruvuma, Figure 4.3). This means PEPFAR resource spending in Tanzania is not geographically equitable and does not follow the severity pattern of the epidemic (Annex D).

**FIGURE 4.3: REGIONAL DISTRIBUTION OF PEPFAR PARTNERS IN TANZANIA**



Source: Authors' calculations based on PEPFAR reports

**What was the amount of money disbursed to PEPFAR implementing partners at local and national levels?**

In 2009/10 a total of nearly USD88.3 million was disbursed to implementing partners at the local level (Annex C). This is equivalent to about 23.5 percent of PEPFAR funds channeled to support the HIV and AIDS response in Tanzania. During the same period (2009/10), a total of USD287.2 million was disbursed to implementing partners working at both the local and national levels (Annex C). This is equivalent to about 76.5 percent of PEPFAR funds provided to support the HIV and AIDS response in Tanzania.

As shown in Annex C, the total amount disbursed to PEPFAR implementing partners is USD375,578,968. This level of resources is about 67 percent of the total spending of the HIV and AIDS national response, but it is largely off-budget – without much oversight or control by the government of Tanzania.

**Recommendation:** The U.S. government and the government of Tanzania are in the process of negotiating the Partnership Framework Implementation Plan that will describe how funding is allocated by goal, targets, and contributions of the U.S. government and government of Tanzania. It is essential during these negotiations to ensure equitable geographical allocation of resources and implementing partners as well as foster greater transparency in the disbursement of funds. In particular, all U.S. government funding should be reported to the **Aid Management Platform** in the MoFEA as a “Dummy” (just for record purposes) even if the funding is off-budget and is not

reflected in the government's exchequer system. Implementing partners at the district level should submit progress being made in implementing their respective HIV and AIDS activities to the CMAC for consolidation with other interventions in the district.

## 4.2 GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA

The Global Fund is the second largest financier (after PEPFAR) of Tanzania's HIV and AIDS national response. As of August 2010, the Global Fund had approved a total of USD986.28 million in 7 rounds of 12 different grants. The disbursements, however, have been low, about USD601.6 million or 61 percent of the total Global Fund grants to Tanzania. The grants include: Round 1, HIV/AIDS, Malaria, and Rolling Continuation Channel; Round 3, HIV/AIDS and TB; Round 4, HIV/AIDS and Malaria; Round 6, TB; Round 7, Malaria; Round 8, HIV/AIDS and Malaria; and Round 9, Malaria and Health Systems Strengthening (HSS).

The following is a brief overview of the Global Fund grants related to the HIV and AIDS national response:

**Global Fund Round 3** focused on HIV and TB programs. Of the approved budget of USD83.4 million for scaling up VCT, only USD54.8 million (or 66 percent) has been disbursed. The round was supposed to close in October 2009 but had a non-cost extension until April 2010. The grant provided support for scaling up TB/HIV programming in 45 districts under PMO-RALG. TACAIDS, African Medical and Research Foundation (AMREF), and Christian Social Support Commission (CSSC) also have a number of recipients under them, including NGOs and faith-based organizations (FBOs).

**Global Fund Round 4** focused on HIV and AIDS interventions: USD283 million was approved and USD227.8 was disbursed (80 percent) to the four recipients (MoFEA, AMREF, Pact, and PSI). The round ended on October 2010. The project aims at filling five critical gaps in scaling up the national response: (1) impact mitigation for OVCs; (2) adequate supply of condoms; (3) support for the National Care and Treatment Plan; (4) initiating a new system for monitoring ART programs; and (5) national coordination of multisectoral partners. TACAIDS is responsible for coordinating the national response and 63 councils are benefiting from these funds. Other implementing partners include AMREF, which supports the care and treatment activities of the MoHSW, PSI which supplies condoms; and Pact in collaboration with the Department of Social Welfare at MoHSW which supports impact mitigation for OVCs. A number of partners (CSOs) are implementing the project under AMREF, PSI, and Pact.

**Global Fund Round 6** focused on TB but with HIV prevention and treatment components designed to cover 31 districts. Total disbursement by August 2010 was USD16.5 million. This is a five-year project and implementation began in November 2007. Of the total grant, TZS12 billion was disbursed during 2007/08 and 2009/10 and distributed as follows: 29 percent to districts, 11 percent to the regions (Regional Medical Offices), and the remaining 60 percent to the national level (National AIDS Control Program [NACP], Medical Stores Department [MSD], etc.). Phase II is waiting for approval.

**Global Fund Round 8** started in 2010 and has focused on HIV and AIDS and Malaria. MoFEA and AMREF are the principal recipients. Tanzania requested more than USD500 million but only USD121 million (24.2 percent) was approved, of which Tanzania has received a disbursement of USD1 million. The HIV and AIDS component is titled "Sustaining the Momentum: The March towards Universal Access to HIV and AIDS Services in Tanzania." The component has three goals: (1) sustaining the HIV and AIDS response; (2) catalyzing funding to identify and unlock systemic bottlenecks; and (3) strengthening implementation coordination. This includes strengthening of HIV

and AIDS key implementing institutions and umbrella organizations<sup>3</sup>. The grant is distributed as follows: 91 percent to the MoHSW, 7 percent to TACAIDS, and 2 percent to PMO-RALG which supports 16 councils. The grant to the MoHSW is divided among several units but the main recipient is MSD, which receives almost 87 percent of the money. Health products, equipment, and pharmaceutical products are supposed to be procured and purchased by MSD. The support to TACAIDS of USD8.2 million is used for strengthening the national-level multisectoral coordination. It is unclear how the LGAs were selected and why funds are allocated equally to the LGAs instead of using a formula. Round 8 has a pipeline of USD120 million up to 2015/16 that can be used to provide grants to the remaining LGAs that have not benefitted from Global Fund support.

**Global Fund Round 9** focused on HSS starting in 2011. This is a five-year project valued at USD176 million. The project funds five health systems objectives: (1) production of health care workers (USD57.8 million); (2) health worker recruitment and retention (USD44million); (3) HSS information systems (USD29.5million); (4) medical products, vaccines, and technology (USD21million); and (5) leadership and management (USD23.3million). Tanzania was not successful in its Global Fund Round 9 HIV and AIDS application titled “Enhancing HIV Prevention Services in Tanzania.”

In November 2011, the Global Fund announced that its next scheduled funding round is cancelled and that no new grants could be funded until 2014. Despite Tanzania having an HIV and AIDS Global Fund Round 8 pipeline as observed above, this news severely hurt Tanzania at a time when there are signs of real progress that has started to generate the most widespread optimism in the country’s history of the AIDS epidemic. Now, *all hopes of entering a new phase of the HIV response are effectively put on hold until at least 2014, and progress on many fronts may actually be reversed due to shortage of funding. The effects on individuals and communities will be devastating.* It is therefore of utmost importance for all implementing organizations and the principal recipients to work hard to make sure that all previous Global Funds rounds are fully utilized and disbursements are up to date through proper and expeditious spending.

### 4.3 UNITED NATIONS AGENCIES

The UNJP of support to Tanzania on HIV and AIDS is an integral part of the One UN Program, which brings the comparative advantage of each agency for more effective support of national priorities. By “working as one” on HIV and AIDS, the UN pools resources and technical expertise so as to become more effective in its contribution to the national response Performance of the UNJP is shown in Table 4.1. Execution has been over 73 percent over the past three years.

**TABLE 4.1: ONE UNJP ON HIV/AIDS, BUDGET VS. ACTUAL (MN USD, %)**

2007/08			2008/09			2009/10		
Budget	Actuals	Execution	Budget	Actuals	Execution	Budget	Actuals	Execution
11.2	9.1	81%	11.6	8.5	73%	15.2	11.5	76%

Source: Authors’ calculations from -UNAIDS (2007/08-2009/10).

Projections indicate reduced funding by the UNJP, which is expected to provide only USD2,463,000 between 2011/12 and 2014/15, or an average of USD615,750 per year, of which 50.6 percent will be provided by UNAIDS.

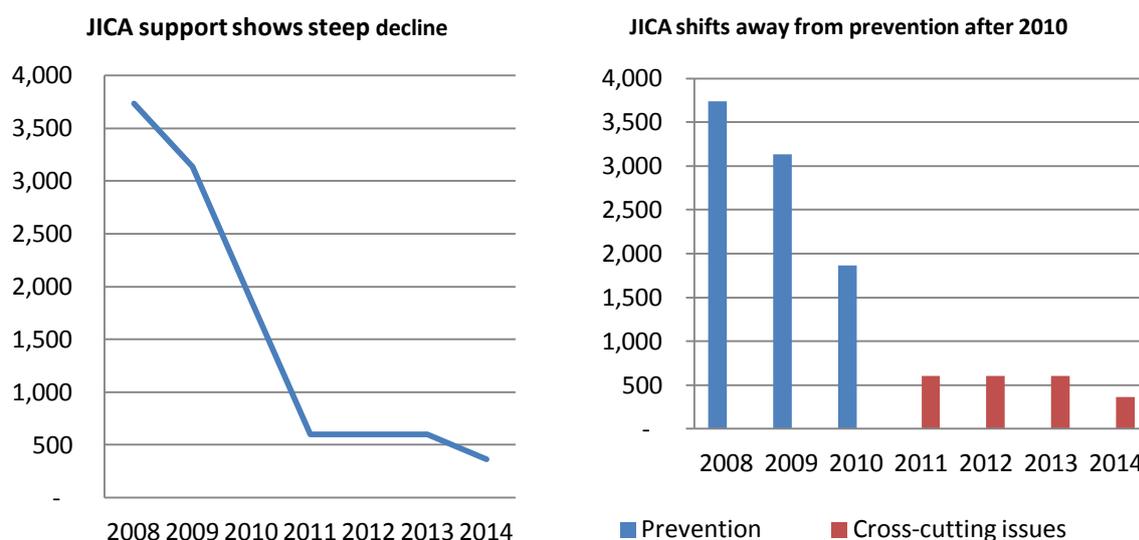
<sup>3</sup> Tanzania National Coordination Mechanism (TNCM), TACAIDS, National AIDS Control Program (NACP), Association of Private Health Facilities in Tanzania (APHFTA), AIDS Business Coalition of Tanzania (ABCT), National Muslim Council of Tanzania (BAKWATA), Christian Social Services Council (CSSC), and National Council of People Living with HIV/AIDS (NACOPHA).

The UNJP provides support to all the NMSF thematic areas. Prevention is accorded priority (45 percent), followed by crosscutting issues (e.g. fighting stigma, discrimination, and advocacy). Care, treatment, and support are allocated 5 percent of the resources, and impact mitigation is allocated 10 percent. Projections indicate these thematic allocations are likely to remain until 2014/15.

#### 4.4 JAPAN INTERNATIONAL COOPERATION AGENCY

Until 2010, the Japanese government through JICA and the Japanese Grant Aid Project was supporting the Tanzanian government in procurement of HIV test kits and STI drugs for about JPY550 million or USD6.628 million. At the same time, JICA has provided technical cooperation to NACP on capacity development in HIV prevention (VCT, STI, etc.) and strengthening the M&E system. Although the Grant Aid Project ended in 2010 and JICA will no longer be supporting the procurement of equipment, JICA will continue supporting NACP's capacity development until 2014 at an average funding of USD 542,300 per year (Figure 4.4).

**FIGURE 4.4: JICA SUPPORT (1,000 USD)**



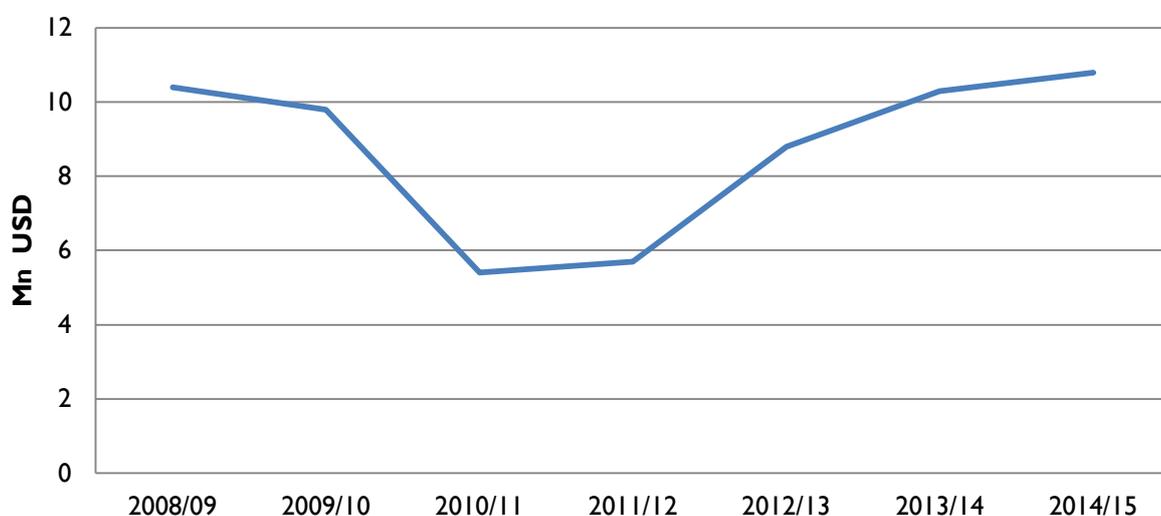
Source: Authors' calculations based on JICA questionnaire information response, May 2012

#### 4.5 CANADIAN INTERNATIONAL DEVELOPMENT AGENCY

The Canadian government through Canadian International Development Agency (CIDA) provides support to the NMSF with an initial grant of CAD20 million (USD19.6 million). CIDA also contributes about 10 percent of the total UNJP funds on HIV and AIDS. The Marie Stopes organization also continues to receive support from CIDA to spend on public-private partnership in the health sector in 13 districts. The new CAD45 million (USD44million) NMSF grant started in 2010/11, of which USD5.4 million was disbursed in 2010/11 and USD5.7 million in 2011/12. Canada and Denmark are the only two countries supporting the NMSF pool fund (Figure4.5).

Execution of the NMSF grant is over 95 percent of the total resources budgeted and accounting follows government structure and processes.

**FIGURE 4.5: INCREASING CANADIAN NMSF SUPPORT SINCE 2011/12**

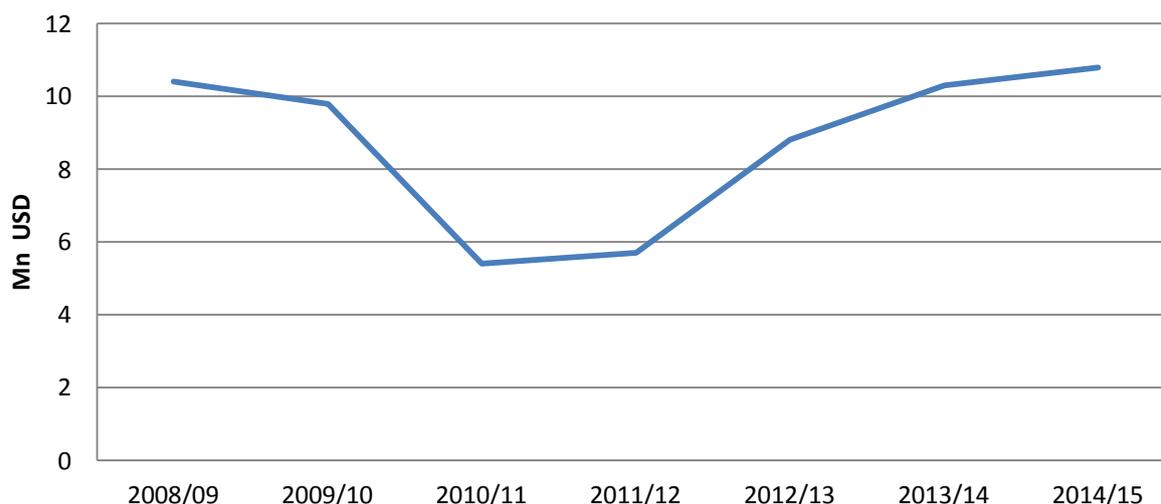


Source: Authors' calculations based on CIDA information

## 4.6 GERMANY DEVELOPMENT COOPERATION

The Germany Development Cooperation (GIZ) in Tanzania has an HIV and AIDS component under its “Tanzanian German Program to Support Health.” Support is provided to the regions of Lindi, Mbeya, Mtwara, and Tanga, largely in the area of prevention services: HBC; distribution of information, education, and communication materials; training; management of STIs; pediatric and eMTCT counseling; peer education in primary schools; provision of learning materials; etc. The German–Tanzanian agreement signed in 2010 provides EUR30 million (USD25.3million) up to 2013 for HIV and AIDS support and an additional EUR14 million (USD17.7million) for technical cooperation. The trend in German support is shown in Figure 4.6.

