National AIDS Spending Assessment (NASA)

ZANZIBAR

Financial Years 2016/17 & 2017/18

Final

20th September 2019

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LIST OF ABBREVIATIONS

ABCZ	AIDS Business Coalition of Zanzibar
ANC	Antenatal Clinic
ARV	Anti-retroviral
ART	Anti-retroviral Therapy
ASC	AIDS Spending Categories
Bn.	Billion
BP	Beneficiary of Services
CDC	Centre for Disease Control
CMS	Central Medical Stores
CSOs	Civil Society Organizations
CTCs	Care and Treatment Centers
DACCOMS	District AIDS Coordinating Committees
DCT	Data Consolidation Tool
DHMTs	District Health Management Teams
FAP	Financing Agents - Purchasers
FBOs	Faith Based Organizations
FE	Financing Entities
FSW	Female Sex Workers
FY	Financial Year
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	Home Based Care
HBS	Household Budget Survey
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioral Survey
IGAs	Income Generating Activities
KPs	Key Populations
KVPs	Key and Vulnerable Populations
KRAs	Key Results Areas
MARPs	Most–At-Risk-Populations
MAT	Methadone Assisted Therapy
MDAs	Ministries, Departments and Agencies
M&E	Monitoring and Evaluation
Mn.	Million
MoH	Ministry of Health
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NBS	National Bureau of Statistics
NCDs	Non-Communicable Diseases
n.e.c	Not Elsewhere Classified
NGOs	Non-Governmental Organizations
OCGS	Office of the Chief Government Statistician

OIs	Opportunistic Infections
OPD	Outpatient Department
OSVP	Office of the Second Vice President
PEPFAR	Presidential Emergency Plan for AIDS Relief
PF	Production Factors
PHCCs	Primary Health Care Centers
PHCUs	Primary Health Care Units
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PS	Providers of Services
PWID	People Who Inject Drugs
RGoZ	Revolutionary Government of Zanzibar
SDG	Sustainable Development Goal
SDM	Service Provision Modalities
SHACCOMs	Shehia AIDS Coordinating Committees
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TGS	Transgender Sex
THIS	Tanzania HIV Impact Survey
THPS	Tanzania Health Program Support
TZS	Tanzanian Shillings
UBRAF	Unified Budget Results Accountability Framework
UNDP	United Nations Development Program
UNESCO	United Nations Educational Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
VCT	Voluntary Counselling and Testing
ZAC	Zanzibar AIDS Commission
ZAPHMoS	Zanzibar HIV & AIDS Program Monitoring System
ZAPHA+	Zanzibar Association of People Living with HIV & AIDS
ZIHHTLP	Zanzibar Integrated HIV, Hepatitis, Tuberculosis and Leprosy Program
ZNSP	Zanzibar National Strategic Plan III for HIV & AIDS

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1.0 BACKGROUND INFORMATION

1.1 Introduction

Zanzibar consists of two main islands, Unguja and Pemba and a number of smaller islands. According to 2012 Population and Housing Census projections, by 2018 Zanzibar had a total population of 1,579,849 inhabitants (768,528 males and 811,321 females). It has an annual population growth rate of 2.8% and a population density of 400 people per square kilometre (km^2). More than half of the inhabitants (53.7%) live in urban areas and the rest (46.3%) in rural areas. The large part of the population is the youth (0 - 17 years) which forms 47% of the total population.[1]

Being one of the countries that form the United Republic of Tanzania (URT), Zanzibar is committed to implement national and international responses to HIV & AIDS. While guided by the 3-ones principles, the response has been led by the Zanzibar AIDS Commission (ZAC). This is a legal entity mandated to provide strategic leadership and coordination of the national response. ZAC has developed and coordinated the implementation of the first, second and now the third National Multi-sectoral Strategic Framework (ZNSPIII) for Zanzibar that inform and guide the implementation of the national response. In addition, the health sector has been mandated to implement and oversee the health sector component of the national response through the Zanzibar Integrated HIV, Hepatitis, Tuberculosis and Leprosy Program (ZIHHTLP) which is a Department under the Ministry of Health (MoH).

