UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE

THE NATIONAL AIDS SPENDING ASSESSMENT (NASA) IN TANZANIA
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1.0 Background

1.1 Introduction

An effective and long-term response to HIV and AIDS in any developing country must have a primary financial commitment from the national resources. As countries prioritize HIV and AIDS through increased budget allocation and development of multi-sectoral plans and work actively to involve government departments outside the health sector in the fight against HIV and AIDS, the role of budgeting and expenditure tracking to the success of these programs is becoming increasingly important. Monitoring of public expenditure for HIV and AIDS in Tanzania is vital for several reasons:

- More than looking at policy or legislation, a country's budget is the clearest, most reliable and telling indicator of a country's prioritization on the response to the epidemic.
- The national budget is key to the **sustainability** of any government program.
- With the increased donor funds being made available to many poor African countries (such as those receiving support from the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the Presidential Emergency Plan for AIDS Relief (PEPFAR), it is important to track these funds and document their items of expenditures.
- With the announcement of many African countries intension to roll-out anti-retrovirals (ARV) programs to all HIV positive citizens, it is necessary to monitor the funds allocated for treatment in relation to other HIV and AIDS interventions.

With the understanding of the above raised points, the Ministry of Health and Social Welfare in collaboration with Ifakara Health Institute (IHI) and with technical support from UNAIDS and WHO launched a study to track and assess the expenditures on HIV and AIDS related interventions starting from the source of funds to beneficiaries with the aim of establishing whether what has been allocated to providers reached the intended beneficiaries through appropriate interventions. The study employed the National AIDS Spending Assessment Tool (NASA) that was developed and supported by UNAIDS.

1.2 The National AIDS Spending Assessment Tool

National AIDS Spending Assessment (NASA) is a framework that calls for the embodiment and resource tracking of HIV and AIDS related activities occurring in all sectors given the multi-sectoral nature of the response. Expenditures are in but not limited to education, social

development, welfare and other non-healthcare delivery branches that are intimately related to the policy perception of the problem by heads of state, governments, national and international authorities (see the NASA Resource Book, UNAIDS 2006). The process follows a harmonized framework of several classifications around HIV and AIDS activities, interventions and programmatic areas. NASA seeks to answer the following questions:

- **Where does the money come from? Who provides the funds?**
  - Financial Sources

- **Which entity manages the funds? Who makes the decision on what services or goods to purchase?**
  - Financing Agents

- **Who provides the services or the goods?**
  - Services and goods providers

- **What does a provider deliver?**
  - Functions / AIDS Spending Categories: prevention, treatment, etc.

- **What does a provider buy to produce the functions?**
  - Objects of expenses: health personnel, medical supplies, etc.

- **Who are the recipients of the services and goods?**
  - Beneficiaries or target groups

1.3 Why NASA?

As mentioned earlier, tracking of public expenditure is vital for two reasons. First, a country's budget is a more telling indicator of the priority accorded to fighting HIV and AIDS than a policy or legislation. Second, the national budget is the key to the sustainability of any government program. Informed budgets and funding mechanisms for HIV and AIDS therefore enhance the ability of the government to plan and implement HIV and AIDS interventions effectively. Tanzania developed a multi-sectoral framework that actively involves government departments outside the health sector in the fight against HIV and AIDS. It is therefore critical to recognize the importance of such responses (through several funding sources), and tracking the expenditures and financial flows to the beneficiary level.

The National Multi Sectoral Strategic Framework (NMSF) operationalizes the National HIV and AIDS Policy under 4 Thematic Areas. These areas are categorized as: Cross cutting Issues; Prevention Interventions; Care and Treatment; and Impact Mitigation (United Republic of Tanzania (URT), 2007a). Whereas the NMSF delineate four thematic areas, NASA has added value as it has more focused thematic areas/AIDS Spending Categories

(ASC). In addition, NASA provides a broad range of the sub-categories which is a departure from broad un-detailed thematic areas of the NMSF.

The Christian Social Service Commission (CSSC) [2005] report on the Commitment by Development Partners with regard to the National Multi-Sectoral Strategic Framework on HIV and AIDS points out difficulties in assessment of funding by thematic areas of NMSF because some of the programs and projects are still reflected in a manner that combines different thematic areas. It has therefore been difficult to categorize such combined funding into specific thematic areas. As such, in this report, programs/projects that could not be aligned to the four thematic areas described above, plus the category "other" have been presented under the category 6 termed "combined." The CSSC assessment, therefore, presents funding by thematic areas using six categories; 1 to 6 as follows:

1. Cross Cutting Issues
2. Preventions Interventions
3. Care and Support/Treatment
4. Impact Mitigation
5. Others
6. Combined thematic areas

In the same report, the condensed combinations under category 6 represent the following combinations:

1. Cross Cutting, Prevention, Care and Support, Impact Mitigation
2. Cross Cutting, Prevention and Care and Support
3. Cross Cutting, Prevention and Impact Mitigation
4. Cross Cutting, Prevention, Care and Support and Others
5. Cross Cutting, Impact Mitigation and Others
6. Cross Cutting, Care and Support
7. Cross Cutting and Prevention
8. Cross Cutting, Prevention and Impact Mitigation
9. Prevention, Care and Support and Impact Mitigation
10. Cross Cutting and Impact Mitigation
11. Care and Support, Impact Mitigation
12. Prevention and Impact Mitigation
13. Prevention, Care and Support

These combinations still represent a medley of seemingly broad themes. Thus, NASA classification has a lot to be desired by counties wishing to sharpen the focus of HIV and AIDS interventions for proper monitoring of activities and financial accountability. Consequently, the motive to use the tool (NASA) in Tanzanian context for effective fight against the pandemic is apparent (see Annex 1 for NASA classifications interventions/AIDS Spending Categories).

2.0 Situation Analysis of HIV and AIDS in Tanzania

It is now more than two decades since the first three cases of AIDS were reported on Tanzania Mainland in 1983. By 2003/04 the prevalence rate was estimated at 7.0% i.e. 6.3% among males and 7.7% among females in the age group 15-49 years. By 2005/2006 the HIV prevalence rate among the antenatal clinic attendees was 8.4%[4] a decrease of about 0.3% from the estimated prevalence rate of 8.7% in 2003.[5] Revised estimates released from UNAIDS in January 2008 using Spectrum EPP indicated a prevalence rate of 6.2% (range from 5.8 – 6.6%) by end 2007. The revision represents changes in methodological approach rather than a decrease in prevalence.

Tanzania Mainland has a generalized HIV prevalence and the primary mechanism for HIV transmission in the country remains unprotected heterosexual intercourse, which constitutes about 80% of all new infections.[6] Mother to child transmission is estimated to account for about 18% of new infections. About 1.8% of young persons aged 15 to 24 who reported that they never had sex were found to be HIV positive. This suggests that they were infected through blood transfusion, unsafe injections or traditional practices, including male circumcision or female genital cutting.

For the past 25 years of the epidemic in Tanzania, reports on HIV infection among the population has consistently depicted strong regional variations ranging from the highest HIV prevalence in Mbeya (14%), Iringa (13%) and Dar es Salaam (11%) to the lowest prevalence in Kigoma (2%) and Manyara (2%). Also within the regions, there are substantial differences which suggest a possibility of different factors fuelling the HIV epidemics. Urban residents have considerably higher infection levels (10.9%) than rural residents (5.3%). Prevalence for both women and men increases with age until it reaches a peak: for women at 30-34 (13%) and for men ten years later 40-44 (12%). The picture also shows that, for both men and women, HIV prevalence increases with education. Adults with secondary or higher education are 50% more likely to be infected with HIV than those with no education i.e. with no education, males 4.2% and females 5.8% while with secondary and above education the rates are 7.3% for males and 9.3% for females. HIV prevalence among separated/divorced/widowed is significantly higher (men 15% and women 19.8%) while those currently in union/married (men 7.8% and women 6.9%) and never in union (men 3% and women 3.8%). HIV prevalence also seems to increase with wealth (poorest men 4.1% and women 2.8%) while the richest (men 9.4% and women 11.4%). So far there has not been any explanation of this great diversity and therefore no specific context programmes?

Tanzania has been fortunate to have benefited from external resources including the Global Fund round 2, 3 and 4, PEPFAR, the World Bank and other Development Partners such as the United Nations System and Bilateral donors. The Multi-sectoral HIV & AIDS Public Expenditure Review (PER) 2005-06 shows that government recurrent spending on HIV and AIDS nearly doubled between 2004-5 and 2005-6. The development partners accounted for around Tsh 204.2 billion ie 90% of total public expenditure on HIV & AIDS in 2005/6. Total expenditure on HIV-AIDS (including donors off-budget spending) was equivalent to roughly 5.6% of Government spending in 2005/6. The 2006-07 HIV & AIDS PER shows that total government plus donor spending on HIV & AIDS increased by two thirds in real inflation adjusted terms in 2006/7 to Tshs 399.2 billions. However, with the immense efforts both financial and human that have gone into the response initiatives, outputs do not match with intended achievements (e.g. a substantial decrease in deaths due to AIDS). This brings about a couple of questions: What is it that the government and their partners are not doing right; are the responses and specific interventions responding to the actual problems that need to be addressed? What if anything needs to be done to address the observed mismatch?