**FIGURE 4.6: GERMAN SUPPORT FLATTENS SINCE 2011**



Source: Authors' calculations based on GIZ data

In the future, GIZ will most likely continue to support the links between sexual and reproductive health (SRH) and HIV services, prevention activities among young people, and quality improvements of HIV-related services. However, the exact focus of GIZ's work will only be determined after the government negotiations scheduled to commence in mid-2012.

#### **4.7 THE WORLD BANK**

The World Bank through the Tanzania Multisectoral AIDS Program (TMAP) disbursed USD70 million between 2003 and 2010 in support of the national response. This support ended in March 2010. TMAP was designed both to scale up the national response to HIV and AIDS through community-based initiatives, and to mainstream HIV and AIDS into workplace programs of all LGAs and line ministries. The closure of this World Bank support has left a big financing gap that is yet to be addressed by other financing sources.

In 2012 the World Bank began to prepare a roads project to rehabilitate the TANZAM corridor from Dar es Salaam to the borders of Zambia and Malawi. In this project the World Bank plans to allocate USD5 million to support HIV and AIDS interventions along the TANZAM corridor.

#### **4.8 THE CLINTON FOUNDATION**

The Clinton Foundation provided USD2.8 million in 2007/08–2009/10 to support care and treatment operations in two southern regions of Tanzania (Lindi and Mtwara). This support has ended, leaving a financing gap that has yet to be filled.

#### **4.9 CIDA AND THE DANISH INTERNATIONAL DEVELOPMENT AGENCY**

The governments of Canada (through CIDA) and Denmark (through the Danish International Development Agency [DANIDA]) are expected to provide USD87.8 million (2012/13–2016/17) in support of the HIV and AIDS national response. These agencies support a pooled NMSF Fund which

provides support for district governments' nonmedical, multisectoral HIV and AIDS activities. DANIDA also supports capacity building of TACAIDS and MSD. CIDA is also supporting a multidonor health workforce initiative.

## 4.10 OTHER SOURCES

Other development partners that deliver support to Tanzania's HIV and AIDS program interventions in recent years (2007/08–2010/11) include: Norway (USD11million), Ireland (USD4.9million), and the U.K (USD3.3million). *Some of these supports have ended or are in the process of winding down, placing further strain on the financing of the country's HIV and AIDS national response.*

## 4.11 SUMMARY OF THE DONOR FINANCING OF THE HIV AND AIDS PROGRAM

As Table 4.2 and Figure4.7 show, development partners' support to Tanzania's HIV and AIDS national response peaked in 2009 but has been declining since then. Some partners have ended their support or are in the process of winding it down.

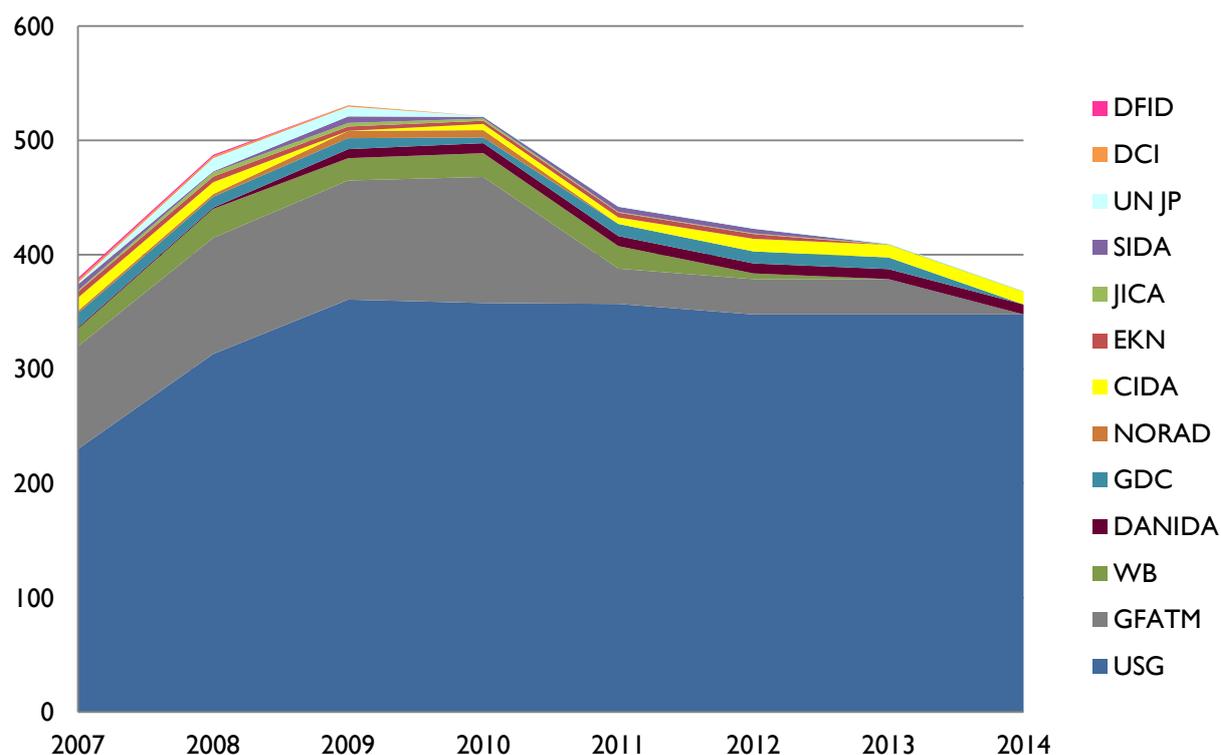
**TABLE 4.2: FUNDS FOR HIV AND AIDS BY DONOR, 2007–2010 AND FORECAST TO 2014 (MN USD)**

Development Partner	2007 Actual	2008 Actual	2009 Actual	2010 Actual	2011 Proj.	2012 Proj.	2013 Proj.	2014 Proj.
PEPFAR (U.S.)	230.30	313.40	361.00	357.97	357.19	348.00	347.98	348.00
Global Fund	89.90	101.60	104.20	110.30	30.90	30.90	30.90	30.00
World Bank	15.40	25.30	19.50	20.80	19.70	5.00	0	0
UNJP	1.60	11.50	8.50	0.71	0.63	0.61	0.61	0.61
DANIDA (Denmark)	1.10	1.10	7.90	8.76	8.76	8.76	8.76	8.76
CIDA (Canada)	11.40	10.40	-	5.40	5.70	11.00	11.00	11.00
GIZ (Germany)	12.50	9.60	9.60	5.00	10.60	10.50	10.20	0
SIDA (Sweden)	5.30	0.80	5.70	1.50	4.50	4.00	0	0
EKN (Netherlands)	5.30	4.90	3.80	2.80	4.20	4.20	0	0
NORAD (Norway)	2.10	2.30	6.40	6.40	1.00	0	0	0
JICA (Japan)	1.10	3.74	3.13	1.87	0.60	0.60	0.60	0.36
DCI (Ireland)	2.00	1.70	1.20	0	0	0	0	0
DFID (U.K.)	2.00	1.30	0	0	0	0	0	0
Total (Mn USD)	380.00	487.60	530.90	521.50	442.80	423.50	410.10	398.70

Source: Authors' calculations based on data provided by development partners or from other sources including PER 2009/10.

Source: Authors' calculations based on Table 4.2

**FIGURE 4.7: DEVELOPMENT PARTNER'S SUPPORT IS DECLINING (MN USD)**



Since development partners finance over 97 percent of the HIV and AIDS program in Tanzania, the declining levels of resources as shown in Figure 4.7 poses a big threat and may reverse the gains already achieved in combating the spread of the HIV pandemic. This clearly demonstrates that the country's financing strategy is not sustainable. The only way out is to mobilize additional domestic resources for the HIV and AIDS national response. In this regard, it is important for the government to fast-track approval for the legal establishment of the proposed TACTF.

#### 4.12 SUMMARY OF ACTUAL TOTAL SPENDING ON HIV AND AIDS, PROJECTIONS, AND RESOURCE GAPS

Actual spending on the HIV and AIDS national response is summarized in Table 4.3.

**TABLE 4.3: TOTAL REAL EXPENDITURE ON HIV AND AIDS (BNTZS)**

	2006/07	2007/08	2008/09	2009/10	2010/11
Government	22.0	23.0	14.0	12.5	11.0
Development partners	282.0	383.3	566.9	566.3	431.8
Total	304.0	406.3	580.9	578.8	442.8
% of total from donors	92.8%	94.3%	97.6%	97.8%	97.5%
% of total from government	7.2%	5.7%	2.4%	2.2%	2.5%

Source: TACAIDS (2012) and Table 4.2

The government contribution to the national response is low and must be scaled up to reduce donor dependency and create a chance for sustaining the HIV and AIDS national response.

Resource requirements show increasing needs, from about TZS1 trillion in 2011/12 to over TZS1.2 trillion in 2014/15 (Table 4.4).

**TABLE 4.4: PROJECTED HIV AND AIDS RESOURCE NEEDS AND FINANCING GAP (BN TZS)**

	2010/11	2011/12	2012/13	2013/14	2014/15
Resource needs	710.0	1,076.8	1,130.6	1,187.2	1,246.5
Projected available funding	442.8	658.6	582.0	114.9	107.4
Unmet gap	267.2	418.2	548.6	1,072.3	1,139.1
Gap as % of requirements	37.6%	38.8%	48.5%	90.3%	91.4%

Based on those projected needs, the financing gap beyond 2012/13 is huge, above 90 percent. This is partly because there are no assurances that once the U.S. government agreement to support Tanzania’s HIV and AIDS response ends in 2013, it will be renewed at current levels. However, indications are that the U.S. government is determined to continue supporting Tanzania through the Global Health Initiative (GHI) framework. The second-largest funder, the Global Fund, has announced it will not solicit further HIV and AIDS proposals until 2014, but as discussed previously, there is a pipeline of USD120 million until 2015/16. Thus, if spending is held constant at the 2010/11 levels (assuming GHI comes on board) with adjustment for inflation, the resource gap is cut by almost half, from above 90 percent in 2012/13 and beyond to 46 percent over the same period. Thus, the resource shortfall will not be so severe if GHI provides continuation financing along the lines of current PEPFAR support to the national response. However, with some of the development partners scaling down their support substantially beyond 2012/13, and the uncertainty of Global Fund financing in the future, it is of critical importance to begin to mobilize internal domestic resources to increasingly channel greater budgetary allocations to the HIV and AIDS national response. In this regard, the proposed TACTF should be accorded priority, not only as a way of sustaining the program but also as a demonstration of government commitment to the national response.

## 5. BUDGET AND EXPENDITURES: NATIONAL LEVEL

### 5.1 INTRODUCTION

This section reviews general spending on HIV and AIDS by selected MDAs, followed by an analysis of six ministries in accordance with the terms of the assignment, namely: MoHSW, MoEVT, Ministry of Agriculture, Food, and Cooperatives (MoAFC), Ministry of Information, Culture, and Sports (MoICS), Ministry of Labor, Employment, and Youth Development (MoLEYD), and the Ministry of Community Development, Gender, and Children (MoCDGC).

### 5.2 MDA SPENDING: BUDGET VERSUS REAL EXPENDITURE – NATIONAL LEVEL

Selected MDAs' spending for HIV and AIDS for 2008/09 to 2011/12 is shown in Table 5.1. The data were extracted from Budget Books under Objective A (all expenditures on HIV and AIDS for all MDAs are shown under this objective). Since 2008/09, over 95 percent of the HIV and AIDS expenditure that passes through the normal government budget system is budgeted as Development Expenditure.<sup>4</sup> The execution of the funds disbursed to MDAs is shown in Table 5.1. Actual performance in 2010/11 for development spending was low, about 66.0 percent. The execution of recurrent spending was even lower, at 34.9 percent in 2010/11. Part of the reason for poor performance is related to late disbursement of funds by both government and development partners.

**TABLE 5.1: BUDGETED AND ACTUAL SPENDING IN SELECTED MDAS (MN TZS)**

	2008/09*			2009/10			2010/11		
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance
Development	100.0	100.0	100.0%	100.0	100.0	100.0%	63.7	42.0	66.0%
Recurrent	3.4	3.4	100.0%	3.4	2.6	76.5%	3.6	1.3	34.9%
<b>TOTAL</b>	<b>103.4</b>	<b>103.4</b>	<b>100.0%</b>	<b>103.4</b>	<b>102.6</b>	<b>99.2%</b>	<b>67.3</b>	<b>43.3</b>	<b>64.3%</b>

Source: Based on selected MDAs' budget records

\* The 2008/09 data do not include MoAFCHIV and AIDS spending.

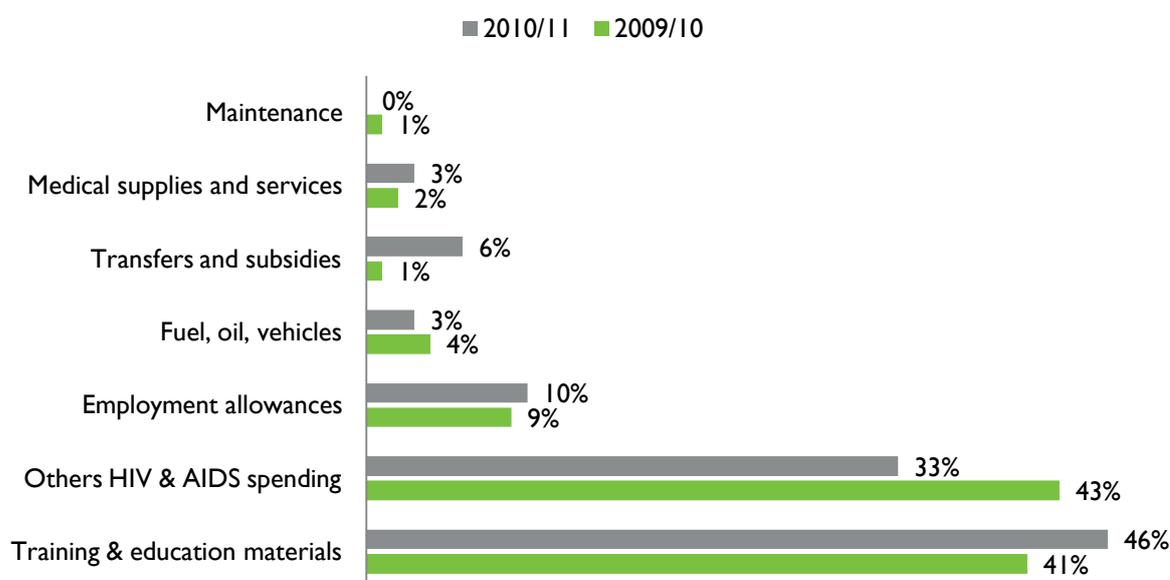
### 5.3 RESOURCE ALLOCATION BY CATEGORY– AGGREGATE FROM SELECTED MINISTRIES

Figure 5.1 provides resource allocation by spending category as percent of the total budget requested by the selected ministries. Spending on training and education increased from 41 percent in 2009/10 to 46 percent in 2010/11. Spending on other HIV and AIDS interventions, largely on preventive

<sup>4</sup>This was also observed in the previous HIV and AIDS PER 2010.

services, decreased by 10 percentage points to 33 percent in 2010/11. Maintenance of the HIV and AIDS infrastructure in the MDAs is negligible, typically less than 1 percent of the total spending.

**FIGURE 5.1: MDAS' HIV AND AIDS RESOURCE SPENDING PATTERNS**



Source: Authors' calculations based on selected ministries' spending on Objective A (HIV and AIDS)

Table 5.2 compares budget execution in the use of government and donor HIV and AIDS resources. It appears the budget execution for government resources varies widely, with performance of only 51 percent in 2008/09, increasing to 91 percent in 2009/10, and declining to 59 percent in 2010/11. Execution of donor support to the MDAs was consistently higher, at 98 percent of disbursed funds. It seems implementers tend to be more cautious and resolute in implementing donor projects – partly because of greater accountability placed on them by the external financiers.