The national response is informed in-country by the global strategies that are guided by existing and new evidences. The united Republic of Tanzania has joined the world by committing to bold targets in the Sustainable Development Goal (SDG) of ending the AIDS epidemic by 2030. The country has adopted and is monitoring the reduction of new infection as guided by UNAIDS, in its Fast-Track commitments on HIV Combination Prevention strategy.

An effective and long-term response to HIV & AIDS in any developing country must have a primary financial commitment from the national resources. As countries prioritize HIV & 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 & AIDS, the role of budgeting and expenditure tracking to the success of these programs is of paramount importance. Thus, monitoring public expenditure for HIV & AIDS in Zanzibar is vital for several reasons:

i. More than looking at policy or legislation, a country's budget is the clearest, most reliable and telling indicator of a country's **prioritization** of the epidemic.
ii. The national budget is the key to **sustainability** of any government program and in ensuring reliable availability of human workforce.

[1]See United Republic of Tanzania (URT), 2012 Population and Housing Census Projections, National Bureau of Statistics (NBS) and Office of Chief Government Statistician (OCGS), Dar es Salaam and Zanzibar.

iii. With the current noticeable fluctuation in availability of **donor funds** to many African countries [such as those from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Presidential Emergency Plan for AIDS Relief (PEPFAR)], it is important for public and non-public structures to track these funds, as well as advocating for increased in country funds allocation.

iv. With the announcement of many African countries to roll-out Anti-retroviral (ARV) programs to all HIV-positive citizens, it is necessary to monitor the funds allocated for **care, treatment and support services as part of ensuring continuum of care**.

v. Sustainable financing of HIV & AIDS programs is a critical element in achieving the **UNAIDS' 90-90-90 goals in line with national and regional policies**.

On understanding this, ZAC in collaboration with UNAIDS launched a study to track expenditures on HIV & AIDS related interventions starting from the source of funds to beneficiaries level 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 (NASA) Tools and principles developed and supported by UNAIDS.

1.2 Rationale of NASA Application in Financial Tracking in Zanzibar

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 & 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 & AIDS therefore enhance the ability of the government to plan and implement HIV & AIDS interventions effectively.

Zanzibar has developed multi-sectoral frameworks that actively involve government departments outside the health sector in the fight against HIV & AIDS. It is therefore important to recognize the importance of such responses (through several funding entities), and tracking the expenditures and financial flows to the beneficiary level.

Zanzibar National Strategic Plan III for HIV & AIDS 2016/17-2020/21 (ZNSP III)[2] operationalizes the Zanzibar National HIV & AIDS Policy 2004.[3] The goals of the Zanzibar HIV & AIDS Policy are to: prevent new HIV infections in the population; treat, care for and support those who are infected; mitigate the impact of HIV & AIDS on the social and economic status of individuals, families, communities living in Zanzibar; and enhance the institutional capacity/key implementers' capacity to develop/implement HIV & AIDS interventions with gender and human rights approaches. ZNSP III operationalizes the policy through 5 Key Results Areas (KRAs) as follows:

[2]Revolutionary Government of Zanzibar [RGoZ] (2016), The Third Zanzibar National Strategic Plan (ZNSPIII) for HIV & AIDS 2016/17 - 2020/21, Office of the Second Vice President (OSVP), ZAC, Zanzibar.
[3] Revolutionary Government of Zanzibar (2004), Zanzibar National HIV & AIDS Policy, ZAC, Zanzibar.

- KRA 1: Strengthening HIV prevention, care and treatment programs.
- KRA 2: Improving programs that target Key Populations (KPs) and vulnerable population.
- KRA 3: Strengthening research, knowledge management, and Monitoring and Evaluation (M&E) programs.
- KRA 4: Establishing alternative and sustainable financing models.
- KRA 5: Strengthening institutional management and integration of services at all levels, enabling environment and impact mitigation interventions.