Equally striking is the fact that reported rates of infection in a number of regions puts sustainability of the response initiatives at a risk as the number of people being infected and needing ART increases. The unpredictable external funding with high

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[4] Ministry of Health and Social Welfare, 2006, Surveillance of HIV and syphilis infections among ante natal clinic attendees 2005-6: National Aids Control Programme NACP, Nov. 2006.

[5] Ministry of Health and Social Welfare, 2005, Surveillance of HIV and syphilis infections among ante natal clinic attendees 2003-4: National Aids Control Programme NACP, April. 2005

[6] National Multisectoral Strategic Framework 2008 - 2012

level of government dependence on external support and with about 50% of Tanzanians living under US 1 dollar per day; neither the household nor the nation can sustain the impacts and cost of treating and caring for the HIV positive people. With unpredictable funding sources and a resource deficiency within the population, an evidence-informed prevention strategy would basically be the main weapon to address the HIV and AIDS epidemic.

2.0 Situation Analysis of HIV and AIDS in Tanzania

HIV and AIDS is still a serious health threat in Tanzania which has a negative impact to social and economic development since it affects all sectors of the economy. The Tanzania HIV and AIDS and Malaria Indicator Survey (THMIS)[7] 2007-08 indicates that 6% of Tanzania adults (aged between 15-49 years) are infected with HIV, with the prevalence higher among women (7%) than among men (5%). This prevalence rate shows a slight decrease when compared with 7% prevalence rate in 2003-04[8]. Further, the THMIS shows that, the prevalence rate differs with age groups whereby the rate is higher for those aged 35-39 years while it is small to the youth aged between 15-19 years. The rate of HIV prevalence is higher in urban (almost double) than in rural areas. The THMIS shows that, HIV prevalence in urban areas is 9% (11% women, 6% men) while in rural areas it is 5% (5% women, 4% men). This pattern is the same to what was observed by the Tanzania HIV indicator survey of 2003-04. THIS revealed that prevalence was higher among women (8%) than among men (6%). HIV prevalence was also higher in urban areas (12 % for women and 9.6% for men) compared to rural areas (5.8% for women and 4.8% for men). Table 1 shows the HIV prevalence rate across age groups, residence and regions in Tanzania as reported by THIS and THMIS.

As Table 1 shows, Iringa is leading other regions with a prevalence rate of 15% followed by Dar es Salaam (9%) and Mbeya (8%). There has been a decrease in the prevalence of HIV in Mbeya region which was leading in the year 2003-04 with a prevalence rate of 14%. Prevalence in Dar es Salaam has also decreased from 11% while in Iringa the prevalence has increased by 2%. Arusha, Kigoma, Kilimanjaro and Manyara are the regions with the lower prevalence rate, below 2%. In all regions except Arusha and Mbeya, women have the higher prevalence rate compared to men.

Table 1: HIV Prevalence by Age, Residence and Regions in Tanzania

	Women		Men		All	
Category	**% HIV positive**	**Number Tested**	**% HIV positive**	**Number Tested**	**% HIV positive**	**Number Tested**
Age						
15-19	1.3	1,756	0.7	1,815	1	3,571
20-24	6.3	1,531	1.7	1,125	4.3	2,656
25-29	7.9	1,422	5	970	6.7	2,392
30-34	10.4	1,164	7.4	954	9.1	2,119
35-39	9.5	1,007	10.6	806	10	1,813

[7] THMIS is a population based survey showing indicators of HIV and AIDS and Malaria in Tanzania. It was previously known as THIS but the name was changed after integrating Malaria into the survey

[8] This figure is from THIS 2003-04

40-44	7.6	668	6.7	615	7.2	1,283
45-49	6.8	630	6.1	580	6.4	1,210
Residence						
Urban	10.6	2065	6.4	1605	8.7	3670
Rural	5.3	6114	4	5260	4.7	11374
Region						
Arusha	0.8	249	2.2	185	1.4	434
Dar es Salaam	10.2	835	7.3	693	8.9	1,528
Dodoma	4	309	2.4	271	3.3	580
Iringa	16.8	323	12.1	254	14.7	577
Kagera	3.8	534	2.9	475	3.4	1,009
Kigoma	1.5	365	0.1	297	0.9	662
Kilimanjaro	2.2	281	1.5	226	1.9	507
Lindi	4.9	201	2.6	155	3.9	356
Manyara	2.6	261	0.7	232	1.7	493
Mara	6.7	341	3.5	278	5.3	619
Mbeya	7.6	448	8.3	432	7.9	880
Morogoro	6.1	308	2.1	277	4.2	586
Mtwara	3.4	267	2.4	200	3	467
Mwanza	6	636	3.7	511	5	1,148
Pwani	6.6	152	3.2	101	5.3	253
Rukwa	4.7	260	4.3	249	4.5	509
Ruvuma	6.3	322	4.4	288	5.4	610
Shinyanga	8.4	691	6.8	656	7.6	1,347
Singida	2.8	167	2.3	151	2.6	319
Tabora	6.8	460	5.3	417	6.1	877
Tanga	5.3	334	2.1	281	3.8	614

Source: URT (2007b).

The decrease in HIV prevalence in the general population from a high of 13% in the late 1990s to 6% is attributed to the large extent by the government and non-state actors' efforts. The government in collaboration with different stakeholders has responded massively to the pandemic by committing resources for formulating policies and strategies formulation, establishing specific institutions to coordinate the response, and by funding direct interventions. The impact of HIV and AIDS is broad, touching socio-economic spheres hence, a compelling reason for a multi sectoral approach. In this respect, HIV and AIDS was declared as a National disaster in December 1999, and in December 2000 Tanzania Commission for AIDS (TACAIDS) was launched to primarily lead a multi-sectoral response to HIV. This was followed by the inauguration of a National Policy on HIV in November 2001 and the launch of a National Multi Sectoral Strategic Framework (NMSF) on HIV and AIDS (2003/07) in May 2003 which was reviewed in 2007. The new National Multi-sectoral Strategic Framework on HIV and AIDS has a five years span lasting from 2008 to 2012. The

latter is translating the National Policy for HIV and AIDS and all stakeholders contribute to the implementation of this Strategic Plan.

3.0 Methods and Data Sources

Data collection and analysis is considered to be a fundamental stage in the whole process of estimating National HIV/Aids Spending Assessment. Data collection as well as data analysis and interpretation took place in the FY 2007/08 for Tanzania Mainland. The entire process went simultaneously with NHA study. NHA followed the International Classification for NHA framework. This is according to 2003 guideline that was developed jointly by the WHO, World Bank and USAID[9]. NASA production followed the 2007 guideline that was developed by UNAIDS[10].

3.1 Dataset Components

After establishing the health accounts framework, the next step was the establishment of the data-set components for NASA. These are Financing Sources, Financing Agents, Providers of Services, AIDS Spending Categories, Beneficiary Population, and Production Factors. Definition of each component is provided in the next section. From these dimensions, six data sets were constructed as follows: -

- Health expenditure by financing source and type of financing agent (FS x FA)
- Health expenditure by financing source and AIDS Spending Categories ASC (FS x ASC)
- Health expenditure by type of financing agent and type of provider (FA x PS)
- Health expenditure by type of financing agent and Aids Spending Categories (FA x ASC)
- Health expenditure by type of provider and Aids Spending Categories (PS x ASC)
- Health expenditure by financing source and Production Factors (FS x PF)
- Providers of Services (PS) and Production Factors (PS x PF)

3.1.1 Financing Sources

Financing sources are institutions or entities that provide funds used for core; health related, non health HIV/AIDS services in the country. This tries to answer the question on "where does the money that is used to fund HIV/AIDS in the country come from?" They are entities who decide the application of resources towards functions related with the response to HIV/AIDS. When they decide to apply resources to AIDS, they become a source of finance.

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[9] WHO. (2003) Guide to producing National Health Accounts (NHA) with special applications for Low Income and Middle Income Countries

[10] UNAIDS (2007) User Guide on NASA Resource Tracking System (RTS)

(a) Public funds

Central government

Through taxation systems, the central government is regarded as one of the major source of funds for health delivery systems in public facilities in the country where HIV/AIDS services are been provided massively.

Local Government

Despite the fact that the districts under the Prime Minister's Office-Regional Administration and Local Government (PMO–RALG), do receive some funds from central government as block grant specifically for health care delivery system, while at the same time, the districts to a certain extent still have the mandate to supplement their revenues from central government by collecting additional funds (revenue) in their localities. It's a discretionary of the district to allocate funds for HIV/AIDS.

(b) Private funds

Private funds include employers that are private firms and parastatals and household funds.

(c) Rest of the World

Donors (Development Partners)

The government funds are also obtained from donors as General Budget Support, health basket funds and specific support to HIV/AIDS. Other government funds are through contributions by various donors/development to the Health Sector Basket Fund.

3.1.2 Financing Agents

Financing Agents are those institutions or entities that are used to channel the funds provided by Financing Sources and use those funds to pay for, or purchase the activities inside the HIV/AIDS boundaries.