**TABLE 5.2: BUDGETED AND ACTUAL SPENDING ON HIV AND AIDS (SELECTED MINISTRIES)(MN TZS)**

	2008/09*			2009/10			2010/11		
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance
Government	203	103	51.0%	1,101	1,001	91.0%	705	416	59.0%
Development partners	7,517	7,377	98.0%	7,269	7,131	98.0%	11,881	11,676	98.0%
Total	7,720	7,480	74.5%	8,370	8,132	95.0%	12,586	12,092	79.0%

Source: Authors' calculations based on selected ministries' spending on Objective A (HIV and AIDS)

\*The 2008/09 data do not include MoAFCHIV and AIDS spending.

MDA's spending on HIV and AIDS by thematic areas is illustrated by two ministries (MoICS and MoEVT) which have three-year real spending data. Overall, HIV and AIDS spending by MDAs are largely on prevention activities and crosscutting issues (e.g., fighting stigma, discrimination, and advocacy) (Table 5.3). Execution in 2008/09 was 100 percent for care, treatment, and support, declining by 6percentage points in 2009/10 to 94.0 percent. The performance in 2010/11 was very poor—care, treatment, and support experienced 7.1 percent performance, while crosscutting issues decreased to 84.9 percent from 100 percent in the previous year. The ministries attribute the low performance in 2010/11 to late disbursement of funds (disbursed in the third quarter of the fiscal

year) and failure to execute planned HIV and AIDS interventions. Improving funding disbursements to MDAs should improve performance in the future.

**TABLE 5.3: PERFORMANCE OF HIV AND AIDS SPENDING BY THEMES IN SELECTED MDAS (MN TZS)**

	2008/09			2009/10			2010/11		
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance
Care, treatment, and support	103.4	103.4	100.0%	13.4	12.6	94.0%	17.8	1.3	7.1%
Prevention	0	0		0	0		0	0	
Impact mitigation	0	0		0	0		0	0	
Crosscutting issues	0.0	0.0		90.0	90.0	100.0%	49.5	42.0	84.9%
<b>Total</b>	<b>103.4</b>	<b>103.4</b>	<b>100.0%</b>	<b>103.4</b>	<b>102.6</b>	<b>99.2%</b>	<b>67.3</b>	<b>43.3</b>	<b>64.3%</b>

Source: Authors' calculations based on selected MDA spending data

\*The MDAs are MoICS and MoEVT.

## 5.4 ANALYSIS OF HIV AND AIDS EXPENDITURE IN THE SELECTED MINISTRIES

This section discusses HIV and AIDS spending in five ministries, namely: MoHSW, MoEVT, MoAFC, MoICS, MoLEYD and MoCDGC. Overall, performance as measured by the difference between budget and actual expenditure is above 80 percent for the MoHSW, MoAFC and MoICS. The remaining ministries have low performance, typically less than 70 percent. The main reason for poor performance is late disbursement of funds to the ministries from the Ministry of Finance or Development Partner supporting the ministry's HIV and AIDS program.

### 5.4.1 MINISTRY OF HEALTH AND SOCIAL WELFARE

**TABLE 5.4: MINISTRY OF HEALTH AND SOCIAL WELFARE REAL SPENDING BY INTERVENTION AREA (MN TZS)**

Intervention	2010/11			2011/12
	Budget	Actual Expenditure	Performance	Budget
<b>Recurrent</b>				
Malaria	187	154	82.4%	249
TB	277	193	69.7%	221
Noncommunicable diseases	146	17	11.9%	1,125
<b>HIV and AIDS</b>	<b>6,526</b>	<b>5,279</b>	<b>80.9%</b>	<b>2,368</b>
Reproductive health	539	347	64.4%	437
Child health	550	331	60.1%	1,394
<b>Total</b>	<b>8,225</b>	<b>6,321</b>	<b>76.8%</b>	<b>5,793</b>
<b>Development</b>				
Malaria	186,383	65,696	35.2%	48,802

TB	6,400	5,100	79.7%	155,730
HIV and AIDS	93,720	78,130	83.4%	90,357
Reproductive health	6,000	6,000	100.0%	8,000
Total	292,504	154,927	53.0%	302,889

Source: URT (2012)

The overall execution of the health budget by MoHSW in 2010/11 was 76.8 percent of the budgeted recurrent funds, and only about 53 percent of the budgeted development funds for key intervention areas (Table 5.4). The performance of HIV and AIDS recurrent spending was 80.9 percent, while in the development category performance was 83.4 percent. When HIV and AIDS budget for 2010/11 is compared with 2011/12, the recurrent and development allocations declined by 64 percent and 4 percent, respectively. This is likely to affect budget execution in 2011/12.

Development partners continue to defray over 95 percent of the HIV and AIDS spending by the MoHSW, largely through NACP.

#### 5.4.2 MINISTRY OF EDUCATION AND VOCATIONAL TRAINING

MoEVT has two HIV and AIDS programs, the Workplace Program and the HIV and AIDS Life Skills School Program. The Workplace Program is managed by the Director of Personnel. This program has a workplace committee team of 10 people and each department at the ministry has two peer educators to oversee workplace interventions. During the period under review, the ministry had developed a workplace M&E tool. The Workplace Program includes financial support of TZS100,000 per month to PLWHA.

The HIV and AIDS Life Skills School Program has four interventions, namely: Peer Education Component, Teaching of HIV and AIDS/Life Skills topics in selected subjects, Counseling Services in Schools, and HIV and AIDS School/Community support. These interventions complement one another.

The performance of the ministry's HIV and AIDS programs is not satisfactory. Both recurrent and development spending shows wide variations (Table 5.5).

**TABLE 5.5: MINISTRY OF EDUCATION RECURRENT AND DEVELOPMENT HIV AND AIDS SPENDING (MN TZS)**

	2008/09			2009/10			2010/11		
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance
Development	500	360	72.0%	500	363	72.5%	500	295	59.0%
Recurrent	100	60	60.0%	100	40	40.0%	365	100	27.4%
Total	600	420	70.0%	600	403	67.1%	865	395	45.7%

Source: Authors' calculations based on MoEVT data sources

Development spending averaged about 70 percent in 2008/09 and 2009/10 but declined to about 60 percent in 2010/11. Similarly, recurrent spending averaged over 60 percent in 2008/09, decreased to 40 percent in 2009/10, and to a further low of 27 percent in 2010/11. Much of this decline is due to lower-than-anticipated disbursement of government and donor financing to the sector.

The main source of funding for MoEVT HIV and AIDS interventions is from donors (Table 5.6).

**TABLE 5.6: SOURCE OF FINANCING FOR THE MINISTRY OF EDUCATION HIV AND AIDS PROGRAMS (MN TZS)**

	2008/09			2009/10			2010/11		
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance
Government	100	60	60.0%	100	40	40.0%	365	100	27.4%
Foreign (development partners)	500	360	72.0%	500	363	72.5%	500	295	59.0%
Total	600	420	70.0%	600	403	67.2%	865	395	45.7%

Source: Authors' calculations based on MoEVT data sources

Development partners fund over 85 percent of the ministry's HIV and AIDS programs, and performance has declined from 72.0 percent in 2008/09 to 59.0 percent in 2010/11. Spending of government resources was weaker, with only 60.0 percent performance in 2009/10 down to 27.4 percent in 2010/11. Again, late disbursement of funds precluded completion of planned interventions.

With regard to thematic areas of intervention, prevention is accorded priority, with average performance of 72.0 percent for the three years under review (Table 5.7). Interventions in impact mitigation and crosscutting issues performed poorly in 2010/11, at 48.3 percent and 27.4 percent, respectively.

**TABLE 5.7: MINISTRY OF EDUCATION HIV AND AIDS SPENDING BY THEMATIC AREAS (MN TZS)**

	2008/09			2009/10			2010/11		
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance
Care, Treatment	-	-							
Prevention	500	360	72.0%	200	138	68.9%	200	150	75.0%
Impact Mitigation				300	225	75.0%	300	144.9	48.3%
Cross cutting issues	100	60	60.0%	100	40	40.0%	365	100	27.4%
Total	600	420	70.0%	600	403	67.1%	865	395	45.7%

Source: Authors' calculations based on MoEVT data

### 5.4.3 MINISTRY OF AGRICULTURE, FOOD, AND COOPERATIVES

Unlike many other ministries, the MoAFC does not receive any donor funding for HIV and AIDS activities. All the activities in the ministry are funded by the government of Tanzania; funding has been increasing overtime, from TZS9.3 million in 2009/10 to TZS30 million in 2010/11, with budgeted resources for 2011/12 at TZS40 million (Table 5.8). The ministry does not allocate funds for HIV and AIDS capital spending – all funds are for recurrent spending, the performance of which during the period of review was 100 percent of the funds budgeted.

**TABLE 5.8: MINISTRY OF AGRICULTURE HIV AND AIDS RECURRENT SPENDING (MN TZS)**

	2009/10			2010/11			2011/12
	Budget	Actual	Performance	Budget	Actual	Performance	Budget
Development	-	-	-	-	-	-	-
Recurrent	9.3	9.3	100%	30.0	30.0	100%	40.0
Total	9.3	9.3	100%	30.0	30.0	100%	40.0

Source: Authors' calculations based on MoAFC data

With regard to thematic spending, care, treatment, and support was accorded priority in 2009/10, but the following year crosscutting issues were prioritized (Table 5.9). In this category, medical supplies and services were allocated over 77.8 percent of the actual spending. Program execution has been good at 100 percent in both 2009/10 and 2010/11.

**TABLE 5.9: MINISTRY OF AGRICULTURE HIV AND AIDS SPENDING BY THEMATIC AREAS (MN TZS)**

	2009/10			2010/11			2011/12
	Budget	Actual	Performance	Budget	Actual	Performance	Budget
Care, treatment, and support	7.2	7.2	100%	4.0	4.0	100%	20.4
Prevention				8.9	8.9	100%	8.5
Crosscutting issues	2.1	2.1	100%	17.1	17.1	100%	11.1
Total	9.3	9.3	100%	30.0	30.0	100%	40.0

Source: Authors' calculations based on MoAFC data

The ministry has an HIV and AIDS Strategic Plan (2011/12–2013/14) but it is not fully implemented due to lack of funds. The ministry's main priority in the future is to increase advocacy and training to its staff.

#### 5.4.4 MINISTRY OF INFORMATION, CULTURE, AND SPORTS

Like MoAFC, MoICS is not supported by any donor. All HIV and AIDS activities in the ministry are financed by government sources. As shown in Table 5.10, the funding for HIV and AIDS activities has been falling overtime, from TZS103.4 million in 2008/09 to TZS43.3 million in 2010/11 – a decrease of 58 percent. Budget execution was 100 percent in 2008/09 and 2009/10, but declined to 64.3 percent in 2010/11 partly due to inadequate funding for the planned activities.

**TABLE 5.10: MINISTRY OF INFORMATION, CULTURE, AND SPORTS  
HIV AND AIDS SOURCE OF FINANCING (MN TZS)**

	2008/09			2009/10			2010/11			2011/12
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance	Budget
Government	103.4	103.4	100%	103.4	102.6	99%	67.26	43.2	64%	42.4
Foreign (development partners)	0	0	0	0	0	0	0	0	0	0
Total	103.4	103.4	100%	103.4	102.6	99%	67.26	43.2	64%	42.4

Source: Authors' calculations based on MoICS data

Most of the HIV and AIDS funding is categorized as development spending, which showed high performance in 2008/09 and 2009/10, but declined to 66.0 percent in 2010/11. Recurrent spending also shows a decline, from 100 percent in 2008/09 to 76.5 percent in 2009/10 to a low of 34.9 percent in 2010/11 (Table 5.11).

**TABLE 5.11: MINISTRY OF INFORMATION, CULTURE, AND SPORTS HIV AND AIDS DEVELOPMENT AND RECURRENT SPENDING (MN TZS)**

	2008/09			2009/10			2010/11			2011/12
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance	Budget
Development	100.0	100.0	100%	100.0	100.0	100.0%	63.7	42.0	66.0%	40.0
Recurrent	3.4	3.4	100%	3.4	2.6	76.5%	3.6	1.3	34.9%	2.4
Total	103.4	103.4	100%	103.4	102.6	99.2%	67.3	43.3	64.3%	42.4

Source: Authors' calculations based on MoICS data

With regard to thematic spending, care, treatment, and support are accorded priority, followed by crosscutting issues (especially fighting stigma and discrimination of PLWHA) (Table 5.12). Overall budget execution was high in 2008/09 and 2009/10, but declined markedly in 2010/11 to only 7.1 percent partly due to reduced funding for some interventions and weaknesses associated with HIV and AIDS program implementation.

**TABLE 5.12: MINISTRY OF INFORMATION, CULTURE, AND SPORTS HIV AND AIDS SPENDING BY THEMATIC AREAS (MN TZS)**

	2008/09			2009/10			2010/11		
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance
Care, treatment, and support	103	103	100%	13	13	94%	18	1	7.1%
Crosscutting issues	-	-		90	90	100%	49	42	84.9%
Total	103	103	100%	103	103	99.2%	67	43	64.3%

Source: Authors' calculations based on MoICS data

Going forward, the issue of decreasing HIV and AIDS funding is of major concern to the ministry, which may require the ministry to find new approaches to fund interventions to curb the spread of the epidemic.

### 5.4.5 MINISTRY OF LABOR, EMPLOYMENT, AND YOUTH DEVELOPMENT

MoLEYD (through the UN contribution to NMSF) received funding in 2009/10 to translate the National Tripartite Code of Conduct on HIV and AIDS into Kiswahili, to print and disseminate the translated Code of Conduct, to conduct situational analysis of workplace programs for the public sector, as well as to print and disseminate the life skills standard and training manual for out-of-school youth. The funding of TZS102 million was channeled through TACAIDS. About 58 percent of the resources were used to fund youth HIV and AIDS activities, while the remaining funds were used to defray costs of administration and inspection.

The ministry needs to develop an HIV and AIDS policy, strategic plan, and workplace programs, as well as an M&E system to assess progress toward combating the spread of the epidemic.

### 5.4.6 MINISTRY OF COMMUNITY DEVELOPMENT, GENDER, AND CHILDREN

MoCDGC's expenditure on HIV and AIDS is largely financed by foreign sources (Table 5.13). Only in 2009/10 did the ministry receive TZS74 million from the government to support HIV and AIDS interventions. Execution of the HIV and AIDS program fluctuates widely, with the 2008/09 performance at about 60 percent while for 2009/10 it jumped to over 255 percent and thereafter declined to about 67 percent in 2010/11. The performance is largely driven by donor disbursements, with higher levels being associated with greater capacity to implement the HIV and AIDS interventions.

**TABLE 1: SOURCES OF FINANCING FOR THE MINISTRY OF COMMUNITY DEVELOPMENT'S HIV AND AIDS PROGRAM (MN TZS)**

	2008/09			2009/10			2010/11		
	Budget	Actual	Performance	Budget	Actual	Performance	Budget	Actual	Performance
Local	0	0	0	74	74	100.0%	0	0	0
Foreign (development partners)	140	81	57.9%	400	1,023	255.8%	832	560	67.3%

Source: Authors' calculations based on TACAIDS data

The ministry needs to develop an HIV and AIDS workplace policy, strategic plan, and an M&E system to assess progress toward achieving the goal of reducing the spread of the epidemic.

## 5.5 CONCLUSION

The overall observation is that budgeted HIV and AIDS resources showed an increasing trend between 2008/09 and 2010/11; however, actual spending declined by about 25 percent during this period, partly due to late disbursements or inadequate funding of planned activities. The main source of financing of MDAs' HIV and AIDS activities is external resources, which averages over 80 percent during the review period. Only MoAFC and MoICS depended solely on government funding of their HIV and AIDS programs.

Program execution performance in all surveyed MDAs fluctuates widely, depending largely on availability of funding for the activities. A major challenge relates to the inability of the government and development partners to disburse committed funds on time, and weak implementation of the workplace HIV and AIDS interventions. In addition, it appears from the survey that HIV and AIDS activities are accorded low priority and some ministries have stopped budgeting government resources to address the HIV and AIDS epidemic. This is an area where TACAIDS should follow closely to understand why some MDAs are not budgeting resources for Objective A in their MTEFs.

Overall, however, most of the MDAs have already established an HIV and AIDS Strategic Plan, an Implementation Plan, and some have even costed the program. But the level of actual

implementation of activities is very weak largely due to lack of adequate funds. It is therefore important for TACAIDS to intensify its coordination efforts with MDAs to ensure HIV and AIDS programs are accorded priority and are allocated adequate funding through Objective A in developing their MTEF plans.