Whereas the ZNSP III delineates 5 KRAs, NASA has added value as it has more focused thematic areas as defined in Annex 1 (Tables A1a-A1i). These thematic areas provide a broad range of sub-categories on who provides the funds, who manages the fund, what interventions/AIDS Spending Categories (ASC) have been devised, what was bought in responding to the pandemic and who are the beneficiaries which is a departure from broad un-detailed thematic areas of the ZNSP III for HIV & AIDS. Thus, NASA classifications have a lot to be desired by Nationals wishing to sharpen the focus of HIV & AIDS interventions for proper monitoring of activities and financial accountability. Consequently, the motive to use the NASA Tools in Zanzibar context for effective fight against the pandemic is apparent.

1.3 Objectives of the NASA in Zanzibar

The primary objective for this project was to collect and analyze data on HIV & AIDS expenditures in Zanzibar for the 2016/17 and 2017/18 financial years using the NASA methodology and produce expenditure report based on the NASA classifications. Specific objectives were to:

1. Adapt the NASA methodology, classifications and tools to the Zanzibar context.
2. Build national level capacity in Zanzibar for systematic monitoring of HIV &AIDS financing flow using the NASA methodology, with a view to a yearly, fully-institutionalized NASA.
3. Using NASA methodology, conduct an HIV & AIDS spending assessment focused on public and donor partner resources, and including larger businesses known to be contributing to the national response.
    - *Identify the HIV financing flows and expenditures by Financing Entity/Source, Financing Agent-Purchaser, AIDS Spending Categories, Service Providers, Production Factors and Beneficiary Populations as per NASA classifications.*
4. Analyze the data by recreating the transactions from the origin of the funds to the utilization by end users and allowing the cross-tabulation between NASA vectors. E.g. cross-tabulation of financing entities and beneficiaries; and AIDS Spending Categories and beneficiaries to show which group benefits most from the HIV interventions.
5. Prepare a report of expenditure trends that will contribute to mid-term reviews, National HIV & AIDS Strategic Framework development, PEPFAR and Global Fund grant making processing, and national policy formulation and resource allocation.

2.0 HIV & AIDS EPIDEMIC

2.1 HIV Prevalence

HIV is one of the major developmental concerns of the Government of Zanzibar as it impacts negatively on efforts to reduce poverty, and undermines the positive strides and gains made in the national socio-developmental agenda including economic growth. The recently finalized Tanzania HIV Impact Survey (THIS) 2016-2017[4] has revealed a downwards HIV infection of 0.4% compared to earlier population based assessments where an HIV prevalence of 0.6% was frequently documented. The noted reduction results from well-planned orchestrated efforts by all key actors from public and non-public sectors alike. With the current HIV prevalence, it is estimated that 6,152 people are living with HIV virus. With this background, Zanzibar has managed to maintain HIV prevalence below 1% for three decades.Despite marked investments in prevention, care and treatment services in the country, the country has noted two epidemics with different peaks among the general and key populations respectively.

HIV prevalence rates in general population in Zanzibar are less than five percent and therefore the HIV epidemic is classified as a "concentrated epidemic," where HIV prevalence is highest amongst particular Most–At-Risk-Populations (MARP). Due to low national prevalence rates, HIV in Zanzibar is considered a potential future threat, thus efforts to halt the spread of the virus before prevalence rates among the general population reach alarming figures is imperative. There is a great concern on the alarming HIV prevalence among Substance Abusers and other MARPs given that these groups can act as "bridging populations" for HIV to cross over into the general population. In view of the above, the ZNSPIII has acknowledged four sub-populations to be categorized as the MARPs. These include

i. Female Sex Worker (FSW)
ii. People Who Inject Drugs (PWID)
iii. Men who have Sex with Men (MSM), and
iv. Correctional facilities students (prisoners)