(a) Financial Agents for Public funds

Ministry of Health and Social Welfare

The Ministry of Health and Social Welfare (MoHSW) is the main agent for the public funds. It channels its funds to government health facilities, training institutions, research institutions, and vertical programme for HIV and AIDS.

Tanzania Commission for AIDS (TACAIDS)

In early year 2000 the government of Tanzania declared HIV and AIDS problem to be a national disaster and now it is one of the government's highest priority in-terms of resource allocation. TACAIDS was established in 2001 and was mandated to provide strategic leadership and coordination of multi-sectoral response as well as monitoring and evaluation including research, resource mobilization and advocacy.

Other Ministries, Departments and Agents

Ministries such as the Ministry of Education and Vocational Training, Ministry of Defense and National Services, Ministry of Home Affairs and others have their own health facilities like hospitals, health centers and dispensaries and do receive funds from central government in order to provide health services to their employees, dependants and communities within their catchments. In this regard they perform the role of financing agencies. Many donors too, provide funds specifically for response towards HIV/AIDS pandemic to other MDAs.

Local Government Authorities

Regional hospitals are owned/(managed through the Regional Administrative Office?) by Regional Administrative Office, and district hospitals, government health centers and dispensaries are owned and run by District Councils. Therefore funds for these facilities are channeled through these authorities from central government.

Private Social Insurance Schemes

National Health Insurance Fund (NHIF) is a scheme operating under the MoHSW. It is a mandatory health insurance scheme for public servants, which covers their spouse and the maximum of four dependants. Each member contributes about 3% of his/her basic salary which is matched up with 3% by the employer ie the government of Tanzania. This scheme is an intermediary for all health conditions including HIV/AIDS conditions.

Community Health Funds

Community Health Fund (CHF) was introduced in the country in 1996. The CHF operates as a voluntary pre-paid scheme for rural households. The communities concerned are at liberty to set voluntarily on how much they would pay, but in most cases its between TShs 5,000 to TShs 10,000 per year, equivalent to US dollar 4.5 to US dollar 8.5. The CHF is conceived as a partnership between the government and communities. The agreement is that the government would provide matching funds according to members contributions. For the households which are not members, user fee is applicable. This is a fee (not actual cost but a subsidized amount) that is paid at the point of health care service delivery.

(b) Private Financing Agencies

Other Private Insurance Scheme

In Tanzania Mainland there are well established private insurance schemes which provide health care benefit package. Most of the private firms and companies and few public parastatals engage these private insurance firms by contributing certain amount of money on behalf of their employees.

Household Out-of-Pocket Payments

A household plays two roles at the same time. They are both source of funds and financing agents. This implies that households raise funds at the same time households make decision how the money should be spent including using the funds to access HIV/AIDS services. Household's contributions are through cost-sharing introduced in government facilities and user fees to private facilities.

Non-Governmental Organizations

Non-Governmental Organization (NGOs) comprises local and international organizations working in the health sector. They are financing agents because some funds from government, donors and other sources pass through these NGOs. Many NGOs do conduct interventions on HIV and AIDS related areas. These NGOs are significant in number. In most cases they work with counterparts such as government, health facilities, private practitioners and communities. Their contributions are in the areas ranging from social awareness and advocacy to more specific aspects of health service delivery.

Parastatal Companies

These are government owned public enterprises. Parastatal as Financing Agents pay out funds to health care providers for their employees and their dependants. They also reimburse the providers directly. More recently, the National Social Security Fund (NSSF) have started similar scheme of Social Health Insurance Benefit (SHIB) package for members. All these, pay for health conditions in general which includes HIV/AIDS specifics.

Private Non-parastatal Firms and Corporations

As Financing Agents, some employers are prepared to pay or subsidize expenditures incurred by their employees including even their dependants. Sometimes payment is in the form of medical allowances consolidated in the salaries. In the analysis it has proved difficult to determine expenditure pattern for medical allowances included in salaries. This is because

sometimes these allowances are spent on different things not related to health. Because of this medical allowances included in salaries have been left out from the analysis.

3.1.3 Health Providers

All entities that are responsible of delivering goods or services of health and other related with the social response towards AIDS. In Tanzania Mainland most of HIV and AIDS services are provided by health facilities that includes hospitals health centers and dispensaries and specialized clinics. Not only that but also a reasonable proportion of the population get its services from traditional practitioners. Other services are provided by pharmacies, diagnostic laboratories, insurance companies and rest of the world.

3.1.4 Functions

These are groups of services and final goods in homogeneous and excluding categories. In general these are mainly referred to as Aids Spending Categories (ASC). HIV/AIDS expenditures can be traced through types of services that are provided to different clients (PLWHA). These functions are summarized as;

- ASC 1. Prevention;
- ASC 2. Care and Treatment;
- ASC 3. Orphans and Vulnerable Children;
- ASC 4. Programme Management and Administration Strengthening;
- ASC 5. Human Resources' Recruitment and Retention Incentives – Human Capital;
- ASC 6. Social Protection and Social Services (excluding OVC)
- ASC 7. Enabling Environment and Community Development
- ASC 8. HIV and AIDS – Related Research (Excluding Operations Research)

3.1.5 Beneficiaries

These are human group towards who the actions comprised in the attention functions are directed.

3.1.6 Budgetary Item

Budgets and elements of spending that represent the acquirements and contracts of the providers for the production and delivering of goods and services.

3.2 Data sources

One of the key components in constructing NASA matrices is the availability of necessary and reliable data. NASA has used data from different sources. In this regard a careful planning was necessary. During planning stages a stock taking of data available from different sources was done. The aim was to understand existing data and the data that was difficult to obtain. The data collection plan was developed to;

- Ensure quality data are timely collected and are cost effective
- Maximize participation or involvement amongst different teams that are involved
- Ensure that the right data are collected through understanding data definitions and boundaries.

Type of data that was used in the NASA matrices was in two main categories; primary and secondary data.

3.2.1 Primary Data Collection

Primary data is data collected from the field using different methods. This could be done through routine data collecting systems, censuses and surveys. During the planning stage, it was noted that data from PLWHA were needed. This survey did not take place due to financial constraints. Instead, data estimation and application of adjusting factors were employed on secondary data that are available. However, other surveys were conducted as narrated below.

3.2.2 Secondary Data Collection

NASA largely used existing data that was obtained from different sources. It should be noted that existing data were not centrally kept which means a special mechanism had to be developed to extract existing information from different offices in the country. The team was responsible in reviewing standard data capturing tools with the aim to customize them to the local environment. Several meetings with stakeholders were held and these fora were used to further polish data capturing tools.

The exercise of collecting data was mainly done by research assistants who were supervised by researchers. Data collection for NASA was done together with the general NHA data. Before undertaking this exercise, one week training was conducted.

The composition of research team[11] was multi-sectoral drawing members from the government especially MoHSW specifically National Aids Control Programme (NACP),

[11] See Annex one, a complete list of data collectors

Ministry of Finance and Economic Affairs, Ministry of Water and Irrigation. Data was collected from the following institutions;

- Public Sector Institutions
- Development Partners
- Non Governmental Organization
- Health Insurance
- Employers/ firms

People Living with HIV and AIDS

People living with HIV and AIDS were not interviewed to establish costs for health care. Interviewing such people needed a special arrangement like ethical clearance etc. Again time span was another obstacle. The estimation techniques were employed for that matter.

1. **PLWHA in stage 1&2 in 2006**

PLWHA were estimated to be around **1,340,341** in Tanzania in 2006. **1,112,063** were assumed to be in stage 1 and 2 hence subjected to the average general household out-pocket health expenditure per annum. This was on the assumption that the expenditures by PLWHA in stages 1&2 are similar to those of the general population.

2. **PLWHA in stage 3&4 Not on ARVs and on ARVs in 2006**

In 2005, it was estimated that there were **167,937** PLWHA who were in need of ARVs but due to several factors were not put on ARVs. On the other hand it was reported[12] that in general there were **60,341** PLWHA and are on ARV. In order to estimate the expenditure for this group, the average expenditure per capita per annum for those in Stage 3&4 is the US$ 478.00[13]. However, this was on the assumption that expenditure patterns exhibited by PLWHA for this group was similar.

3.3 Data Analysis.

3.3.1 Estimation techniques for actual expenditure data

In some cases where actual expenditures were missing, disbursed funds were adjusted using actual expenditure trend analysis and other triangulation methods to estimate actual expenditures.

3.3.2 Estimation techniques to fill the expenditure data gaps

[12] Data was for public facilities reported to National Aids Control Programme

[13] Sources HIV/AIDS Care and Treatment Plan-Business Plan by the Clinton Foundation

Carefully, existing data were assessed to identify weaknesses. Adjusting factors were employed to make them more suitable for analysis.

The conduct of data surveys and review of secondary sources aimed to capture actual expenditures. Some of the primary and secondary data collection provided estimates on earmarked spending for HIV/AIDS. To the extent that such information was available for programmatic and for some personal spending, it was incorporated first. However, such data were not always available at the level of detail needed. In such cases, estimation techniques were used to allocate expenditures on personal health care based on the share of HIV. These techniques are described below.