## 6. BUDGET AND EXPENDITURES: LOCAL LEVEL

LGAs are key in ensuring that HIV and AIDS services are provided at the council, district, and community levels where the majority of Tanzanians live. LGAs have at their disposal several sources of funding for combating the HIV and AIDS epidemic, including development partners' on- and off-budget funding (see Section 4.1.3, PEPFAR implementing partners), NMSF Grant Fund, various domestic and international NGOs, and government support. This section reviews funding that uses the government systems and structures found at the LGA level.

### 6.1 PLANNING AND BUDGETING

The planning process at LGAs is guided by the system developed by the government, which requires all councils to follow in the implementation of local plans and strategies. The system of planning and budgeting is a bottom-up process which demands that identification of needs and priorities starts at the lower (village) level, going up to the council level. The councils are required to compile the needs from different villages and wards and develop a council budget for HIV and AIDS. During compilation the council needs to prioritize the planned activities from villages and wards to match available resources and ceilings provided by PMO-RALG.

The general experience from the field review undertaken as part of this PER observed several challenges facing the planning and budgeting process. These include:

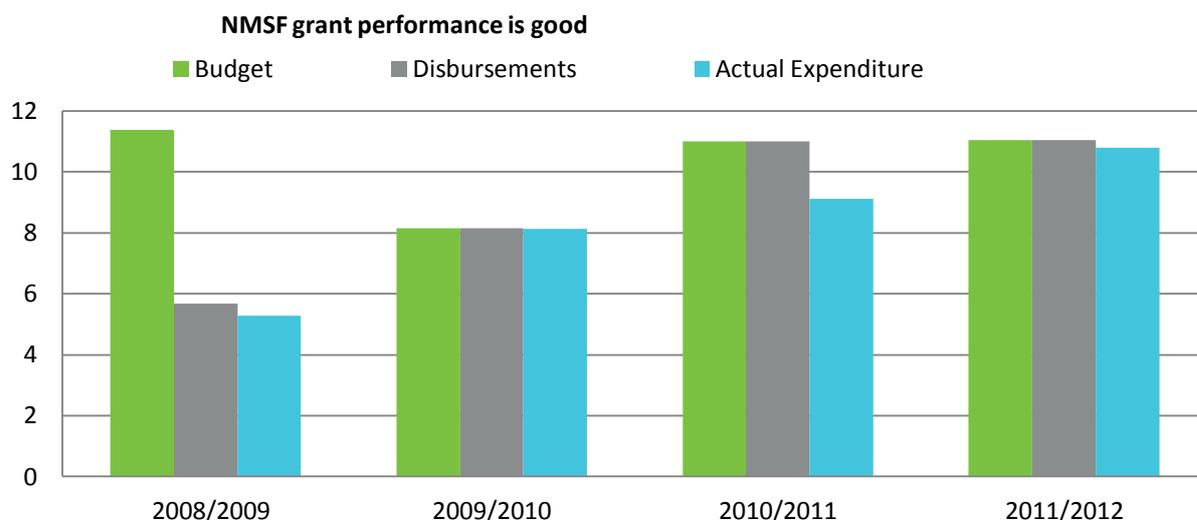
- Most villages/wards do not consider HIV and AIDS a priority. As such, during the budget process they come up with other development needs that do not include HIV and AIDS interventions. This has led to council failure to capture the HIV and AIDS needs from the village/ward level; instead, most of the interventions which appear in council budgets are developed at the council level.
- Councils do not involve wards/villages in the process of budgeting to inform them about timing of budget sessions so that they can identify their needs and send them to council level on time. The study revealed that most of the villages do not know when and how they can develop their budget and send them to the council for further process and feedback.
- Most village HIV and AIDS committees do not have the capacity to plan and budget. As a result, some councils obtain village/ward needs through councilors by assuming they represent the people.

The analysis of the budget for 2009/10 and 2010/11 showed that most HIV and AIDS interventions are done at the district level, with little involvement or interventions at the village/ward level. For example, events such as commemoration of World HIV and AIDS day and support of school fees and materials to PLWHA and OVCs are done at the council level. The observations from the 10 councils surveyed are described in the following sections.

### 6.2 HIV AND AIDS SPENDING AT THE LGA LEVEL

The health-related aspects of HIV and AIDS spending at the LGA level are mainly financed from funds that are either centrally managed by the government through MoHSW, or are off-budget funded by donor support such as the U.S. government (PEPFAR), Health Baskets Fund, and the Global Fund. PEPFER support for HIV and AIDS is channeled through NGOs and CSOs directly, while Health Basket Funds support HIV and AIDS activities through the normal government system.

**FIGURE 6.1: LGAS' AND REGIONS' HIV AND AIDS EXPENDITURE (BN TZS)**



Source: Authors' calculations based on TACAIDS NMSF Reports

ARVs are largely financed by funds from the Global Fund through MSD, which are the recipient and distributor of these drugs to councils. Apart from ARV services the Global Fund also implements other activities in selected LGAs under the coordination of PMO-RALG. All these activities are captured in the LGAs' MTEFs under Objective A.

HIV and AIDS financing at the LGAs that passes through the government system is largely funded through the NMSF Grant Fund. TACAIDS submits a deposits request to CIDA and DANIDA, which are the current financiers of the grant, on the basis of projected needs from all recipients (including LGAs, regions, TACAIDS, and PMO-RALG). CIDA and DANIDA disburse funds directly to an HIV and AIDS account maintained at the Bank of Tanzania (BOT) within MoFEA. MoFEA informs TACAIDS upon receipts of funds from the donors, which in turn instruct MoFEA to release funds to respective LGAs and other recipients according to the approved budget under the FATWC for the NMSF grant. The LGAs are informed of the fund disbursement and allocation by PMO-RALG. Each council has an account for HIV and AIDS which were opened during the World Bank-funded TMAP project, into which the NMSF grant is directly deposited for use by LGAs according to their planned MTEF HIV and AIDS activities. The performance of the grants at LGAs and regions is shown in Figure 6.1 and Table 6.1.

**TABLE 6.1: NMSF GRANT BUDGET AND ACTUAL EXPENDITURE AT LGAS AND REGIONS (BNTZS)**

	<b>Budget (A)</b>	<b>Disbursements (B)</b>	<b>Actual Expenditure (C)</b>	<b>Performance (C/B)</b>
2008/09	11.37	5.68	5.29	93.1%
2009/10	8.16	8.16	8.13	99.6%
2010/11	11.00	11.00	9.12	82.9%
2011/12	11.04	11.04	10.80	97.8%

Source: TACAIDS financial reports regarding NMSF grants

The grant performance of resources disbursed to the LGAs and regions is generally good, with the lowest performance being in 2010/11, at 82.9 percent of the funds disbursed. Part of the reason for

the low performance during this year relates to late disbursement of funds. The agreement is that the NMSF grant funds will be disbursed to council in two phases within the financial year (within the first and second quarters). This has been difficult to achieve due to conditions stipulated in the Memorandum of Understanding on funds deposits; one of the requirements is the submission of income and expenditure report from all councils. This has been a challenge for a long time. Most councils have failed to report on time due to different reasons, including inadequate capacity and working environment issues. The survey undertaken as part of this PER shows that the NMSF grant funds are disbursed during the second, third, or even fourth quarter of the fiscal year. This has led to poor performance and delays in the implementation of HIV and AIDS plans in some LGAs, as shown in Table 6.2.

### 6.3 NMSF EXPENDITURES AND EXECUTION IN THE SELECTED COUNCILS

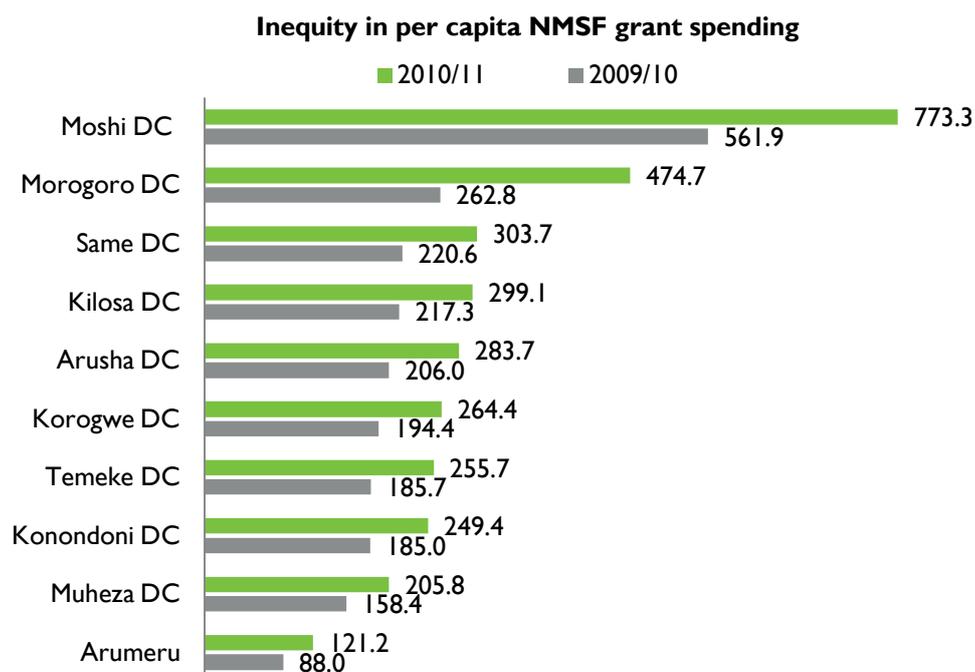
The NMSF grant execution at the selected local councils is satisfactory (Table 6.2). In 2008/09, the worst performer (Korogwe DC) achieved 84.4 percent level of actual spending compared with resources disbursed to the council. All others had performance above 91.6 percent in that year. In 2009/10 the performance was even better, at 100 percent, except for Morogoro DC which attained only 57.1 percent—a dismal performance compared with the previous year. In 2010/11 performance ranged between a low of 5.8 percent (Moshi) and 100 percent (Arumeru and Korogwe). Moshi DC attributed the low performance to late disbursement of funds (third quarter) during the 2010/11 fiscal year.

**TABLE 6.2: HIV AND AIDS SPENDING IN SELECTED COUNCILS (MN TZS)**

	2008/09			2009/10			2010/11		
	Budget	Real Exp.	Performance	Budget	Real Exp.	Performance	Budget	Real Exp.	Performance
Muheza DC	29.7	27.2	91.6%	44.1	44.1	100.0%	57.3	28.7	50.0%
Korogwe DC	11.5	9.7	84.4%	50.6	50.6	100.0%	68.8	68.8	100.0%
Arusha DC	43.4	43.8	100.7%	58.0	58.0	100.0%	79.9	68.4	85.6%
Arumeru Dc	34.4	34.4	100.0%	45.3	45.3	100.0%	62.4	62.4	100.0%
Konondoni DC	139.8	135.6	97.0%	200.5	200.5	100.0%	270.3	227.8	84.3%
Temeke DC	101.6	101.6	100.0%	142.7	142.7	100.0%	196.5	188.6	96.0%
Kilosa DC	75.2	75.2	100.0%	106.1	106.1	100.0%	146.0	145.2	99.4%
Morogoro DC	42.3	43.1	101.8%	59.9	34.2	57.1%	108.2	101.1	93.5%
Same DC	36.4	36.4	100.0%	46.7	46.7	100.0%	64.3	43.6	67.7%
Moshi DC	22.6	22.6	100.0%	80.8	80.8	100.0%	111.2	6.5	5.8%
Total	536.9	529.5	98.6%	834.7	809.0	96.9%	1,165.0	941.0	80.8%

Source: Authors' calculations and TACAIDS NMSF grant reports

**FIGURE 2: PER CAPITA NMSF GRANT ALLOCATION TO SELECTED COUNCILS (TZS)**



Source: Authors' calculations based on NMSF Grant to LGAs

The NMSF grants are not distributed equitably among the councils (Figure 6.2). For example, in 2010/11 Moshi DC was allocated more than six times as much per capita as Arumeru District, and Morogoro DC was allocated more than twice the level given to Muheza DC. The allocations in both years (2009/10 and 2010/11) show similar patterns.

The inequities exist despite using an elaborate formula. The current formula for sharing the NMSF grant among the LGAs is based on the following criteria: population (70 percent), number of poor residents (10 percent), district service delivery route (10 percent), and the council's estimated HIV and AIDS prevalence rate (10 percent). The formula is based on objectively verifiable indicators; they are transparent and linked to the policy objectives of the sector grant. Most councils are aware of this formula, but there is concern about the applicability of the formula. The surveyed councils suggested review of the formula to reflect the current needs and development changes taking place in the country and make the resource allocation more equitable.

## 6.4 AUDITED REPORT OF THE NMSF GRANT FUND

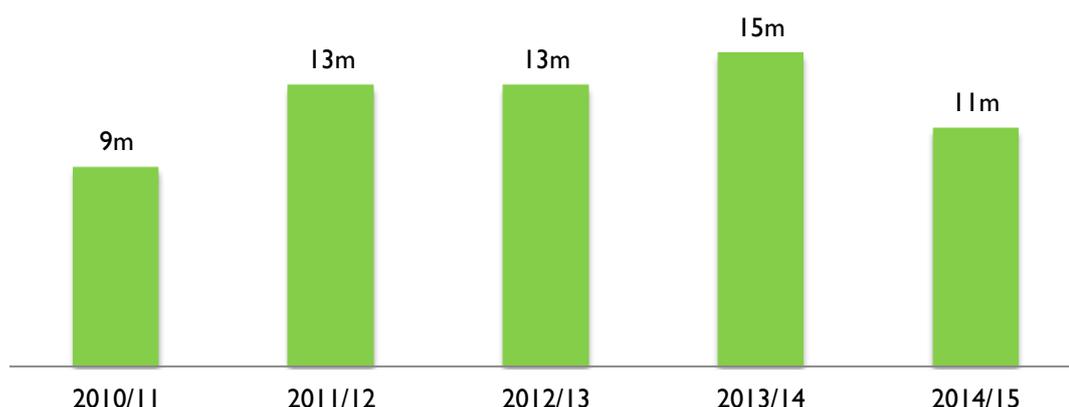
In 2009/10, about TZS7,530,996,000 was disbursed to LGAs, and TZS630,000,000 to the regions, from the NMSF Grant Fund. TACAIDS has received expenditure reports from all LGAs and regions for actual expenditure of the funds received under the NMSF grant.

The Controller and Auditor General has completed an audit of the NMSF grant funds disbursed to LGAs and regions for 2009/10. The main observation made was the delay in transferring the funds to the LGAs and regions. As a result, in some of the LGAs funds could not be spent in time by the end of the financial year. Part of the reason for delay in disbursements relates to poor reporting compliance by some LGAs and weak enforcement mechanism for those that do not report on time. Thus, it is essential to stress to LGAs and regions the need for expeditious compliance with all grant stipulations. Also, there is a need for the development partners supporting the NMSF Grant Fund, TACAIDS, and MoFEA to ensure timely disbursement of approved HIV and AIDS funds so as to enhance effective and efficient implementation of planned interventions at the regional and LGA levels.

## 6.5 RESOURCE PROJECTIONS FOR FUNDING THE NMSF STRATEGIC PLAN

The Tanzanian government established the NMSF Grant Fund in 2009/10 to finance the HIV and AIDS national response. This fund is currently financed by the governments of Canada and Denmark. Funds for the grants are channeled through the government system and are compliant with the country's financial regulations and procedures. The management of the fund is led by the grant Memorandum of Understanding signed between the governments of Tanzania, Canada, and Denmark. The grant covers a period of five years with an estimated grant of USD60.7 million (Figure 6.3).

The resources are inadequate to support an effective and efficient national response. Every effort must be made to entice the government and development partners to increase their HIV and AIDS financing support channeled through the NMSF Grant Fund.