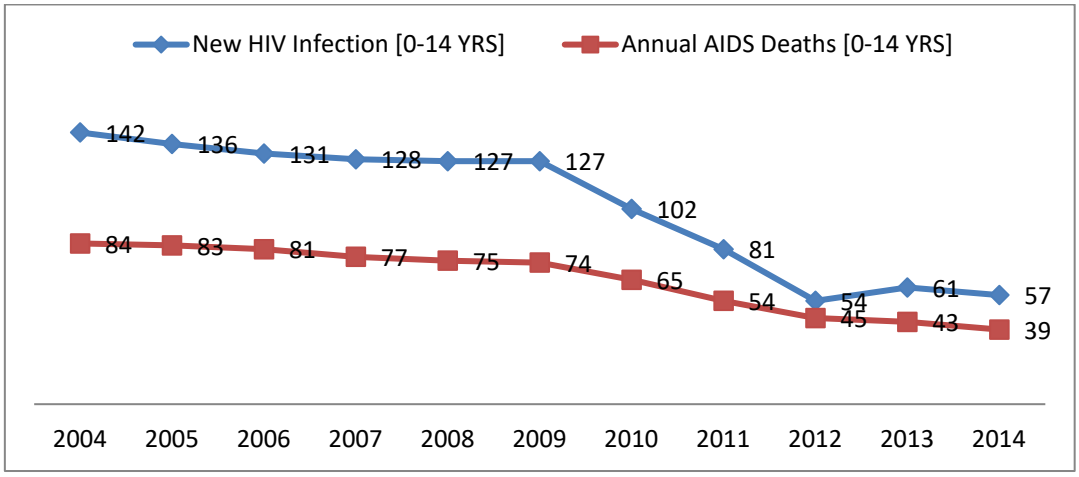
The number of People Living with HIV (PLHIV) has been steadily increasing year by year due to the effective establishment of care and treatment services since 2005 and access to Anti-retroviral Therapy (ART) that improved health outcome of PLHIV. Generally, it is estimated that there is one new infection in every 1,000 people [2014][5]. Based on Spectrum data, it is estimated that an average of 6,830 people including adults and children were living with HIV in 2018.

Generally, there is a marked reduction of new HIV infection and AIDS related mortalities in the country. This has been markedly attributed by a remarkable increase in access to HIV services especially early initiation of ART [Option B+ among exposed mothers] as well as early

[4] Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC). Tanzania HIV Impact Survey (THIS) 2016-2017: Final Report. Dar es Salaam, Tanzania. December 2018.
[5]RGoZ (2016), ZIHHTLP Annual Report 2015, Ministry of Health, Zanzibar.

ART initiation to all (Diagnose and Treat Approach) especially among children and other vulnerable populations as shown in Figure 1 below.[6]

Figure 1: Reported HIV Infection Mortality Pattern of Children



Source: RGoZ (2016), ZNSPIII.

Although the HIV prevalence among general population is low, the prevalence of HIV infection among Key Populations (KPs) is relatively high: 11.3% among PWID, 2.6% among MSM and 19.3% among SWs. The KPs' population size estimate is 3,000 for PWIDs, 3,958 for FSWs, and 2,175 for MSMs[7].

Furthermore, the introduction of ART utilization to all those in need in 2005 has positively contributed to the noted longevity among PLHIV, minimized HIV & AIDS associated complications including death and also has reduced the number of AIDS orphans. In addition, the newly introduced HIV Management Policy among pregnant women has strongly contributed to the reduction of vertical transmission leading to HIV free delivered newborn with promised longevity.