3.3.3 Approaches to distribute expenditures by IP/OP

To obtain ratios for distribution of expenditures to HIV/AIDS specifically at provider level, whether in or outpatient, one has to make a number of assumptions. These assumptions were found to be plausible by experts from the NACP.

3.3.3.1 For allocation of outpatient visits

The starting point was the table on number of OPD cases (HIV/AIDS) produced every year by the Ministry through HMIS. This is reported for those over and under five years of age separately. This report covers public, as well as private, health facilities. The experts then suggested the average number of visits by diagnosis and the number of cases was multiplied by assumed number of visits. It is important to state that the listing of OPD cases probably under-reports HIV/AIDS and opportunistic infections because of stigma.

It was also noted that the list of OPD cases did not include provision of anti-retrovirals. The number of out patient visits for this was calculated using coverage rates for the interventions applied on the target population to get the number of individuals and then multiplied by the number of visits.

3.3.3.2 For allocation of in-patient days

The starting point was the list of inpatient diagnosis routinely reported by the Ministry of Health and Social Welfare every year. This covers both public and private but does not include the teaching hospitals. This analysis reports diagnosis for inpatients for patients below and above five years of age. Based on expert opinion, average length of stay was assumed for PLWHA. To obtain the number of inpatient days for PLWHA, the number of admissions by diagnosis was multiplied by the assumed average length of stay.

For determining the expenditures associated with inpatient days and outpatient visits, the total expenditures of the hospitals were distributed based on total number of bed-day equivalents. Total bed day equivalents included the total number of bed days as estimated above and in addition, the total number of bed-day equivalents equal to the total number of out patient visits. Using a regression equation[14], this was determined to be a 5:1 ratio, meaning five outpatient visits equals to one bed day equivalent.

3.3.4 Approaches to distribute outpatient pharmaceuticals expenditure

Since pharmacy survey was not conducted the non earmarked funds for pharmaceuticals were allocated by using the same shares as it was done to allocate by HIV/AIDS diseases.

3.3.5 Approaches to deal with co-morbidities and joint expenditure

Traditional accounting methods suggest that each transaction should be reported only once. However, for the patients with complex health problems the most important cause of morbidity from a medical perspective might not be the one that is responsible for incurring a majority of the costs.

For the purposes of this study HIV/TB programmatic expenditure of the Global Fund were allocated based on the principal purpose of the grant. As an example, Global Fund support was allocated as HIV expenditure if the principal purpose of the grant was HIV even though HIV positive patients were treated with TB or interventions were targeting HIV positive patients.

3.4 Mapping NHA HIV Sub Account to HIV NASA

This NASA was conducted simultaneously with NHA study. Hence some matrices for HIV sub accounts were mapped to NASA tables. This exercise was done manually by matching Producer Guide - HIV codes related to NASA codes. Generally, the process mainly followed the Guidelines for data collection fir GFATM 5 year Impact Assessment – Annex … and also depended upon expert opinion.

3.5 Limitations of the study

(a) Estimation of people living with HIV and AIDS

[14] Adam T, Evans DB. Determinants of variation in the cost of inpatient stay versus outpatient visits in hospitals: a multi-country analysis. Soc Sci Med. 2006 Oct;63(7):1700 -10

People living with HIV and AIDS were not interviewed to establish costs for health care. Interviewing such people needed a special arrangement like ethical clearance etc. Again time span was another obstacle. The estimation techniques were employed for that matter, hence this is a very important limitation.

(b) Double counting

In a process of trucking flows of funds for HIV/AIDS there is high probability of double counting some of funds if one entity is not that much clear or even transparent of its source and down flows.

(c) Harmonization of Financial Year versus Calendar Year

The government uses July to June as its fiscal year, while most donors use varying dates. Proposals were made to harmonize these two types of yearly financial reporting. It was proposed to use 2006 figures for 2005/06 in case an entity is using calendar year.

(d) General Health Expenditures

Even if we take into account the funds which are directly dedicated to HIV and AIDS, a proportion of the general health expenditures must also be seen as a funding relevant for HIV and AIDS. The CSSC has noted that HIV and AIDS funds also build capacities in the health sector, which will benefit general treatment and prevention[15].

(e) Estimating expenditures by beneficiaries and objects of expenditure

Since the collected data were mainly from the central sources with little data collected from the program implementers, estimating the expenditures by beneficiaries and objects of expenditure was based on the proportions reported by Kessy et al., (2007).

15 One of such examples is the improvement of Blood Banks as in a CDC project for South Tanzania.

4.0 Tanzania National AIDS Spending Assessment

4.1 Definitions and Concept of HIV and AIDS Expenditure

In this study, HIV and AIDS expenditures were defined as expenditures incurred on activities that are:

- Primarily intended to have an impact on the health status of People Living with HIV and AIDS (PLWHA) in a given period of time;
- Intended to prevent the spread of HIV and AIDS in the population at large; and
- Intended to mitigate the impact of HIV and AIDS.

These expenditures included the following:

- Direct health expenditures: those primarily and entirely associated with health care such as curative care (treatment and care), pharmaceuticals and non-durables, prevention and public health services, ancillary services such as laboratory and general health administration;
- Health-related expenditures: related to an HIV and AIDS activity though overlapping with other fields of study such as education, overall "social" expenditure, and research and development. These include education and training (workshops), research and development, and capital formation; and
- Non-health expenditures: activities aimed at mitigating the impact of HIV and AIDS on individuals and the population such as care for orphans and vulnerable children and policy advocacy.

Following from this definition of HIV and AIDS activities and using data collection methods and data sources as described in chapter three of this report, expenditures on categories presented in Table 2 were collected (Annex 1 provides sub-categories for each major category).[16]

Table 2: AIDS Spending Categories

AIDS Spending Categories (ASC)
ASC 1: Prevention
ASC 2: Care and Treatment
ASC 3: Orphans and Vulnerable Children (OVC)
ASC 4: Program Management and Administration Strengthening
ASC 5: Human Resources' Recruitment and Retention Incentives (Human Capital)
ASC 6: Social Protection and Social Services (Excluding OVC)
ASC 7: Enabling Environment and Community Development

[16] No data were available on ASC 6.

ASC 8: HIV and AIDS Related Research (Excluding Operations Research)

4.1 Total HIV and AIDS Expenditure

A summary of key statistics on HIV and AIDS spending is presented in Table 3. As the Table portrays the total HIV and AIDS expenditure in 2006 was around TShs 329,105 million an equivalent of US$ 267 million representing about US$ 7 per capital per adult population living with HIV and AIDS. Adding the non-health HIV and AIDS expenditure the total expenditure amounted to TShs 345,474 million which is equivalent to USD$ 280. As discussed in the next section, the major contributors to this expenditure are donors at who provided 68% of the total HIV and AIDS expenditure. This is similar to other countries which have undertaken similar studies such as Kenya, Malawi, Rwanda, Zambia, and Zimbabwe where the majority of these expenditures are borne by donors. The general HIV and AIDS health expenditure as percentage of total health spending was 30% in the year under study. This finding is portraying that HIV and AIDS has received a significant amount of funding compared to other components of the health care.

Table 3: Summary of General Indicators for HIV and AIDS Expenditure, 2006/07

General Indicators	2006
Total HIV and AIDS expenditure (TShs)	329,105,239,894
Total HIV and AIDS expenditure (US $)	266,697,925
General HIV and AIDS and non-health expenditure (TShs)	345,474,403,620
General HIV and AIDS and non-health expenditure (US $)	279,963,050
Per capita HIV and AIDS expenditure (TShs)	8,776
Per capita HIV and AIDS expenditure ($)	7
Total HIV and AIDS expenditure as % of GDP	2
Total HIV and AIDS expenditure as % of total health spending	29
General HIV and AIDS health expenditure as % of total health spending	30

4.2 Source of Funds for HIV and AIDS: Where Does the Money Come From?

As pointed out earlier, donors are the main contributor to the HIV and AIDS expenditure followed by the government. Donors spending as a proportion of the total HIV and AIDS contribution were found to be 68% (Table 4). Global Fund and PEPFAR contributed 14.2% and 22% of the total HIV and AIDS expenditure in 2006 respectively. Donor financing for HIV and AIDS is likely to continue to increase in both relative and absolute terms for the short to medium term given the donor commitments in particular the Global Fund and PEPFAR. Such a large increase in financial resources brings into question four key issues:

(1) Absorptive capacity and efficient use of the resources. For instance, only 49% of the approved Global Funds have been disbursed to-date due to several reasons;

(2) The sustainability of financing for HIV and AIDS goods and services should there be an about-turn in donor support;

(3) Whether government is really directing the national response to the crisis as stipulated in the National Multi-Sectoral Strategic Framework;

(4) The extent that the resources are used to strengthen the health delivery system overall rather than only for HIV and AIDS.