**FIGURE 6.3: NMSF GRANT FORECAST (MN USD)**

Source: TACAIDS (2011b)

## 6.6 CONCLUDING REMARKS AND IMPLEMENTATION CHALLENGES AT LGAS

LGAs are major players in the government efforts to build an HIV- and AIDS-free society. To this end, the government has established functional systems and institutional structures at the LGA level to ensure efficient implementation of the NMSF. In particular, the PER Team observed that at regional level, the AIDS Teams were functioning properly, as were the CMACs. Similarly, at the ward level, the WMACs and VMACs were doing a commendable job toward facilitating provision of HIV and AIDS services, although capacity building is still needed to improve their functionality further. All systems for planning, budgeting, and reporting have been developed and are functional. However, the PER Team survey in the 10 selected districts observed several challenges constraining efficient implementation of HIV and AIDS activities at the local level. Some of these challenges are as follows:

- There is inadequate capacity at the village/ward and district levels to plan, budget, and report on HIV and AIDS interventions/activities. All systems for sound planning, budgeting, financial management, and reporting have been developed and are operational. For example, the expenditure system for NMSF grants to all councils follows normal government transaction procedures and all payments are using the EPICOR payment system. There is a strategy of linking PLANREP (planning system) and EPICOR. The EPICOR system is working properly and all transactions can be easily traced to the reports from the EPICOR system. However, the survey observed that few staff understand how the tools work, there is poor record keeping at the district level (councils cannot easily monitor, follow up, or track expenditures), and there is

general weakness in documentation (not all reports could provide details of expenditure of funds disbursed). Supporting documents with receipts, superiors' approval, and the criteria for quotations, meeting notes, or signed pay lists were in some cases missing; cash books or check registers in some districts are manually operated and few records are computerized. But even where records are electronically kept, frequent power outages pose severe challenges to meeting timely reporting requirements.

- The O&OD tool is poorly understood and not effectively used at the village/ward level. This provides a challenge for communities to incorporate HIV and AIDS activities in their plans. National tools are in place but communities need capacity building support to undertake the planning more effectively.
- The NMSF grant disbursements are often delayed, impacting negatively on implementation of HIV and AIDS activities at the local level. The delays are often related to poor communication between the implementers of the grant, inconsistent guidelines, and weak instructions on how to use the funds. However, implementers in the LGAs visited appreciated the NMSF grant guidelines and the flexibility it provides on how the funds are to be used for the HIV and AIDS interventions.
- The PER Team observed that guidelines and ceilings are sometimes made available late, and releases are delayed and often lower than those approved. This derails councils' action plans which are mostly not fully implemented, resulting in poor performance.
- With regard to plans, budgeting, and reporting of HIV and AIDS activities, the PER Team observed that the management of the NMSF grant is improving toward desired goals. The districts have now been able to create functional routines for planning and budgeting; they have initiated, or re-initiated, mapping of CSOs and CBOs; and they have developed useful ways to collaborate between departments within the council. The districts put strong emphasis on participation of all stakeholders in planning and budget preparation, but the challenge is how to involve civil society (such as FBOs, CBOs, and the private sector) in LGA HIV and AIDS programs, including deciding on the levels of their funding from various donors.
- The PER Team also observed that LGAs aim to capture the transfer of HIV and AIDS funds to the district from all sources (even off-budget donor funds) and to integrate the different programs within their overall comprehensive council plans. However, the modality of implementing this idea still poses a challenge and may require active involvement of PMO-RALG.

## 7. ASSESSMENT OF HIV AND AIDS ACTIVITIES IN THE PRIVATE SECTOR

### 7.1 INTRODUCTION

The private sector and CSOs play an important role in the country's HIV and AIDS national response. These have been recognized as champions in complementing government efforts. In 2011/12 it was estimated that there were over 6,000 CBOs and CSOs that provide HIV and AIDS services to communities in Tanzania. The services include prevention, care and support, impact mitigation, and advocacy.

With regard to coordination, ABCT has been at the forefront in coordinating the private sector in the national response. The mission of ABCT is to enhance and facilitate the use of the private sector's competencies and product marketing through leveraging the skills and networks of companies to control and manage HIV and AIDS in the workplace and beyond. At the district level, CMACs coordinate participation of CSOs in the national HIV and AIDS response in their respective operational areas.

Companies weigh a number of considerations in determining whether, and to what extent, to offer HIV and AIDS services to their employees. In addition to cost considerations, the PER Team survey found that businesses also weigh benefits from improved productivity, reduction of absenteeism, improved institutional memory, and employee demand for those services.

With regard to funding, the PER Team survey found that private companies fund their HIV and AIDS workplace programs largely from own sources, while services provided by CSOs are funded by various sources which include RFE, Foundation for Civil Society, the Global Fund through AMREF, PEPFAR, CSSC, and other direct donor assistance.

The results of the company survey<sup>5</sup> conducted as part of this PER are discussed in the following sections.

### 7.2 GENERAL INFORMATION ON COMPANY HIV AND AIDS PROGRAMS

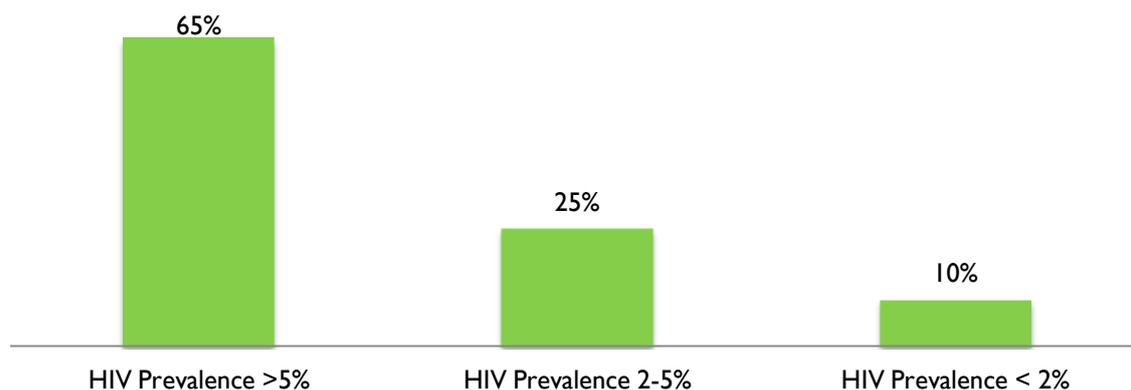
**HIV prevalence:** The companies were asked to rank the perception of HIV and AIDS prevalence among employees, whether high (>5 percent), moderate (2–5 percent), or low (< 2 percent).

The result in Figure 7.1 shows that business firms have a severe HIV and AIDS problem. The most frequent perception is that greater than 5 percent of the employees are either HIV-positive or are living with AIDS.

---

<sup>5</sup>See Annex F for the list of companies surveyed. A total of 29 companies which responded to the PER Team and NHA questionnaire had workplace interventions. These are the companies analysed in this report.

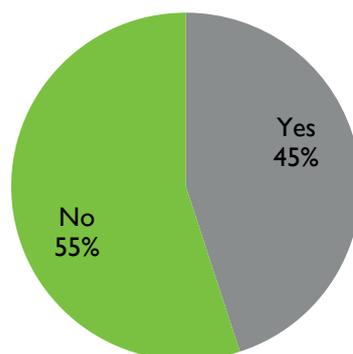
**FIGURE 7.1: COMPANY PERCEPTION OF HIV PREVALENCE**



**Company HIV and AIDS policies:**

Companies were asked whether the firm had an HIV and AIDS policy. It appears from Figure 7.2 that many companies do not have an HIV and AIDS policy – about 55 percent of the surveyed companies do not. However, the reason given was that there is no need to have a company policy when a national policy exists. Some asserted that is better to use the national policy and tailor it to suit company workplace policies.

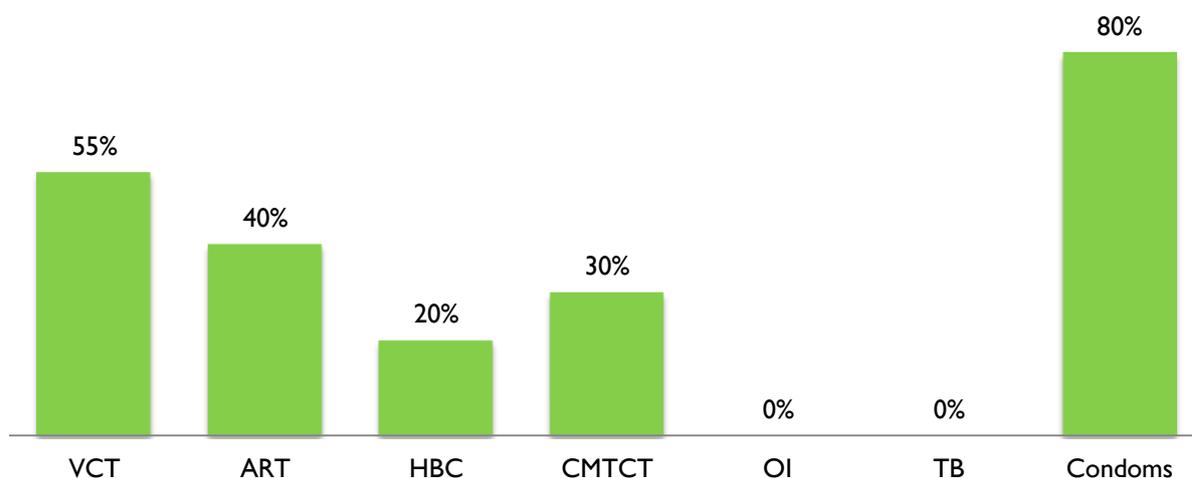
**FIGURE 7.2: COMPANY HIV AND AIDS POLICY**



**Company HIV and AIDS services provided:**

The companies that were surveyed and had HIV and AIDS programs most provided services that are within the NMSF thematic areas. As Figure 7.3 shows, 80 percent offer free condoms, usually found in toilet premises. About 55 percent offer VCT. Some companies provide ARVs to the staff whose status is among PLWHA. Some 30 percent of the companies offered drugs for control of mother-to-child transmission (CMTCT), while 20 percent offered HBC. None of the surveyed companies said they offered OI or TB drugs.

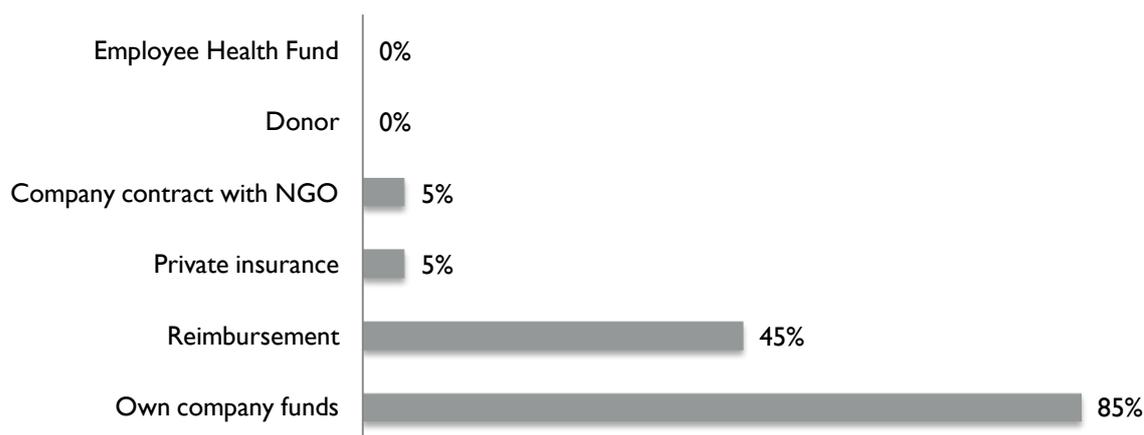
**FIGURE 7.3: HIV AND AIDS SERVICES PROVIDED BY COMPANIES**



**Company sources of financing for HIV and AIDS interventions:**

As Figure 7.4 shows, the main source of funding for HIV and AIDS interventions in the companies is their own resources (85 percent of the firms surveyed). About 5 percent contracted private service providers, while another 5 percent worked through the employee private insurance firms to defray the cost of HIV and AIDS services offered. None of the surveyed companies has received any funding from donors for provision of HIV and AIDS services.

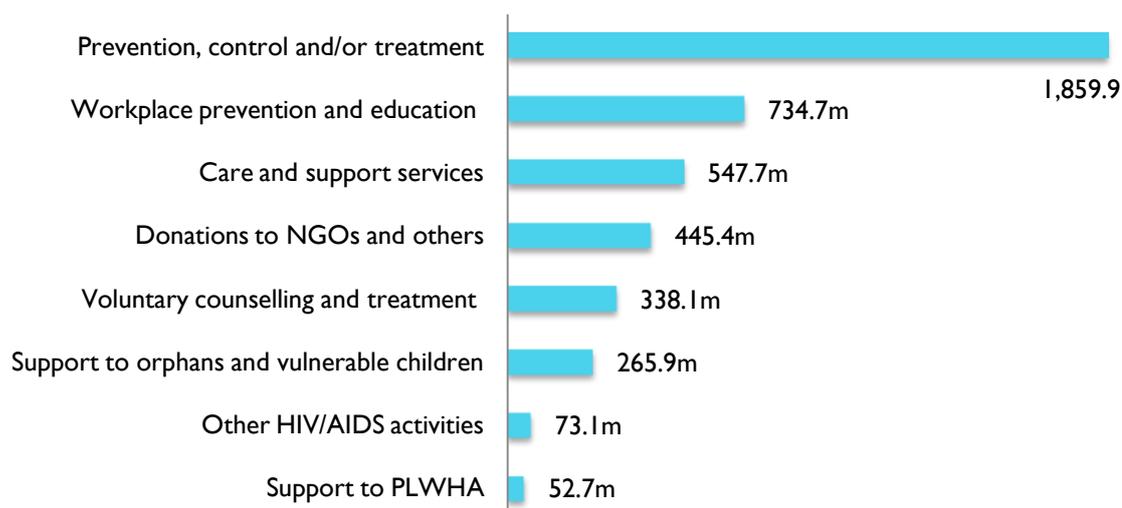
**FIGURE 7.4: COMPANY SOURCES OF FUNDING HIV AND AIDS INTERVENTIONS**



**Actual spending by companies on HIV and AIDS activities in 2009/10:**

According to the data from the questionnaires, companies used over TZS4,317 million for the provision of HIV and AIDS services in 2009/10. Figure 7.5 shows the main areas of spending as reported in the questionnaires.

**FIGURE 7.5: COMPANY HIV AND AIDS ACTUAL SPENDING IN 2009/10 (MN TZS)**

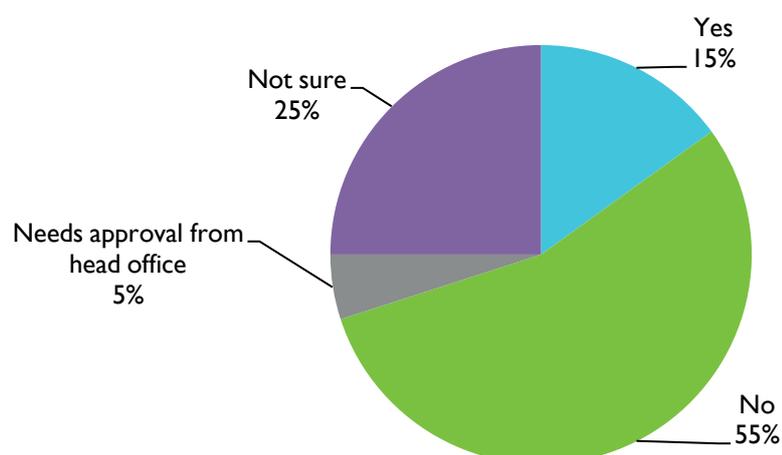


The majority of companies described their services as being in the category of prevention, control, and/or treatment (TZS1,859.9 million); others used the category of workplace prevention and education (TZS734.7million). Companies reported spending TZS547.7 million for the provision of care and support services. The least amount of spending was on PLWHA, about TZS52.7 million. The accuracy of the company data could not be verified and the PER Team relied solely on the spending figures entered onto the questionnaire instrument by the company official.

**Willingness of companies to support financing of the proposed TACTF:**

The response is depressing (Figure 7.6). Only four companies or 15 percent of those surveyed, responded that they are willing to support the financing of the TACTF. About 55 percent said categorically they will not support the fund, while 25 percent said they were not sure. These were of the opinion that a request has to come from the government and support will depend on a decision made by management. About 5 percent said they have no authority to make such decisions and have to ask their head office for approval when requested to do so by the government. However, most felt there was no need to support the fund because they are already providing HIV and AIDS services that would have been provided by the government. The results imply the need for mandated contribution from private businesses through legislative order upon approval of the TACTF.

**FIGURE 7.6: COMPANY WILLINGNESS TO SUPPORT TACTF**



## 7.3 CHALLENGES AND CONCLUSION

### Challenges

The main challenges facing private companies with regard to their HIV and AIDS interventions include:

- Inadequate involvement of top management officials of the private companies in HIV and AIDS workplace interventions, instead relegating this task to junior staff who in most cases cannot make binding decisions.
- Inadequate implementation of HIV and AIDS workplace interventions, even when these have been authorized by company management.
- Lack of HIV and AIDS workplace policies, which hinders effective and efficient implementation of HIV and AIDS workplace interventions.
- Inadequate financial resources within ABCT to play an effective role in coordinating the private sector's HIV and AIDS response.