2.2 Type of HIV Epidemic in Zanzibar

A review and synthesis of HIV biological and behavioral data was conducted in 2013 to determine the key modes of HIV transmission versus the populations where the largest numbers of new HIV infections were occurring. It was shown that about 314 new infections will occur yearly, and the highest proportion will be contributed by stable heterosexual relationships (35.0%), followed by clients of sex workers (28.6%), PWID (10.8%) and partners of PWID (6.7%). The other sub-populations that will contribute to a higher proportion of the new HIV infections are partners of those having casual heterosexual sex (6.5%), MSM (3.7%) and partners of sex workers' clients (2.3%).[8] None of the new HIV infections are from blood

[6]RGoZ (2016), ZNSPIII, Zanzibar.
[7]Ibid.
[8]RGoZ (2013), Integrated Behavioral and Biological Surveillance Survey (IBBS) among Key Populations at Risk in Zanzibar, 2011-2012, ZAC

transfusion. Therefore according to this model, Unguja should be characterized as a mixed epidemic whereby new HIV infections are equally contributed by general population as well as key populations.[9]

2.3 Risk Behaviour among Key Populations

Zanzibar carried out IBBS in 2011/12. The Survey estimated the size of KPs as 2,156 for MSM, 4,000 for SWs and 3,000 for PWID. Downward variations in HIV prevalence were observed in 2011 as compared to 2007 for MSMs (12.3% vs. 2.6%) and PWID (16% vs. 11.3%). A total of 486 and 589 KPs were reached for prevention and care services in the year 2012 and 2013 respectively.[10]This coverage on service utilization by KP is sub-optimal hence a call for scaled up of planned well-orchestrated interventions. Of the KPs interviewed, 59% had access to counselling and education, 48% received behavioral change communication interventions, 48% received Sexually Transmitted Infections (STIs) services, and 17% Prevention of Mother to Child Transmission (PMTCT) services. HIV Program data shows out of 1,745 KPs living with HIV, only 62 are on therapy, representing ART coverage of 3.6% among the KPs. The key barriers reported to accessing services include: fear of being stigmatized or judged by service providers (62%) and the perception that the health facility is too far away (51%).

2.4 Services Utilization Levels in Line with NASA Classifications[11]

2.4.1 HIV Counselling and Testing Services

During 2016, the number of Counselling and Testing sites offering HIV counselling and testing services were123 including 26 sites providing Voluntary Counselling and Testing (VCT) alone, 50 Provider Initiated Testing and Counselling (PITC) alone and 47 both PITC and VCT. A total of 94,507 individuals from general population were counselled and tested for HIV in 2016 compared with 101,669 clients in 2015. Among the clients tested, 46,146 (48.8%) were females and 48,353 (51.2%) were males.

2.4.2 Prevention of Mother to Child Transmission Services

A total of 43,937 pregnant women were tested for HIV which is 72% of all estimated pregnant women and 235 (55%) HIV positive pregnant women out of 423 estimated HIV positive pregnant women were initiated on ART. Number of infants born to HIV positive mothers who received HIV antigen test (DNA PCR) within 2 months of birth was 146/232 (63%) and all were covered with Co-trimoxazole prophylaxis within two months of birth.

2.4.3 Key Population Services

As of December 2016, about 4,135 of KPs including 2,294 FSWs, 588 MSMs and 1,253 PWIDs were reached with different services. A total of 281 (70% of the year one target) clients who inject/use drugs were enrolled at Methadone Assisted Therapy (MAT). As of December 2016,

[9]RGoZ (2016), ZNSPIII, Zanzibar.
[10]RGoZ (2013), A KP Service Utilization Study Report, Zanzibar.
[11]RGoZ (2017), ZHHTLIP Annual Report - 2016, Ministry of Health, Zanzibar.

number of clients who have been on MAT for six months and above were 194 (69%) of whom 30 (15.5%) are HIV positive clients who continue receiving HIV care and treatment services at different Care and Treatment Centers (CTCs).

2.4.4 Sexually Transmitted Infections Control and Prevention Program

In 2016, a total of 8,354 STI cases were reported and managed which is a decrease from 9,063 episodes reported in 2015. There was a slight decrease in STI cases diagnosed compared to 2015. Of these episodes, 7,787 were syndromic and 567 were etiological. Number of male condoms distributed through various condom outlets in Zanzibar has declined from 15,860 in the year 2015 to 8,773 in the year 2016. This decline was due to frequent stock out of male condoms in health facilities.