Table 4: Distribution of National Total HIV and AIDS by Financing Source, 2005/06

Financing Source	**Total (TShs)**	**% (2005/06)**
Public (Ministry of Finance) as % of total HIV and AIDS expenditures	89,881,208,732	26.0
Private as % of total HIV and AIDS expenditures	21,453,426,043	6.2
➢ Employers Funds	5,255,449,411	2.0
➢ Household Funds	16,197,976,632	4.7
Donors as % of total HIV and AIDS expenditures	234,138,095,670	67.8
➢ Global Fund	46,586,089,500	13.5
➢ All Other Donors	187,552,006,170	54.3
National Total HIV and AIDS by Source	**345,506,953,620**	**100.0**

The private and households spending on HIV and AIDS was significantly smaller when compared with the finances from the donors and the public. These financing sources represent only 6.5% and 4.9% of the total financing respectively. This financing trend can be explained by the roll out of several public programs in particular ARV whereby the services are offered free of charge. The government has gone an extra milestone by entering into Public Private Partnership (PPP) with private facilities to provide ARV to People Living with HIV and AIDS (PLWHAs). As will be discussed later, intensification of several programs such as voluntary counseling and testing is also observed.

The fact the funds allocated by employers represent only 1.5% of the expenditures is of concern given the wide spread campaigns on work place interventions. Thus, the need for TACAIDS and other key stakeholders (MoHSW in particular) to reinforce campaigns for employers to spend more on HIV and AIDS in the workplace is imperative Evidence indicates such programs (including condom distribution, VCT, provision of antiretroviral drugs, treatment of opportunistic infections) are a cost-effective way for firms to improve productivity through reduced staff illness and lower absenteeism

4.3 HIV and AIDS Financing Agents: Which Entities Manages the Funds?

Transfers of funds are made initially from funding sources to financing agents, which allocate the funds to providers. In this way, financing agents manage and control the use of HIV and AIDS funds. Table 5 provides a summary of financing agents whereas Table 6 provides a detailed account of financing agents. In the year under study, the public sector was the major financing agent—managing 60% of the funds. Under the public sector, the major controller/manager of HIV and AIDS is the Ministry of Health and Social Welfare (MoHSW). This might be signifying the role of the National AIDS Control Program (NACP) which is under this Ministry and which is responsible for the care and treatment component of the national HIV and AIDS multi-sectoral strategic framework and which have received a significant amount of funds to intensify care and treatment programs including rolling out of ARVs. TACAIDS managed 11% of the funds in 2006 and its role has been mainly in coordinating the multi-sectoral response. TACAIDS is responsible for coordinating service delivery on prevention (Voluntary Counseling and Testing (VCT), distribution of commodities like condoms and health learning materials, research, and may influence policy making through the technical jurisdiction in the delivery of health service. Non-governmental Organizations play a significant role in managing the funds and they have been vibrant in particular in prevention related programs. This has been the case since some development partners channel their funds through the NGOs and not the government exchequer system.

Notably, the role of donors in managing HIV and AIDS funds is significantly small (4.5%). This is an encouraging finding which is portraying the fact that national ownership and management of the programs has been created. In order to sustain this, there have to be strong accountability mechanisms to make sure that funds are allocated efficiently and to the intended use.

Table 5: Summary of Distribution of National Total HIV and AIDS by Financing Agents, 2005/06

Financing Agents	**% (2005/06)**
Public sector as % of total HIV and AIDS expenditure	63.1
Private as % of total HIV and AIDS expenditure	32.4
Donor as % of total HIV and AIDS expenditure	4.5

Table 6: Detailed Distribution of National Total HIV and AIDS by Financing Agents, 2005/06

Financing Agents	Total (000 TShs)	% (2005/06)
Ministry of Health and Social Welfare	127962	37.0
Ministry of Education	577	0.2
Other Ministries (or equivalent sector entities)	41603	12.0
TACAIDS (National AIDS Commission)	36319	10.5
Local/municipal entities not elsewhere classified	2379	0.7
Government employee insurance programs	112	0.0
Parastatal organizations	894	0.3
Other Public Financing Agents not elsewhere classified	8143	2.4
Private insurance enterprises [other than social insurance]	190	0.1
Private households' (out-of-pocket payments)	15875	4.6
Not-for-profit institutions (other than social insurance)	91597	26.5
Private non-Parastatal organizations and corporations (other than health insurance)	4195	1.2
Government of Germany	579	0.2
Government of Switzerland	46	0.0
World Health Organization (WHO)	987	0.3
United Nations Children's Fund (UNICEF)	1049	0.3
Other International not-for-profit organizations not elsewhere classified	6572	1.9
Other International Financing Agents not elsewhere classified	6395	1.9
National Total HIV and AIDS by Financing Agent	**345,506**	**100.0**

4.4 HIV and AIDS Service Providers: Where do HIV and AIDS Fund Go?

Providers of services use HIV and AIDS funds to deliver goods and services to the population. These include public and specialty hospitals and health centers, public health providers such as those providing VCT, IEC and STI prevention services, and providers of non-health HIV and AIDS services such as PLWHA support, orphans and vulnerable children care, and policy advocacy expenditure. Table 7 provides a list of providers of HIV and AIDS services. Note that a lot of providers could not be classified under NASA categories since disaggregated data on service providers are not available. About 60% of the providers of the services could not be classified. Unclassified public providers were the second dominant group providing about 30% of the services. Public general hospitals provided 4.4% of the services signifying their roles in treatment for opportunistic infections and provision of ARV. The large group of unclassified providers could be portraying the non-governmental organizations which deliver a big chunk of prevention and impact mitigation programs. Government institutions only acts as providers of services mainly at program management level but only on a few occasions they do acts as program/project implementer at the

grassroots level. Funds are also channeled to non governmental organizations for implementation of HIV and AIDS programs and projects.

The role of Faith Based Organizations (FBOs) hospitals in providing HIV and AIDS related services is shown to have declined significantly—from 11% in 2003 to 1% in 2006 (URT-NHA, 2008). This is possibly signifying problems with data capturing. Increasing role of the faith based organizations and private for profit health facilities has been observed in other studies given the government commitment to strengthen Public Private Partnership (PPP), location of these facilities (located even in far to reach remote areas) and the fact that these facilities deliver about 40% of the health care in this country. The role of the private-for-profit hospitals is also shown to be low but this can also be attributed to the weaknesses in data capturing given their current role in the provision of ARVs under contractual arrangements with the government.

Table 7: Expenditures by HIV and AIDS Service Providers, 2005/06

Providers Categories	**TShs ('000)**	**% (2005/06)**
Public general hospitals	15,057	4.4
Public specialty hospitals	153	0.0
Public outpatient care centers	2,517	0.7
Public providers not elsewhere classified	104,739	30.3
Private non-profit general hospitals	3,759	1.1
Faith Based Organizations	1,201	0.3
Private for profit general hospitals	3,496	1.0
Private for profit physician offices	1,575	0.5
Private for profit laboratory and imaging facilities	225	0.1
For profit pharmacies and medical goods retailers	4,404	1.3
Traditional informal providers	550	0.2
For profit providers not elsewhere classified	2,309	0.7
Providers not elsewhere classified	205,521	59.5
Grand Total	**345,506**	**100.0**

It is worth noting that the provision and administration of public health programs is mainly done by TACAIDS, MOHSW and Non Governmental Organizations. TACAIDS coordinates the multi-sectoral response and is responsible for;

- Formulating policy guidelines for the response of HIV and AIDS epidemic and management of its consequences in Mainland Tanzania.
- Developing strategic framework for planning of all HIV and AIDS control programs and activities within the overall national strategy.
- Fostering national and international linkages among all stakeholders through proper coordination of all HIV and AIDS control programs and activities within the overall national strategy.

- Mobilizing, disbursing and monitoring resources and ensuring their equitable distribution.
- Disseminating and sharing information on the HIV and AIDS epidemic and its consequences.
- Promoting research, information sharing and documentation on HIV and AIDS
- Promoting high level advocacy and education on HIV and AIDS prevention and control.
- Monitoring and evaluating of all on going HIV and AIDS activities.
- Coordinating all activities related to the management of the HIV and AIDS epidemic in Tanzania.
- Facilitating efforts to find a cure, promoting access to treatment and care and developing a vaccine.
- Protection of human rights of people infected and affected with HIV and AIDS, and
- Advising the government on all matters relating to HIV and AIDS in the country.

Thus, TACAIDS, MOHSW work in collaboration with NGOs, local government authorities, and other stakeholders in fulfilling its roles.

4.5 What Did the Provider Deliver? (Expenditure by Functions/AIDS Spending Categories)

The total sum reported above was spent on the interventions presented in Table 8. Interventions are referred to as "AIDS Spending Categories (ASC)" in the NASA classification. A big chunk of HIV and AIDS funds (30.5%) is spent on prevention programs (this is justified by the fact that 94% of the population is uninfected and it needs protection) followed by care and treatment category which was allocated 28.7% of the funds. Note that as noted above, the findings capture only small proportion of funding from health facilities. Thus, inclusion of all HIV and AIDS expenditure at health facilities will increase the care and treatment expenditure.