### Conclusion

Many of the businesses surveyed have experienced increased costs and reduced productivity as a result of HIV and AIDS. In response, some have increased their corporate social responsibility through investment in prevention programs, especially in employee education and condom distribution. Some are even supporting HBC, PLWHA, support for OVCs, and control of mother-to-child transmission. The 29 companies that reported having HIV and AIDS programs claimed to have invested TZS4,317 million (USD2.9 million) in their workplace programs in 2009/10.

While most companies surveyed are unwilling to support funding to the proposed TACTF, some expressed interest in being involved upon further direction from the government. The PER Team is of the opinion that once establishment of the fund is approved through appropriate legislation, all large domestic and international investment firms operating in Tanzania should be mandated to support the financing of the fund.



## 8. ASSESSMENT OF THE COORDINATION FRAMEWORK OF THE NATIONAL RESPONSE

### 8.1 ACHIEVEMENTS

TACAIDS is the lead government organization for coordinating the HIV and AIDS national response. As such, under the “Three Ones” principle (one strategy, one coordinating body, and one M&E system), the coordination directorate at TACAIDS has managed to perform its duties and responsibilities, albeit with many challenges. The PER Team found that HIV and AIDS focal persons are in place and functional in all MDAs. Similarly, at the regional and local levels, the TACAIDS Regional Multisectoral AIDS Coordinators, CHACs, DACCs, as well as the ward and village AIDS coordinators were all in place and functional. During the review period, TACAIDS has undertaken several tasks to strengthen the HIV and AIDS coordination system, including:

- Undertaking training to regional, district, ward, and village AIDS coordination committees
- Establishing Regional Coordinator TACAIDS posts in all 21 regions
- Working with umbrella HIV and AIDS organizations to achieve more effective and efficient coordination of the national response
- Reviewing the National HIV and AIDS Policy of 2001 and facilitating the development of the second National HIV and AIDS Policy 2011
- Strengthening TOMSHA to improve HIV and AIDS physical and financial reporting at all levels
- Managing to track the financial resources allocated for M&E activities by HIV and AIDS implementers through TOMSHA.

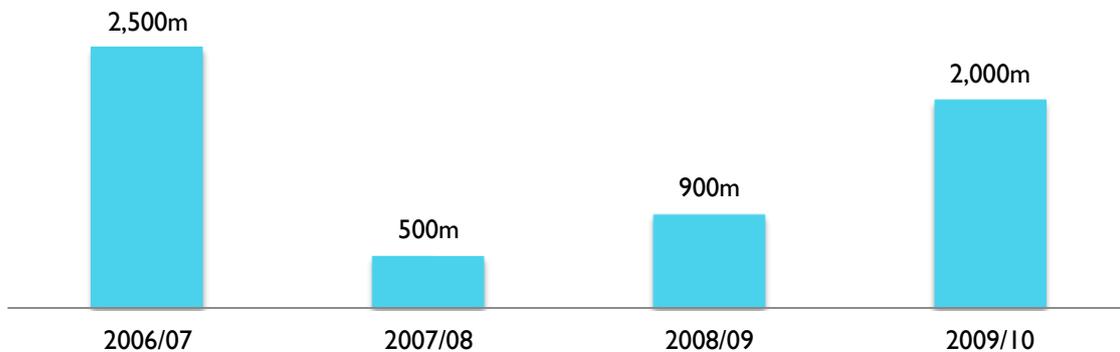
Despite these successes, a few challenges remain:

- The coordination and oversight system at regional and LGA levels is still weak and needs further strengthening. In particular, HIV and AIDS committees at ward and village levels have inadequate capacity to supervise and coordinate HIV and AIDS interventions in their respective areas – which leads to weak contribution at these levels to the national response.
- There are still observed weak planning, budgeting, and M&E and reporting in some MDAs, regions, and LGAs, coupled with low reporting compliance, all of which require greater efforts to improve system-wide performance.
- There is weak coordination among implementers in the private and informal sectors. In this regard, TACAIDS should encourage all private companies, NGOs, CBOs, and FBOs to report their HIV and AIDS activities to TACAIDS. This may be done through quarterly or annual mandatory reporting to TACAIDS to enable M&E of the trend of HIV and AIDS epidemic interventions by nongovernmental actors.

## 8.2 SPENDING ON COORDINATION

The financial resources at the disposal of TACAIDS to enable effective and efficient coordination of the HIV and AIDS national response is inadequate and varies widely from year to year (Figure 8.1). This financing situation must end if Tanzania is to have sound coordination and a better-functioning M&E system at all levels – MDAs, regions, and LGAs, down to the village level. The proposed TACTF management should be able to stabilize funding for TACAIDS to ensure more effective coordination of the HIV and AIDS national response.

**FIGURE 8.1: TACAIDS SPENDING ON COORDINATION (MN TZS)**



Source: TACAIDS (2011b)

## 9. TANZANIA AIDS CONTROL TRUST FUND

### 9.1 BACKGROUND

As discussed previously, Tanzania's HIV and AIDS epidemic is still a big threat to the lives of many people, given an HIV prevalence averaging 5.7 percent or more. Funding of the national response is in serious jeopardy. Over 97 percent of the HIV and AIDS national response is funded by donors, but their support is declining. The resource needs for the national response is over TZS1 trillion (USD670 million) per year, but currently only TZS550 billion (USD367 million) per year are made available from all sources, which is about 50 percent of the requirements. The major financiers are the U.S. government through PEPFAR and the Global Fund, which together defray 91 percent of the cost of the response; their programs are coming to an end in 2013.<sup>6</sup> This means the national HIV and AIDS response is not sustainable the way it is currently being funded.

The government through TACAIDS has recognized this problem and taken a number of important steps, including developing proposals for the establishment of an AIDS trust fund; establishing technical teams to advise on the sources of revenue for the fund, sharing the proposals with MoFEA, Tanzania Revenue Authority (TRA), and other relevant stakeholders; visiting Zimbabwe and Seychelles to learn from the experience of these two countries in managing AIDS trust funds; and developing Cabinet Paper No. 3 with attachments for seeking legislative approval for the establishment of the AIDS trust fund. Thus, the proposed TACTF has a large buy-in by many in the public and private sectors and the donor community. The PER Team urges the government to fast-track approval and implementation of the proposed TACTF as a key way of reducing donor dependency and enhancing sustainability of the response.

With due respect to all proposals made to date on how to fund and operationalize the TACTF, the PER Team suggests additional recommendations as shown in Table 9.1.

**TABLE 9.1: PROPOSED FUNDING MECHANISMS**

<b>Proposed Mechanism</b>	<b>Expected Revenue (BnTZS)</b>
Levy on all passenger and freight traffic	120
0.5% tax on annual gross earnings of large companies	117
Government allocation of 5% of domestic revenue	1,440
Tanzania Union for Government Health Employees donation of 30% of the 2% employee levy	4
Fundraising campaign	10

<sup>6</sup>However, we understand the U.S. government is willing to continue to fund PEPFAR beyond the expiry date through GHI, which has a six-year worldwide budget of USD63 billion to support health interventions, including HIV and AIDS.

These mechanisms are detailed in the following section.

## 9.2 PROPOSED FUNDING MECHANISMS

### Proposal I: Levy on airline traffic

#### Background

UNITAID is the first organization that introduced an air levy in September 2006. Since then the levy has raised approximately USD1 billion to combat HIV and AIDS, malaria, and TB. The UNITAID airline levy is designed to provide a sustainable and predictable funding mechanism that allows for longer-term projects to succeed (UNITAID 2009). France was the first country to introduce a solidarity tax on airline tickets. Currently, seven countries (Chile, Cote d'Ivoire, France, Republic of Korea, Madagascar, Mauritius, and Niger) apply this levy. Additionally Jordan, Kenya, and Burkina Faso have pledged their intention of introducing it in the near future (UNITAID 2008). In view of declining donor resources for supporting the HIV and AIDS response, Tanzania proposes to introduce an airport levy as one of the mechanisms to fund the TACTF.

**Recommendation I: The PER Team proposes a small levy on all passenger and freight air traffic (excluding flights in transit) of USD2.50 per passenger and USD0.05 per ton of cargo.**

This levy will be applied in a similar fashion to the airport tax and deposited to the trust fund account. The expected revenue for 2012/13–2015/16 would be about USD80 million or TZS120 billion.

Table 9.2 provides examples of the airline levy in three countries: Kenya, Niger, and France.

**TABLE 9.2: EXAMPLES OF AIRLINE LEVY RATES**

Example of airline levy rates: Kenya			
Options	Levy Rate	Expected Revenue (2010–14)	Implementing Modality
1. Levy on outbound passenger traffic	USD1.00	USD12.37 million	This levy is usually applied in a similar fashion to airport taxes.
	USD2.50	USD30.9 million	
	USD5.00	USD61.86 million	
2. Levy on both outbound and inbound passenger traffic	USD1.00	USD30.19 million	It can be implemented as a landing levy that is added to general airport landing taxes.
	USD2.50	USD75.48 million	
	USD5.00	USD150.97 million	
3. Levy on all passenger and freight traffic (excluding flights in transit)	USD2.50 per passenger; USD0.05 per ton of cargo	USD159.77 million	This levy is usually applied in a similar fashion to airport taxes.
Example of airline levy rates: Niger			
	Domestic	Regional/International	
Economy class	USD1.20	USD4.70	
Business and first class	USD6.00	USD24.00	
Example of airline levy rates: France			
	Domestic	Regional/International	
Economy class	EUR1 (USD1.37)	EUR4 (USD5.47)	
Business and first class	EUR10 (USD10.67)	EUR40 (USD54.67)	

Sources: Based on GoK (2010) [Kenya example]; UNITAID (2008)

## Proposal 2: Levy a small tax on large domestic and international businesses operating in Tanzania

Tanzania receives domestic and international investments in mining, banking, tourism, telecommunications, and other businesses that contribute revenue to the government coffers. As part of their philanthropic and corporate social responsibility, the government is urged to ask these businesses to contribute to the TACTF.

**Recommendation 2:** *The government should mandate all large domestic and international businesses operating in Tanzania to contribute 0.5 percent of their annual gross earnings to the TACTF.*

This corporate social responsibility levy will be collected by Tanzania Revenue Authority (TRA ) and deposited to the fund account. It is expected such a levy will yield TZS117 billion for the trust fund between 2012/13 and 2014/15.

## Proposal 3: Commit significant national funding to the HIV and AIDS national response from domestic budget resources

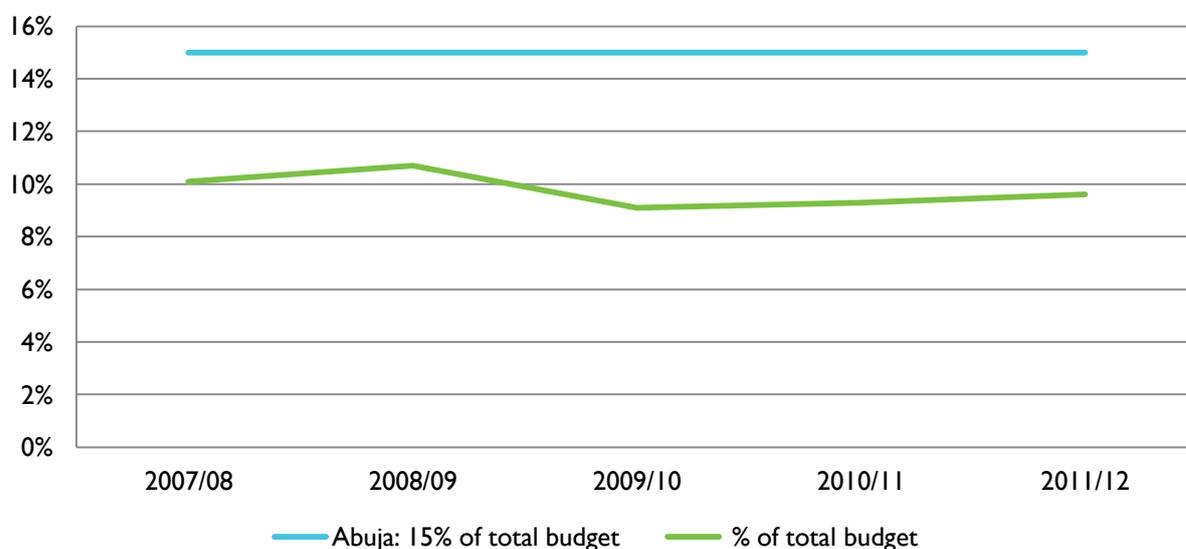
Currently, the government contributes less than 3 percent of the resources financing the HIV and AIDS national response. This is low compared with other countries (Kenya, Botswana, South Africa, etc.), which finance over 10 percent of their countries' HIV and AIDS programs.

**Recommendation 3:** *The government is urged to allocate 5 percent of domestic revenue to the TACTF.*

The expected revenue for 2013/14–2015/16 will be TZS1.44 trillion, bringing the country to within 3 percentage points short of reaching the Abuja health spending commitment. The Prime Minister will seek legislative approval to effect this proposal.

This proposal should be implemented as part of the Tanzanian government commitment made in 2001 under the Abuja Declaration on HIV and AIDS, TB, and Other Related Infectious Diseases of April 2001. Signatory countries (including Tanzania) pledged to spend 15 percent of their national budgets on the health sector (OAU 2001). However, health spending has averaged about 9 percent of total government expenditure over the past three fiscal years. (While it has shown a progressive increase, from 9.1 percent[2009/10] to 9.6 percent[2011/12][Figure 9.1], given the country's recent high inflation, this is a decline in real terms of about 4.5 percentage points.)

**FIGURE 3: TANZANIA HEALTH SPENDING AS PERCENTAGE OF TOTAL BUDGET**



Source: UNICEF (2011)

**Recommendation 4: The Tanzania Union for Government Health Employees is urged to consider donating 30 percent of the 2 percent employee levy it collects monthly, as its contribution to the TACTF.**

It is estimated that this contribution will add TZS4 billion to the fund between 2012/13 and 2014/15.

**Recommendation 5: Carry out a fundraising campaign at the national level, targeting the general public and external partner organizations.**

Strong *high-level political advocacy and consensus building* is needed, demonstrating strong resolve by Tanzania's political leaders and equally strong commitment from external partners to join in fashioning a multimillion-shilling financing plan for the HIV and AIDS national response. A set of important high-level meetings could be organized under the leadership of the President and Prime Minister to kick-start the national campaigns. These would be followed by roundtable meetings and other devices to ensure regular resource mobilization for the TACTF.

**Recommendation 6: TACAIDS is urged to adopt best practices in the management of the TACTF.**

This may include, but is not limited to, the following:

1. There should be efficient funds management and administration. In particular, the TACTF Committee and TACAIDS Secretariat should use existing planning, budgeting, financial management, and reporting systems that have already been put in place by PMO-RALG, as well as the financial management systems that are in place for managing the NMSF grant. The rich experience learned so far should inform the management of the fund, including ensuring timely disbursement of planned HIV and AIDS resources to spending units.
2. TACAIDS should review existing standard guidelines and other guiding principles to ensure the focus on HIV and AIDS interventions is consistent and based on the NMSF priorities and strategies. This may also entail integrating the TOMSHA database as a module into the Local Government Monitoring Database. In this regard, TACAIDS will have to procure computers and their accessories for over 63 councils that are not yet integrated into the national database.
3. With regard to resource allocation from the fund, TACTF management could use the current formula for sharing the NMSF grant among the LGAs, which is based on elaborate and verifiable criteria. However, as observed in Section 6.3, the allocations are not equitable across districts in per capita terms. Therefore, the criteria have to be reviewed by first conducting a survey to determine the reasons for inequity amidst the seemingly good resource allocation criteria.

## 10. RECOMMENDATIONS OF THE HIV AND AIDS PUBLIC EXPENDITURE REVIEW 2011

This review of HIV and AIDS public spending in Tanzania for the period 2009/10–2010/11 provides the following observations and recommendations:

1. The government is urged to fast-track the establishment of the TACTF to ensure sustainability of the HIV and AIDS national response. This is urgent because as observed by the PER Team, donor financing of the response is progressively declining. The Global Fund has declared that no new proposals will be solicited until 2014. The United States government support agreement is coming to an end in 2013 and there is no assurance of continuation of the program at current levels of support. Other donors have also scaled down their support. Therefore, the government needs to increase its commitment to the HIV and AIDS national response by allocating greater budgetary resources.
2. TACAIDS is urged to appoint a team of technical experts to deliberate and recommend an appropriate institutional, administrative, and management structure, operational modalities, and related financial accountability systems. The team will also review already-recommended sources and mechanisms for funding the TACTF and map out their implementation strategy. The PER Team proposes additional possible sources of financing the trust: (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.
3. TACAIDS should develop a guiding tool for the private sector to use during the implementation of HIV and AIDS activities in workplaces. TACAIDS (in collaboration with other stakeholders) should ensure that the private sector has a reporting mechanism and effective workplace HIV and AIDS programs. In addition, the financial capacity of the ABCT should be enhanced to enable it to play its role of coordinating the private sector's response more effectively and efficiently.
4. Execution of HIV and AIDS interventions in MDAs and LGAs should be scaled up in order to realize the objectives and goals of the national response. The challenges contributing to low execution should be addressed. In particular, late or non-release of funds, lengthy procurement procedures, and low absorption capacity should be addressed, especially at the LGA level where capacity building is most needed. In addition, the release of the NMSF grant in full and on time will 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.
5. TACAIDS, in collaboration with relevant stakeholders, should encourage development partners to develop and test an exit strategy for their programs before ending or winding down their HIV and AIDS support. Often, ending a program that has many beneficiaries risks losing the gains already achieved through huge 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.
6. The coordination of the HIV and AIDS NMSF should be strengthened to improve effectiveness and efficiency of the national response at all levels. In particular, there is a need to ensure 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 national, sector, regional, district, and ward/village levels. In addition, TACAIDS should facilitate achievement of greater private-public partnership in the HIV and AIDS national response by providing appropriate guidance to private businesses. This may also entail providing

support to the Tanzania Association of Employees and the ABCT to enable these organizations to play a more effective role in coordinating the private sector's response.

# ANNEXES

# ANNEX A: TANZANIA HIV AND AIDS PUBLIC EXPENDITURE REVIEW 2011: SCOPE OF WORK

## OBJECTIVE OF THE STUDY

To assess HIV and AIDS activities of the public and private sector in Tanzania, including expenditures on HIV and AIDS activities, identification of gaps, and recommendation of measures for ensuring a more effective contribution to the National Multisectoral Strategic Framework (NMSF) and ways to enhance and explore public and private sector contribution to the HIV and AIDS response.

## ACTIVITIES/TASKS

- Review the HIV and AIDS Public Expenditure Review (PER) 2007–2009 findings and actions taken by the sector (if any) in response to those findings, indicating unaccomplished/pending actions and reasons as well as implications and the way forward.
- Review the general Health Sector PER 2010/11 for data and actions that may be relevant to the HIV and AIDS PER.
- Review the soon-to-be completed National Health Accounts (NHA) HIV and AIDS Subaccount (report expected by the end of April 2012) for data that may be relevant to the HIV and AIDS PER.
- Extract from Medium-Term Expenditure Frameworks (MTEFs) of the ministries, departments, and agencies (MDAs), local government authorities (LGAs), and business plans and strategies of the selected public sector entities and business companies the current plan of the HIV- and AIDS-related activities/budget and out-turns for 2009/10, 2010/11, 2011/12, 2012/13, 2013/14, and 2014/15.
- Identify current programs and the extent of implementation in the following sectors for more analysis: health, agriculture, education, community development, labor and employment, and information, culture, and sports.
- Identify current programs of HIV and AIDS in the private sector, especially sectors such as mining, fishing, communication, production, and umbrella organizations. The study should recommend on how the government can work better with the private sector in terms of private sector contribution to the national response and mechanisms to be used by the government.
- Review the implementation of HIV and AIDS activities during the above-mentioned years.
- Provide clarity on the adequacy of funding for all aspects of the NMSF with the focus on under-spending in priority areas (the PER working group will assist with the identification of priorities).
- Visit at least 10 companies to assess HIV and AIDS activity level, budget, and program content.
- Provide a summary status report on development and implementation of HIV and AIDS activities (i.e., an assessment of plans vs. budgets vs. actual expenditures), including the identification of specific bottlenecks or obstacles to the realization of planned expenditures.
- Assess ongoing development partner support to the HIV and AIDS response and how useful it is.
- Assess trend of six years of budget and expenditure.

- Obtain views on the readiness to support NMSF implementation and ideas on future support.
- Assess allocation of funds for 2010/11 and 2011/12 based on the thematic areas in the NMSF.
- Review and make recommendations to improve the HIV and AIDS response.

## **DELIVERABLES**

1. A full draft report (between 40 and 50 pages, excluding appendices), including annexes, tables, and figures should be submitted by May 15, 2012 in electronic form (MS word and MS Excel).
2. The finalized report taking account of comments/recommended amendments should be submitted in electronic form June 15, 2012.



## ANNEX B: MEMBERS OF THE FINANCE AND AUDIT TECHNICAL WORKING COMMITTEE AND PUBLIC EXPENDITURE REVIEW TEAM

### Finance and Audit Technical Working Committee Members

Dr. Elly Ndyetabura	UNDP
Dr. Peter Bujari	HDT/TAF
Gerwalda Henjewe	TACAIDS
Milton Lupa	TACAIDS
Richard Ngirwa	TACAIDS
E. Malangalila	WORLD BANK
Tracy Carson	PEPFAR
D. Haazen	WORLD BANK
Abdala Mwinchande	CONCERN
Focus Lutinwa	PricewaterhouseCoopers
Dr. Inge Baumgarten	GTZ
Marjorie Mbilinyi	TGNP
S. Magonya	Ministry of Finance and Economic Affairs
Aaron Karnell	USAID
Chris Armstrong	CIDA
Focus Lutinwa	PricewaterhouseCoopers
Nada Margwe	PricewaterhouseCoopers
Beng'ilssa, Chair	TACAIDS

### Public Expenditure Review 2011 Team

Dr. William Kafura	TACAIDS
Mwagule Dickson	TACAIDS
Juliana Masanja	TACAIDS
Hatibu Kunga	TACAIDS
Karisti Mn yako	TACAIDS
Innocent Pantaleo	Consultant
Dr. Daniel Ngowi	Consultant – Team Leader



## ANNEX C: PEPFAR IMPLEMENTING PARTNERS

In 2009/10 a total of nearly USD88.3 million was disbursed to implementing partners at the local level. This is equivalent to about 23.5 percent of PEPFAR funds channeled to support the HIV and AIDS response in Tanzania.

### PEPFAR Implementing Partners in the Districts/Regions

Project/ Program Title	PEPFAR Implementing Partner	Description of Project/Program	Funds Disbursed 2009/10 (USD)
Arusha (ZTC)	CEDHA	Provide support to ZTC to provide an opportunity to develop master trainers and training curricula, and oversee training of providers	1,080,000
Primary Health Care Inst.	Iringa ZTC	Provide support to ZTC to provide an opportunity to develop master trainers and training curricula, and oversee training of providers	1,050,000
Kigoma ZTC	Kigoma ZTC	Provide support to ZTC to provide an opportunity to develop master trainers and training curricula, and oversee training of providers	540,000
MAISHA	JHPIEGO	Reduce maternal and newborn mortality	7,776,900
CAPACITY	IntraHealth	Human resources for health and OVCs	6,266,259
Pamoja Tuwalee	PACT	Care for OVCs	968,692
Pamoja Tuwalee	Family Health Int'l	Care for OVCs	5,214,774
Pamoja Tuwalee	World Education	Care for OVCs	1,000,000
Pamoja Tuwalee	Africare	Care for OVCs	2,299,696
TPPI	PharmAccess	HIV prevention, PMTCT, counseling and testing, HIV care and treatment, pediatric care and support, pediatric ART, harmonization of HIV/TB, HBC, OVC, and police child-friendly services	3,725,088
Stradcom	Johns Hopkins Univ.	Prevention of HIV/AIDS	1,977,777
URI	Univ. of Rhode Island	Health of coastal residents	200,000
AWF	African Wildlife Fndn.	Health of farmers	200,000
Pact Tanzania	PACT	System strengthening, care to OVCs, and S&D	4,500,000
Selian	Selian Lutheran Hospital	HIV care and treatment	2,000,000
EGPAF	Elizabeth Glaser Pediatric Foundation	PMTCT	6,287,965
JGI	Jane Goodall Institute	AIDS education and care services	200,000
CHAMPION	Engender Health	Behavior change to prevent HIV/AIDS	2,050,000
UHAI	JHPIEGO	HIV counseling and testing access	3,075,656

<b>Project/ Program Title</b>	<b>PEPFAR Implementing Partner</b>	<b>Description of Project/Program</b>	<b>Funds Disbursed 2009/10 (USD)</b>
Savannas Forever	Savannas Forever	HIV counseling and testing in northern and western Tanzania	155,000
Tunajali	Deloitte	Community-based care	3,471,473
BOCAR	Deloitte	Capacity building of CSOs helping people with HIV	1,100,000
Baylor International Pediatric AIDS Initiative	Baylor College of Medicine	Develop two Pediatric Centers of Excellence to catalyze access to HIV/AIDS care and treatment for children	4,600,000
MRH	Mbeya Referral Hospital	Health systems strengthening	5,065,879
PAI-DOD	PharmAccess	HIV Prevention, PMTCT, counseling and testing, HIV care and treatment, pediatric care and support, pediatric ART	5,111,200
MHN	Mbeya HIV Network Tanzania	HIV and AIDS interventions	2,936,123
SONGONET	SONGONET-HIV Ruvuma	HIV and AIDS interventions	1,186,629
MRMO	Mbeya Regional Medical Office	Health systems strengthening	5,875,000
RKRMO	Rukwa Regional Medical Office	Health systems strengthening	3,775,000
RRMO	Ruvuma Regional Medical Office	Health systems strengthening	3,270,000
KIHUMBE	KikundiHudumaMajumbani	Home-based care	1,373,750
<b>Subtotal</b>			<b>88,332,861</b>

Source: Authors' calculations based on URT ((2012)) and PEPFAR reports

ZTC = Zonal training college

PMTCT = Prevention of mother to child transmission

S&D = Special and differential treatment

### Other PEPFAR Implementing Partners

In 2009/10 a total of USD287.2 million was disbursed to implementing partners working at both local and national level. This is equivalent to about 76.5 percent of PEPFAR funds provided to support the HIV and AIDS response in Tanzania.

Project/Program Title	PEPFAR Implementing Partner	Description of Project/Program	Funds Disbursed 2009/10(USD)
Operational Research	Ifakara Health Inst.	Malaria rapid diagnostic test (RDTs), case management, and surveillance	669,000
T-MEMS	The Mitchell Group	M&E	365,000
Health Policy Initiative	Futures Group	Policy assistance for HIV/AIDS, family planning, gender-based violence	3,535,000
Wajibika	Abt Associates	Health systems strengthening	3,275,000
Febrile Illness Program	URC	Febrile illness assistance for children in Lake Zone	3,050,000
PASADA	PASADA	HIV care and treatment	3,878,347
Tanzania Angaza/Zaidi	AMREF	Counseling and testing services	750,000
University Research Corp.	URC	HIV-related research	400,000
Maisha Kikamilifu	Mildmay International	Home-based palliative care	789,940
African Palliative Care Association	APCA	Palliative care	450,000
Axios	Axios Tanzania	Palliative care	350,000
ROADS	FHI	HIV prevention	7,466,455
UJANA	FHI	Prevention of HIV/AIDS	6,301,125
SPS	MSH	Technical assistance to pharmacies	699,999
Health Systems 20/20	Abt Associates	Systems strengthening and financial management	100,000
Deliver 3	JSI	Commodity logistics	9,674,000
Deliver 1	JSI	Commodity logistics	1,200,000
International Youth Fdn.	IYF	Youth counseling	1,200,000
Touch PPP	Touch Foundation	Support for expansion of health worker training	2,000,000
Health systems strengthening	Kilimanjaro Int'l Corp	Support services for HIV/AIDS program management	118,575
Education Sector Project	TBD	Schools skills HIV-related training	200,000
Tanzania Capacity & Communications Program	JHU-CCP	Increase adoption of safer behaviors by Tanzanian adults to prevent HIV, support family planning use to reduce unmet need, and address other health issues	5,044,547

<b>Project/Program Title</b>	<b>PEPFAR Implementing Partner</b>	<b>Description of Project/Program</b>	<b>Funds Disbursed 2009/10(USD)</b>
Tanzania Social Marketing Program	PSI	Build sustainable social marketing infrastructure, establishing coverage for a range of essential health products	8,260,000
RODI	Resource Oriented Development Initiatives	HBC and Faith based organizations (FBO)	1,271,450
ICB	Management Sciences for Health, Inc.	Health systems strengthening	1,350,000
MoHSW	Ministry of Health and Social Welfare, Tanzania	Health systems strengthening	965,680
NIMR	National Institute for Medical Research	Research on HIV-related issues	1,749,750
IHI-MC	IntraHealth International, Inc.	Counseling and testing	2,583,259
UTAP	Tulane University	Male circumcision and other HIV-related interventions	200,000
NACP	National AIDS Control Program Tanzania	HIV- and AIDS-related interventions	3,049,432
WHO	World Health Organization	MSD and other support	500,000
ZACP	Ministry of Health and Social Welfare, Tanzania – Zanzibar AIDS Control Program	HIV-related interventions	2,377,000
SAVVY & DSS	Ifakara Research Center	Strategic HIV and AIDS information	275,000
UCC	University Computing Center Ltd.	Strategic HIV and AIDS information	255,000
UTAP UCSF-MARPS	University of California at San Francisco	Health systems strengthening	700,000
AMREF Lab	African Medical and Research Foundation	Support for laboratory infrastructure	463,158
ICAP	Columbia University	PMTCT and improve MCH and PMTCT services, care, and treatment	12,795,000
BMC	Bugando Medical Center	Counseling and testing	1,499,000
ASCP Lab	American Society of Clinical Pathology	Increasing laboratory capacity to support HIV/AIDS care and treatment	1,080,222
CLSI Lab	Clinical and Laboratory Standards Institute	Laboratory infrastructure support	700,000
ASM Lab	The American Society for Microbiology	Laboratory infrastructure support	50,000
Pathfinder International	Pathfinder International	Adult care and treatment, OVCs, PLWHA	4,210,000
BIG	Balm in Gilead	Sexual prevention, OVCs	1,400,000

<b>Project/Program Title</b>	<b>PEPFAR Implementing Partner</b>	<b>Description of Project/Program</b>	<b>Funds Disbursed 2009/10(USD)</b>
Single eligibility FOA	National Tuberculosis and Leprosy Control Program	Integrated TB/HIV services; Strengthen surveillance of HIV in TB patients	2,490,000
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation	Pediatric HIV and other HIV-related activities	8,389,231
Track 1.0-EGPAF	Elizabeth Glaser Pediatric AIDS Foundation	HIV-related services in 34 districts	5,006,215
Track 1.0-ICAP	Columbia University	HIV-related services in 23 districts and Zanzibar	4,400,000
MUHAS-SPH	Muhimbili University College of Health Sciences SPH	Health systems strengthening	650,000
DCC	Drug Control Commission	Drug use control support	789,450
MARPS	Columbia University	Support for intravenous drug users, sex workers, and men having sex with men	400,000
Helpline & Youth	Tanzania Youth Alliance	Youth HIV prevention activities	950,000
AFENET	The African Field Epidemiology Network	Health systems strengthening	1,035,000
FXB	Francois-Xavier Bagnoud Center	Health systems strengthening, PMTCT	831,523
Africare	Africare	Care and treatment support	1,698,742
UNICEF	UNICEF	OVC services	944,000
UNAIDS-M&E TA	UNAIDS	Strategic HIV and AIDS information	223,151
Prevention Scenario Model	NASTAD	Development of prevention model	300,000
P4H	CDC Foundation	Care and treatment, PMTCT, strategic information	1,173,099
MoHSW	Ministry of Health and Social Welfare, Tanzania	HIV and AIDS interventions	3,150,000
Fellows	Association Schools of Public Health	Technical support	709,424
Columbia	Columbia University	PMTCT, care and treatment	2,182,047
MoHSW	Ministry of Health and Social Welfare, Tanzania	HIV and AIDS interventions	1,250,000
MOBIS	MOBIS	HIV and AIDS interventions	200,000
IDIQ Gesis Study	Christian Social Service Commission	HIV and AIDS interventions	420,000
IPC TA MOHSW	Johns Hopkins University	Biomedical prevention	948,750
Data Warehouse	Research Triangle Institute	Health information systems	100,000