Table 8: HIV and AIDS Expenditures by Spending Categories , 2005/06

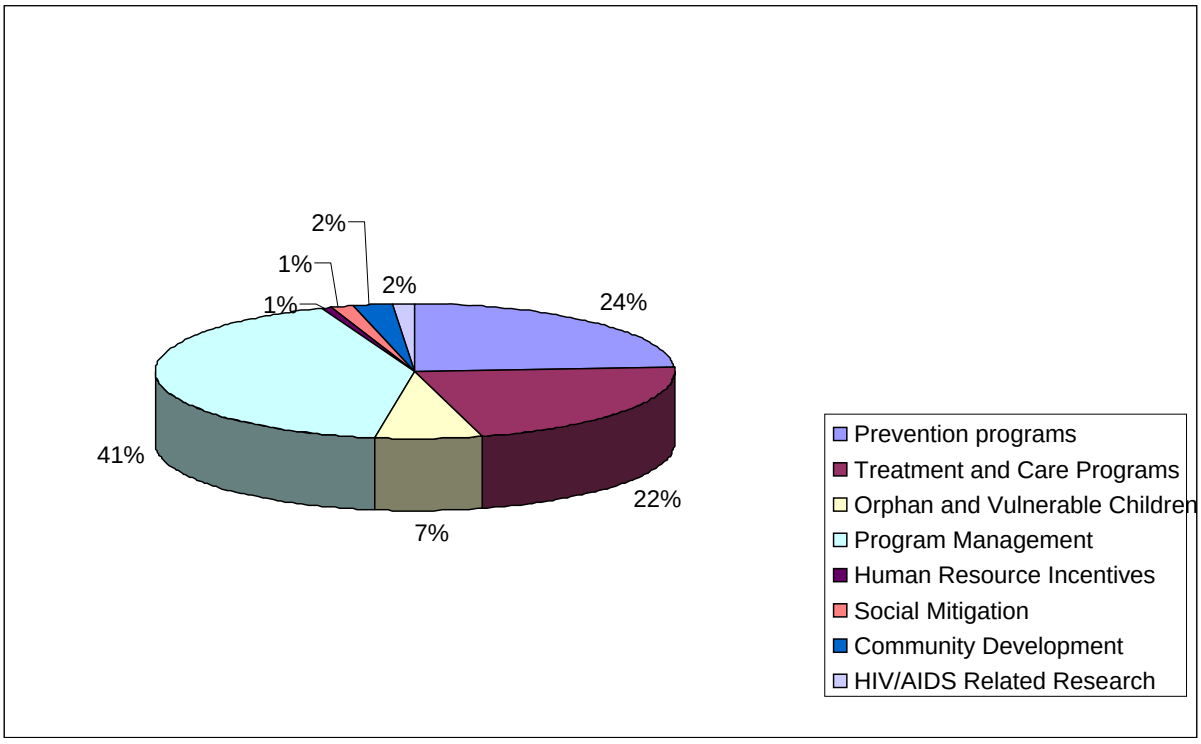
AIDS Spending Categories (ASC)	**TShs ('000)**	**% (2005/06)**
ASC 1: Prevention	105,374.81	30.5
ASC 2: Care and Treatment	99,076.00	28.7
ASC 3: Orphans and Vulnerable Children (OVC)	32.550	0.000096
ASC 4: Program Management and Administration Strengthening	52,424.67	15.2
ASC 5: Human Resources' Recruitment and Retention Incentives (Human Capital)	1,000.22	0.3
ASC 6: Social Protection and Social Services (excluding OVC)	-	-
ASC 7: Enabling Environment and Community Development	662.35	0.2
ASC 8: HIV and AIDS Related Research (excluding operations research)	1,496.00	0.4

HIV and AIDS activities not elsewhere classified	85,440.94	24.7
Grand Total	**345,506.00**	**100.0**

When these findings are compared with the findings by Kessy et al. (2007) which analyzed expenditure by functions for the year 2004/05, there is improvement in HIV and AIDS spending as much money is now channeled to interventions compared to program management. The study by Kessy et al. (2007) shows that a big percentage was spent on program development (41%) and it was followed by prevention programs and treatment and care that consumed 24% and 22% respectively (Figure 1).

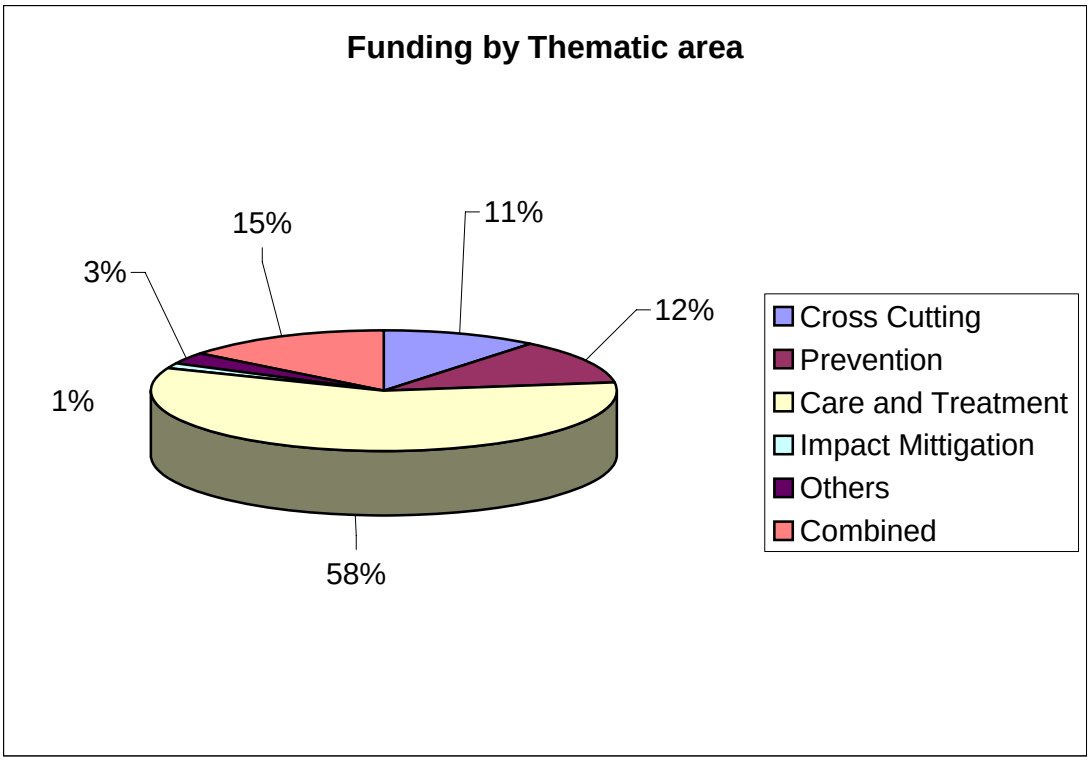
The findings by CSSC (2005) on the development partners' support shows that funds committed for care and treatment in 2005 amounted to 58.4% compared to 16.1% in 2004. This is well explained by recent emphasis on treatment, including the introduction of ARVs. Among other channels, substantial amounts have been committed for care and treatments by the Clinton Foundation and Global Fund. Funds committed to Prevention were also substantial (21.6%). This could be explained by PEPFAR, which emphasizes prevention activities (Figure 2).

Figure 1: Proportional Expenditure by NASA Functions in 2005/06



Source: Kessy et al., (2007).

Figure 2: Percentage of Total External Funding by NMSF Thematic Areas 2005 (Donor Commitments)



Source: CSSC, (2005)

4.6 Objects of Expenditure: What Did the Provider Buy to Deliver Services?

Table 9 presents expenditure by budgetary items. Four items namely administrative services (15.1%), wages (12.6%), other material supplies not elsewhere classified (12.1%), food and nutrients (10.3%) and medical and surgical supplies (10.1%) consumed a big share of the budget items. Administrative expenses takes largest share, this is not healthy since the lions share needs to be for main objectives of the preventions and care and treatment programmes.

Table 9: HIV and AIDS Expenditure by Objects/Budgetary Items, 2005/06

AIDS Spending Categories	TShs ('000)	% (2005/06)
Wages	43,653	12.6
Non-wage labor income	14,439	4.2
Monetary incentives for doctors, nurse, other staff	4,030	1.2
Anti-retrovirals	9,682	2.8
Other drugs and pharmaceuticals (excluding anti-retrovirals)	19,476	5.6
Medical and surgical supplies	34,922	10.1
Condoms	5,708	1.7
Reagents and materials	9,738	2.8
Food and nutrients	35,594	10.3
Other material supplies not elsewhere classified	41,638	12.1

Administrative services	52,048	15.1
Maintenance and repair services	2,015	0.6
Transportation and travel services	9,738	2.8
Services not specified by kind	31,229	9.0
Services not elsewhere classified	11,449	3.3
Other buildings not elsewhere classified	10,745	3.1
Laboratory and other medical equipments	5,373	1.6
Other equipment not elsewhere classified	4,030	1.2
Grand Total	**345,474**	**100.0**

4.7 Who Benefited from the Expenditure?

The findings on beneficiaries of HIV and AIDS funds are drawing from the study by Kessy et al. (2007) based on the data collected from 16 districts and 189 non-governmental organizations. Table 10 summarizes the beneficiaries of the expenditure reported in the sample sites. Health care workers benefited from 35.7% of the total funds tracked. The second group is non-targeted/general population (benefiting 26.5%) followed by people living with HIV who either has or not diagnosed AIDS who benefited from 25.8% of the expenditure of the total funds tracked. It is worth noting that although orphans and vulnerable children category received a big number of responses (as an area which these organizations were working on) only 7.2% of the tracked funds were spent on this category.