<b>Project/Program Title</b>	<b>PEPFAR Implementing Partner</b>	<b>Description of Project/Program</b>	<b>Funds Disbursed 2009/10(USD)</b>
Blood IT	American Association of Blood Banks	Blood safety	551,104
RTI-BPE	Research Triangle Institute	Health Systems Strengthening	1,294,000
Muhimbili-TAP	Muhimbili University College of Health Sciences	Technical assistance	1,350,000
CRS Follow On	Catholic Relief Services	Care and treatment	900,000
EGPAF Follow On	Elizabeth Glaser Paediatric AIDS Foundation	HIV- and AIDS-related interventions	809,000
IPC TA MoHSW	JHPIEGO	Technical assistance	625,784
TACAIDS-M and E	Tanzanian Commission for AIDS	M&E support	100,000
Donor mobilization	Regents of the University of Minnesota	Blood donor mobilization	1,050,000
Harvard	Harvard University School of Public Health	Technical assistance	1,608,546
UCSF	University of California at San Francisco	Human resources for health	1,125,000
CSSC	Christian Social Services Commission	HIV-related services	720,000
FBO Networks	Tanzania Interfaith Partnerships	Counseling and testing, OVC, prevention	896,079
ITECH	University of Washington	Human resources for health	5,667,441
Twinning	American International Health Alliance	Human resources for health	2,800,000
Track 1.0-CRS	Catholic Relief Services	Care and treatment	1,063,792
MDH	Harvard University School of Public Health	Human resources for health	7,400,600
CRS	Catholic Relief Services	HIV-related services	16,548,799
Track 1.0-Harvard	Harvard University School of Public Health	Human resources for health	6,786,072
Fogarty	U.S. National Institutes of Health	Human resources for health	450,000
U.S. Peace Corps	U.S. Peace Corps	Health systems strengthening	199,500
Grants	U.S. Department of State	Grants for CSOs and OVCs	150,000
RPSO	Regional Procurement Support Office/Frankfurt	Procurement of essential drugs	10,010,432
Wajibika	Abt Associates	Health systems strengthening	1,400,000
MEASURE DHS	ICF Macro	Strategic information	425,000
DQA-MEASURE EVALUATION	Measure Evaluation	Monitoring and assessment of results	1,500,000

<b>Project/Program Title</b>	<b>PEPFAR Implementing Partner</b>	<b>Description of Project/Program</b>	<b>Funds Disbursed 2009/10(USD)</b>
Condom procurement	Central Contraceptive Procurement	Condom procurement	1,000,000
Solar Aid-PPP	Solar Aid	Solar electrification in rural health centers	200,000
IQC BPE	Deloitte Consulting Limited	Strategic information	255,000
MAISHA	JHPIEGO	Care and treatment	2,516,990
CAPACITY	IntraHealth International, Inc.	Care and treatment	5,666,259
FHI-System Strengthening	Family Health International	HBC and health systems strengthening	2,050,000
Touch-PPP	Touch Foundation, Inc.	Health systems strengthening	1,000,000
TPPI	PharmAccess	Care and treatment	2,495,088
STRADCOM	Johns Hopkins University	Health systems strengthening	2,280,000
URI	University of Rhode Island	Health human resources	200,000
AWF	African Wildlife Foundation	Prevention activities	200,000
PACT	Pact, Inc.	Care and treatment, OVCs	4,500,000
Selian	Selian Lutheran Hospital	Care and treatment	1,901,289
OVC Employability	Development Alternatives Inc.	OVC services	1,188,123
PATH	Program for Appropriate Technology in Health	Care, PMTCT	2,000,000
EGPAF-USAID	Elizabeth Glaser Pediatric AIDS Foundation	Prevention-PMTCT	6,287,965
AMREF	African Medical and Research Foundation	Counseling and testing, PMTCT	3,109,000
URC	University Research Corporation, LLC	PMTCT, ART, OVC, and related MCH services	2,050,000
Acquire Project	Engender Health	PMTCT and related MCH services	2,050,000
MaishaKikamilifu	Mildmay International	Care and treatment	789,940
African Palliative Association	African Palliative Care Association	Technical assistance	100,000
Axios	Axios Partnerships in Tanzania	Care and treatment	350,000
ROADS	Family Health International	Sexual prevention	3,673,286
UJANA	Family Health International	Sexual prevention	6,001,125
SPS	Management Sciences for Health	Health systems strengthening	699,999
BIPAI-PPP	Baylor College of Medicine International Pediatric AIDS Initiative/Tanzania	Human resources for health	3,200,000
CHAMPION	Engender Health	Sexual prevention, 13 districts	3,360,000

<b>Project/Program Title</b>	<b>PEPFAR Implementing Partner</b>	<b>Description of Project/Program</b>	<b>Funds Disbursed 2009/10(USD)</b>
Community Services	Deloitte Consulting Limited	HBC and OVCs	4,945,693
UHA1	JHPIEGO	Counseling and testing	2,940,000
JGI	Jane Goodall Institute	Sexual prevention, care and support	200,000
FANTA II	Academy for Educational Development	OVCs, PLWHA	800,000
Field Support/Annual	JHPIEGO	Male circumcision and health system strengthening	1,301,078
Fintrac	Fintrac	Sexual prevention	430,000
Health Systems 20/20	Health Systems 20/20	Health systems strengthening	250,000
TechnoServe	TechnoServe	Sexual prevention	200,000
HIF-PPP	HIF	Health insurance fund	400,000
Coordinated OVC Care-RFA-FHI	Family Health International	HBC, OVCs, health systems strengthening	3,964,774
Gen Mills-PPP	General Mills	Food and nutrition for PLWHA	150,000
Coordinated OVC Care-RFA-Pact	Pact, Inc.	OVCs	1,791,766
TCCP	Johns Hopkins University	Sexual prevention	650,000
Social Marketing	Population Services International	Prevention interventions	4,160,000
AIDSTAR II	AIDSTAR I	Health systems strengthening	41,988
Coordinated OVC Care-RFA-Africare	Africare	HBC, OVCs	1,812,152
IYF OVC	International Youth Foundation	Youth services	600,000
HUSIKA	Population Services International	HIV and AIDS interventions	2,411,872
TF Inc	Touch Foundation, Inc.	Health systems strengthening	50,000
Madaktari PPP	Madaktari Africa	Health systems strengthening	100,000
<b>Subtotal</b>			<b>287,246,107</b>

Source: Authors' calculations based on URT (2012) and PEPFAR reports

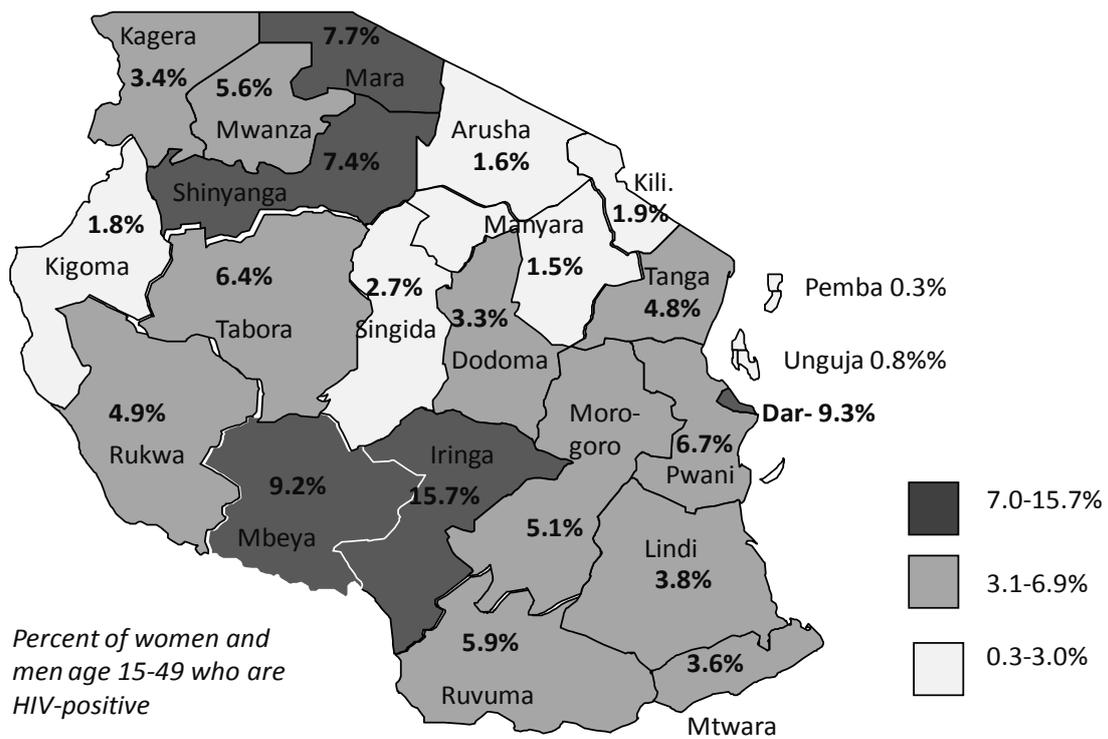
PMTCT = Prevention of mother to child transmission

MCH = Mother and child health

# ANNEX D: HIV PREVALENCE IN TANZANIA BY REGION

The HIV and AIDS epidemic is serious, with some regions having HIV prevalence greater than 7 percent (Figure A1.1)

**FIGURE A1.1: HIV PREVALENCE BY REGION**



*Percent of women and men age 15-49 who are HIV-positive*

2007-08 THMIS: NBS, TACAIDS, and Macro International, Inc.

Source: TACAIDS (2010)



## ANNEX E: COMPANY SPENDING ON HIV AND AIDS WORKPLACE PROGRAMS, 2009/10

	Name of Firm	HIV and AIDS Interventions	TOTAL (TZS)
1	TANZANIA PLANTING COMPANY	Workplace HIV/AIDS programs	3,262,035,068
2	GEITA GOLD MINE	Workplace HIV/AIDS programs	692,608,500
3	MAMUJEE PRODUCTS LTD	Total amount contributed to HIV groups, schools, churches, youth groups	486,604,486
4	TANZANIA PETROLEUM DEVELOPMENT CORPORATION	Workplace HIV/AIDS programs	305,404,505
5	COLLEGE OF BUSINESS EDUCATION	Prevention, control, and/or treatment expenses for HIV/AIDS for employees	242,770,979
6	MWANANCHI COMMUNICATIONS LTD	Workplace HIV/AIDS programs	215,636,000
7	Tanzania Breweries Ltd	Workplace HIV/AIDS programs	217,810,000
8	KIBO MATCH GROUP LTD	Workplace HIV/AIDS programs	172,627,969
9	PEACOCK HOTEL	Workplace HIV/AIDS programs	129,477,855
10	TANZANIA AVIATION AUTHORITY	Workplace HIV/AIDS programs	125,204,651
11	TANESCO	Workplace HIV/AIDS programs	97,967,537
12	TANZANIA METEOROLOGICAL AGENCY	Workplace HIV/AIDS programs	96,583,592
13	BONITE BOTTLERS LTD	Workplace prevention and education programs	61,375,740
14	A TO Z TEXTILES MILLS LTD	Total amount of HIV/AIDS health-related use	56,646,562
15	SWISSPORT	Prevention, control, and/or treatment expenses for HIV/AIDS for employees in own health facilities	54,478,605
16	TANZANIA PRINTERS LTD	Workplace HIV/AIDS programs	54,218,852
17	COCA COLA CO LTD	Prevention, control, and/or treatment expenses for HIV/AIDS for employees	46,492,261
18	SAGERA ESTATES LTD	Care and support services	38,843,357
19	BRAEBURN SCHOOL (T) LTD	Total amount of HIV/AIDS health-related use	32,369,464
20	KILOMBERO SUGAR COMPANY	Workplace HIV/AIDS programs	25,000,000
21	ROTIAN SEED COMPANY LTD	Other HIV/AIDS activities	24,277,098
22	PAN AFRICAN ENTERPRISES LTD	Workplace prevention and education programs	16,184,732
23	SHUME FOREST PLANTATION	Total Amount of HIV/AIDS health related	8,739,755

	<b>Name of Firm</b>	<b>HIV and AIDS Interventions</b>	<b>TOTAL (TZS)</b>
		expenditures	
24	TANADALE PORTERS COOPERATIVE SOCIETY	Other HIV/AIDS activities	8,092,366
25	TANZANIA TOBACCO PROCESSORS LTD	Workplace HIV/AIDS programs	7,402,143
26	ALFA MATCH INDUSTRIES LTD	Workplace HIV/AIDS programs	6,473,893
27	LM INVESTMENT LTD NGUDU SISAL ESTATE	Social support services to PLWHA (in-kind benefits), widows, and families	3,236,946
28	BURHANI SAO MILLS LTD	Total amount contributed to HIV groups, schools, churches, youth groups	3,230,903
29	MIKUMI NATIONAL PARK	Workplace HIV/AIDS programs	1,700,000
<b>Total company investments in HIV and AIDS in 2009/10</b>			<b>6,493,493,820</b>

Source: Authors' calculations based on HIV and AIDS PER 2011 Company Field Survey and NHA (2012).

## ANNEX F: REFERENCES

---

- Government of Kenya (GoK). 2010, August. Report of the Technical Working Group on Sustainability for the Kenya HIV and AIDS Program. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.
- International Business Monitor (IBM). 2010. Kenya Freight Transport Report 2010. Nairobi, Kenya: IBM
- International Civil Aviation Organization. 2008. Annual Report of the Council: 2008. Montreal, Quebec: International Civil Aviation Organization.
- Organisation of African Union (OAU). 2001, April. Abuja Declaration on HIV and AIDS, TB and Other Related Infectious Diseases. Addis Ababa, Ethiopia.
- Tanzania Commission for AIDS (TACAIDS). 2012, March. Country Progress Report: Part A: Mainland. Dar es Salaam, Tanzania: TACAIDS
- Tanzania Commission for AIDS (TACAIDS). 2011a, November. National Multisectoral Strategic Framework Programmatic and Financial Gap Analysis. Dar es Salaam, Tanzania: TACAIDS.
- Tanzania Commission for AIDS (TACAIDS). 2011b. August. National HIV and AIDS Response Report 2010 for Tanzania Mainland. Dar es Salaam, Tanzania: TACAIDS.
- Tanzania Commission for AIDS (TACAIDS). 2010. Tanzania HIV and AIDS and Malaria Indicator Survey (THMIS) 2007–2008. Dar es Salaam, Tanzania: TACAIDS.
- Tanzania Commission for AIDS (TACAIDS). 2007, October. The Second National Multisectoral Strategic Framework on HIV and AIDS (2008–2012). Dar es Salaam, Tanzania: TACAIDS.
- UNAIDS. 2007/08-2009/10. One UNJP Outputs, Annual, and Progress Reports. Dar es Salaam, Tanzania: UNAIDS.
- UNGASS. 2010. 'UNGASS Reporting for 2010: Tanzania Mainland and Zanzibar.' Dar es Salaam, Tanzania: UNAIDS.
- UNICEF. 2011, November. Strengthening child-focused public financial management in Tanzania. Dar es Salaam, Tanzania: UNICEF.
- UNITAID. 2009. Strategy 2010–2012: Improving Global Markets to Address HIV and AIDS, Tuberculosis, and Malaria. Geneva, Switzerland: World Health Organization.
- UNITAID. 2008. Innovative Financing for Health: The Air Tax – A Journey to Access. Geneva, Switzerland: World Health Organization.
- United Republic of Tanzania (URT). 2012. Health Sector Public Expenditure Review 2010/11. Dar es Salaam, Tanzania: Ministry of Health and Social Welfare.
- United Republic of Tanzania (URT). 2009. Millennium Development Goal Report Midway Evaluation 2000–2008. Dar es Salaam, Tanzania: President's Office, Planning Commission.
- United Republic of Tanzania (URT). 2012. National Health Accounts (NHA). Dar es Salaam, Tanzania: Ministry of Health and Social Welfare.
- United Republic of Tanzania (URT). 2009/10. Public Expenditure Review 2007-2009 HIV and AIDS. Dar es Salaam, Tanzania: TACAIDS.
- United Republic of Tanzania (URT). 2010. Tanzania Demographic and Health Survey 2010. Dar es Salaam, Tanzania: National Bureau of Statistics.