Expenditure on sex workers in Tanzania is low although anecdotal evidence shows the number of sex workers to be increasing. This is a reflection of the fact that in the Tanzanian Laws, the name ‘sex worker’ is neither used nor recognized. This lack of recognition has also been applied to the group of men who have sex with men (MSMs), which is considered illegal in Tanzania, and the silence has persisted particularly in the prisons. No expenditure has been reported for prisoners and other institutionalized persons. This is due to the fact that:

- There is a silence and secrecy on what is happening in the prisons regarding men who have sex with other men (see the Commission of Human Rights recent report published in Mwananchi Newspaper, on 25th August 2006). The prisoners and prison officers were reluctant in disclosing information on the magnitude of the practice (men to men sex in the prisons) although it is common.

- Due to operational regulations, few NGOs could penetrate the system and send the messages to the prisoners. This is on understanding that it is illegal to distribute condoms to the prisoners because MSM in Tanzania is illegal.

Table 10: Expenditure by Beneficiary Groups in 2004/05

Sn.	Beneficiary Categories	% of the Total Expenditure
1.	People Living with HIV who either has or not diagnose AIDS	25.8
2.	Injecting Drug Users (IUD)	0.0
3.	Sex workers (SWs) and their clients	0.1
4.	Orphan and Vulnerable Children (OVC)	0.00009
5.	Migrants, refugees and internally displaced persons	0.0
6.	Prisoners and other institutionalized persons	0.0
7.	Men and women separated from their families	0.0
8.	Women and Children affected by trafficking and violence	0.0
9.	Youth in social risk, out of the school, living in the street, members of gangs or institutionalized in centers for minors	1.2
10.	Partners of the people living with HIV and AIDS	0.1
11.	Children in school	0.7
12.	Youth at school	1.5
13.	Migrants workers, truck drivers and salespersons	0.1
14.	Women attending reproductive health clinics	0.8
15.	Military, police, sailors	0.0
16.	Health care workers	35.7
17.	General population/ Non targeted population	26.5
18.	Men who have sex with men (MSM)	0.0
19.	Special populations (unclassified)	6.9
	Total	**100.0**

Source: Kessy et al., (2007).

5.0 Conclusions and Recommendations

This study tracked expenditures on HIV and AIDS related interventions. The sources of funds, financing agents, service providers, and services provided/AIDS spending categories, budgetary items and beneficiaries have been covered. HIV and AIDS expenditure tracking was undertaken with the aim of establishing whether or not what has been allocated to providers reached the intended beneficiaries through appropriate interventions. A number of challenges and therefore limitations arose in the course of conducting this study. These among others include:

- Harmonization of government Financial Year (July to June) and financial year used for reporting by non-government facilities (calendar year i.e. January – December).

- Different reporting formats on HIV/AIDS expenditures against NASA format

- The absence of PLWHA survey

Based on the preceding analysis and discussion a number of conclusions can be drawn as follows.

1. Donors were found to be dominant sources of financing for HIV and AIDS activities (68% of all expenditures on HIV and AIDS). Thus, the sustainability of financing for HIV and AIDS goods and services is questionable should there be an about-turn in donor support. Further, this findings questions whether government is really directing the national response to the crisis as stipulated in the National Multi-Sectoral Strategic Framework.

2. We also observed inadequate funding for HIV and AIDS services by employers. Thus, the need for TACAIDS and other key stakeholders (MoHSW in particular) to reinforce campaigns for employers to spend more on HIV and AIDS in the workplace is imperative. Evidence indicates such programs (including condom distribution, VCT, provision of antiretroviral drugs, treatment of opportunistic infections) are a cost-effective way for firms to improve productivity through reduced staff illness and lower absenteeism.

3. HIV and AIDS expenditure was found to be 30% of the Total Health Expenditure (THE). This raises the question on the extent that the resources are used to strengthen the health delivery system overall rather than only for HIV and AIDS. There is significant flow of funds for HIV and AIDS resources in the face of limited capacity. Thus, there is a need for TACAIDS to build national capacity to effectively handle and allocate increased resources for HIV and AIDS through training to develop skills in

procurement, planning and budgeting and distribution, and offering remuneration packages to attract highly skilled workers.

4. The public was the major financing agent for the HIV and AIDS activities (60%). the role of donors in managing HIV and AIDS funds is significantly small (4.5%). This is an encouraging finding which is portraying the fact that national ownership and management of the programs has been created. In order to sustain this, there have to be strong accountability mechanisms to make sure that funds are allocated efficiently and to the intended use.

5. About 80% of the expenditure could not be classified by providers. This reflects the fact that no disaggregated data are available to show expenditure by providers as provided in the NASA classification.

6. A big chunk of HIV and AIDS funds (30.5%) is spent on prevention programs (this is justified by the fact that 94% of the population is uninfected and it needs protection) followed by care and treatment category which was allocated 28.7% of the funds. The need for TACAIDS to reconsider funding priorities to ensure that a fairer proportion of HIV and AIDS funds are directed to health systems strengthening in particular treatment and care of patients with opportunistic infections, which currently is funded primarily from Treasury resources, in addition to prevention and public health and mitigation of the disease is of essence. This can be done through further reduction of expenditures on administration of HIV and AIDS activities and make sure that more funds reach the target beneficiaries.

7. No funds have been captured on the area of social protection. This may be reflecting the fact that funding on social protection interventions had been disbursed in disjointed manner and no proper recording on what has gone into that area. The Ministry of Finance and Economic Affairs is finalizing the National Social Protection Framework. Implementation of this Framework will guide all the work and expenditures on social protection.

8. Expenditures on sex workers in Tanzania is low although anecdotal evidence show that the number of sex workers has been increasing. This is a reflection of the fact that in the Tanzanian Laws, the terminology of ‘sex worker’ does not exist. We advocate for acknowledgement of the rights of CSWs to protection and treatment, and that the work of organizations dealing with HIV and AIDS with this group receive the attention and support they deserve.

9. The silence with regard to men who have sex with men (MSMs) has also persisted in the prisons. No expenditure has been reported for prisoners and other institutionalized persons. This is due to the fact that:

- There is a silence and secrecy on what is happening in the prisons regarding men who have sex with other men.
- Due to operational regulations, few NGOs could penetrate the system and send the messages to the prisoners. This is on understanding that it is illegal to distribute condoms to the prisoners because MSM in Tanzania is illegal.

10. The findings found limited expenditure that benefited women specifically women and children affected by trafficking and violence.

11. About 62% of the tracked funds benefited health care workers (primarily through training which ultimately benefits PLWHAs) and general population (35.7% and 26.5% respectively). This is justified given the fact that 94% of the Tanzanian population who is not infected needs to be protected. About 25.8% of the reported expenditure benefited people living with HIV and AIDS directly. Of concern was the low share going to OVCs (0.00009 %).

12. NASA classification is a practical tool that should be viewed as:

    a) Input in the subsequent review of the National Multi Sectoral Strategic Framework.

    b) Input to the National HIV and AIDS Public Expenditure Review (PER) process. Currently, PER concentrates only on the figures reported at the national level and budget books. No efforts have been made to track fund from the national level to the grassroots. Understanding that conducting a full fledged NASA is an expensive endeavor, we recommend for inclusion of a special NASA Module in the HIV and AIDS PER process. This Module will track funds from the national level to the grassroots level on sampled districts, per cycle. Lessons learnt from these districts could be used to scale up interventions to other districts.

    c) A tool developed to capture all classifications of actors and activities that better reflect the national policy agendas/priorities, and that allows for internal and external standardization and hence improved comparison within the country, and within the region and globally.

13. Assessment of the budgetary performance in Tanzania is mainly based on the size and trends of the resource allocation, without opening up and looking at the nature of expenditure of the allocated resources. Thus, such studies have failed to gauge what exactly the allocated resources have been used for (i.e. which specific items have these resources been purchasing). Thus, not only sustainability of such programs is not guaranteed, but particularly many beneficiaries are either marginalized and/or

left out. Reporting system fails and overall effectiveness of efforts to fight the pandemic is therefore jeopardized. The relevance and especially need for employing monitoring instruments such as NASA is therefore pertinent.

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ANNEXES

Annex 1: AIDS Spending Categories

ASC.1 PREVENTION
ASC.1.01 Communication for social and behavioral change
ASC.1.01.1 Communication for social and behavioral change programs targeting the health risks of HIV prevention campaigns
ASC.1.01. 2 Communication for social and behavioral change programs targeting the non-health risks of HIV prevention campaigns
ASC.1.01.98 Communication for social and behavioral change not desegregated according to the content as health or as non-health activities.
ASC.1.02 Community mobilization
ASC.1.03 Voluntary counseling and testing
ASC.1.04 Risk-reduction for vulnerable and special populations (Programs for vulnerable and special populations)
ASC.1.04.1 VCT as part of programs for vulnerable and special populations
ASC.1.04.2 Condom provision as part of programs for vulnerable and special populations
ASC.1.04.3 STI prevention and treatment as part of programs for vulnerable and special populations
ASC.1.04.4 BCC/IEC as part of programs for vulnerable and special populations
ASC.1.04.98 Programmatic interventions for vulnerable and special populations not desegregated by type
ASC.1.04.99 Other programmatic interventions for vulnerable and special populations not elsewhere classified (n.e.c.).
ASC.1.05 Prevention - Youth in school
ASC.1.06 Prevention - Youth out-of-school
ASC.1.07 Prevention of HIV transmission aimed at persons living with HIV (PLHA)
ASC.1.08 Prevention programs for sex workers and their clients.
ASC.1.08.1 VCT as part of programs for sex workers and their clients
ASC.1.08.2 Condom provision as part of programs for sex workers and their clients
ASC.1.08.3 STI prevention and treatment as part of programs for sex workers and their clients
ASC.1.08.4 BCC/IEC as part of programs for sex workers and their clients
ASC.1.08.98 Programmatic interventions for sex workers and their clients not desegregated by type
ASC.1.08.99 Other programmatic interventions for sex workers and their clients not elsewhere classified (n.e.c.)
ASC.1.09 Programs for men who have sex with men (MSM)
ASC.1.09.1 VCT as part of programs for men who have sex with men (MSM)
ASC.1.09.2 Condom provision as part of programs for men who have sex with men (MSM)
ASC.1.09.3 STI prevention and treatment as part of programs for men who have sex with men (MSM)
ASC.1.09.4 BCC/IEC as part of programs for men who have sex with men (MSM)
ASC.1.09.98 Programmatic interventions for men who have sex with men (MSM) not desegregated by type
ASC.1.09.99 Other programmatic interventions for men who have sex with men (MSM) not elsewhere classified (n.e.c.)
ASC.1.10 Harm-reduction programs for injecting drug users (IDUs)
ASC.1.10.1 VCT as part of programs for injecting drug users (IDUs)
ASC.1.10.2 Condom provision as part of programs for injecting drug users (IDUs)
ASC.1.10.3 STI prevention and treatment as part of programs for injecting drug users (IDUs)
ASC.1.10.4 BCC/IEC as part of programs for injecting drug users (IDUs)

ASC.1.10.98 Programmatic interventions for injecting drug users (IDUs) not desegregated by type
ASC.1.10.99 Other programmatic interventions for injecting drug users (IDUs) not elsewhere classified (n.e.c.).
ASC.1.11 Prevention programs in the workplace
ASC.1.12 Condom social marketing
ASC 1.13 Public and commercial sector condom provision
ASC.1.14 Female condom
ASC.1.15 Microbicides
ASC.1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI) (Improving management of STI)
ASC.1.17 Prevention of mother-to-child transmission (PMTCT)
ASC.1.17.1 Pregnant women counseling and testing
ASC.1.17.2 Antiretroviral prophylaxis for HIV-infected pregnant women and newborns
ASC.1.17.3 Safe infant feeding practices (including substitution of breast milk)
ASC.1.17.98 PMTCT not-desegregated by intervention
ASC.1.17.99 PMTCT activities not elsewhere classified (n.e.c.)
ASC.1.18 Blood safety
ASC.1.19 Post-exposure prophylaxis (PEP)
ASC.1.19.1 PEP in health care setting
ASC.1.19.2 PEP after high risk exposure (violence or rape)
ASC.1.19.3 PEP after unprotected sex
ASC.1.19.98 Post-exposure prophylaxis not-desegregated by intervention
ASC.1.20 Safe medical injections
ASC.1.21 Male circumcision
ASC.1.22 Universal precautions
ASC.1.99 Prevention activities not elsewhere classified (n.e.c.)
ASC.2 CARE AND TREATMENT
ASC.2.1 Outpatient care
ASC.2.1.01 Provider initiated testing and counseling
ASC.2.1.02 Opportunistic infection (OI) prophylaxis
ASC.2.1.03 Antiretroviral therapy
ASC.2.1.03.1 Adult antiretroviral therapy
ASC.2.1.03.1.1 First line ART – Adults
ASC.2.1.03.1.2 Second line ART – Adults
ASC.2.1.03.1.3 Adult multi-drug ART after 2nd line treatment fail
ASC.2.1.03.1.98 Adult antiretroviral therapy not-desegregated by line of treatment
ASC.2.1.03.2 Pediatric Antiretroviral therapy
ASC.2.1.03.2.1 First-line ART – Pediatric
ASC.2.1.03.2.2 Second-line ART – Pediatric
ASC.2.1.03.2.3 Pediatric multi-drug ART after 2nd line treatment fail
ASC.2.1.03.2.98 Pediatric antiretroviral therapy not-desegregated by line of treatment
ASC.2.1.03.98 Antiretroviral therapy not-desegregated by age or line of treatment
ASC.2.1.04 Nutritional support associated to ARV therapy
ASC.2.1.05 Specific HIV-related laboratory monitoring
ASC.2.1.06 Dental care and services for people living with HIV
ASC.2.1.07 Psychological treatment and support services
ASC 2.1.08 Palliative care
ASC.2.1.09 Home-based care
ASC.2.1.09.1 Home-based medical care

ASC.2.1.09.2 Home-based non medical /non-health care
ASC.2.1.09.98 Home-based care not-desegregated
ASC.2.1.10 Alternative and informal care and treatment services
ASC.2.1.99 Outpatient care services not elsewhere classified (n.e.c.)
ASC.2.2 In-patient care
ASC.2.2.1 Opportunistic infections' (OI) treatment
ASC.2.2.99 In-patient services not elsewhere classified (n.e.c.)
ASC.2.3 Patient transport and emergency rescue
ASC.2.99 Care and treatment services not elsewhere classified (n.e.c.)
ASC.3 ORPHANS AND VULNERABLE CHILDREN (OVC)
ASC.3.1 OVC Education
ASC.3.2 OVC Basic health care
ASC.3.3 OVC Family / Home support
ASC.3.4 OVC Community support
ASC.3.5 OVC Administrative / Organization costs
ASC.3.6 OVC Institutional care
ASC.3.99 OVC services not elsewhere classified (n.e.c.)
ASC.4 PROGRAMME MANAGEMENT AND ADMINISTRATION STRENGTHENING
ASC.4.01 Program management
ASC.4.01.1 Program Administration
ASC.4.01.2 Transaction costs
ASC.4.02 Planning and coordination
ASC.4.03 Monitoring and evaluation
ASC.4.04 Operations research
ASC.4.05 Serological-surveillance (Sero-surveillance)
ASC.4.06 HIV drug-resistance surveillance
ASC.4.07 Drug supply systems
ASC.4.08 Information technology
ASC.4.09 Supervision of personnel and patient tracking
ASC.4.10 Upgrading and construction of infrastructure
ASC.4.10.1 Upgrading laboratory infrastructure and new equipment
ASC.4.10.2 Construction of new health centers
ASC.4.10.99 Upgrading and construction of infrastructure not elsewhere classified (n.e.c)
ASC.4.99 Program management- administration strengthening not elsewhere classified (n.e.c)
ASC.5 HUMAN RESOURCES' RECRUITMENT AND RETENTION INCENTIVES - HUMAN CAPITAL
ASC.5.1 Monetary incentives for physicians
ASC.5.2 Monetary incentives for nurses
ASC.5.3 Monetary incentives for other staff
ASC.5.4 Formative education to build-up an HIV workforce
ASC.5.5 Training
ASC.5.99 Incentives for human resources not elsewhere classified (n.e.c.)
ASC.6 SOCIAL PROTECTION AND SOCIAL SERVICES (EXCLUDING OVC)
ASC.6.1 Social protection through monetary benefits
ASC.6.2 Social protection through in-kind benefits
ASC.6.3 Social protection through provision of social services
ASC.6.4 HIV-specific income generation projects
ASC.6.99 Social protection services and social services not elsewhere classified (n.e.c)

ASC.7 ENABLING ENVIRONMENT AND COMMUNITY DEVELOPMENT
ASC.7.1 Advocacy and strategic communication
ASC.7.2 Human rights
ASC 7.3 AIDS-specific Institutional Development
ASC.7.4 AIDS-specific programs focused on women
ASC.7.99 Enabling environment and community development not elsewhere classified (n.e.c)
ASC.8 HIV AND AIDS-RELATED RESEARCH (EXCLUDING OPERATIONS RESEARCH)
ASC.8.1 Biomedical research
ASC.8.2 Clinical research
ASC.8.3 Epidemiological research
ASC.8.4 Social science research
ASC.8.5 Behavioral research
ASC.8.6 Research in economics
ASC.8.7 Research on capacity strengthening
ASC.8.7.1 Research on capacity strengthening - private entities
ASC.8.7.2 Research on capacity strengthening - government and civil society institutions
ASC.8.7.98 Research on capacity strengthening not-desegregated by sector
ASC.8.8 Vaccine-related research
ASC.8.99 HIV and AIDS-related research activities not elsewhere classified (n.e.c.)
HIV and AID Activities not elsewhere Classified(n.e.c)