2.4.5 Care and Treatment Services for PLHIV

The care, support and treatment program provides comprehensive services to PLHIV which include free ART, psychosocial support, prevention and treatment of Opportunistic Infections (OIs) including effective management of Tuberculosis (TB) and other AIDS management complications. By 2016, a total of twelve CTCs were providing care and treatment services where 9,289 patients were enrolled in CTCs of whom 6,956 (75%) were among the ever started (cumulative number of all those registered on HIV care and treatment services) on ARVs in these facilities. However, patients who are currently on ARVs including the transfer in are 4,346 which is 60% (4,346/7229) of patients estimated to be in need of treatment[12]. About 71.3% of patients who have been initiated on ART are still alive and known to be on treatment 12 months after initiation of the treatment. The percentage of patients who have been screened for TB has remained the same at 99%. A total of 5,373 patients were screened for TB of whom 73 patients were diagnosed with TB and were initiated on TB treatment in line with the TB management protocol.

2.4.6 Home Based Care Services

During 2016, a total of 2,351 patients received Home Based Care (HBC) services which is a decrease as compared to 2,694 clients reported in 2015. Among those received HBC, 1,255 were PLHIV (817 females and 438 males) and 1,096 were chronically ill patients (575 females and 521 males). Children below 15 years of age were 179.

2.4.7 Tuberculosis Control Services

For TB services, a total number of all registered TB suspected cases were 723, where number of new smear positive TB cases was 384. TB success rate was 93% and the cure rate was 90.2%. For TB/HIV collaborative activities, 718 TB patients tested for HIV a total of 110 (15%) were found positive for HIV. Eighty-eight percent (88%) of the co-infected patients were placed on ART management under the one roof service.

[12] Based on client denominator estimated from spectrum application on year 2016 (N = 7229)

2.4.8 Laboratory Services

A total of 23,797 clinical tests were performed in 2016 in six (6) laboratories. Samples for Early Infant Diagnosis, diagnosis of HIV in exposed infants and children less than 18 months of age were collected from PMTCT sites and transported to Muhimbili National Hospital, Dar es Salaam for HIV testing and confirmation. A total of 222HIV exposed infants and children less than 18 months of age have been tested by DNA-PCR. For TB diagnosis, in 2016, diagnostic performance decreased from 5,934 (2015) with 518 positives to 4,914 (2016) with 356 positives. Mnazi Mmoja laboratory examined 2,737 samples using Gene expert.

3.0 ZANZIBAR SOCIO-ECONOMIC CONTEXT

3.1 General Administrative and Governance System

Administratively, the Revolutionary Government of Zanzibar (RGoZ) maintains its own government with full autonomy over non-union matters. It has its own President, Cabinet, Legislature and Judiciary System. The RGoZ has 14 ministries at national level, five (5) regional authorities, two (2) in Pemba and three (3) in Unguja, 11 districts: seven (7) in Unguja and four (4) in Pemba and about 389 Shehias at the grass roots level - Shehia being the lowest administrative structure in the government system. About 46.3% of its population resides in the rural areas with agriculture as the main source of livelihood.

3.2 Socio-economic Situation

3.2.1 Economic Growth

Zanzibar is a low-income country with an annual per capita income of US$ 913 (as of 2018). The Gross Domestic Product (GDP) of Zanzibar has registered relatively healthy levels of growth in the last 5 (five) years. It grew by about 6.4% in 2014 declined to 5.8% in 2016 and increased to 7.1% in 2018 (Table 1). The observed growth in the economy was a result of enhanced tourism industry and the general improvements in service industries. Notably, the number of tourists increased to 520,809 in 2018 compared with 433,474 in 2017; which also increased production shares in accommodation and food services (from 14.7% in 2017 to 17% in 2018). Maintenance of impressive economic growth has resulted to increased government revenues and expenditures. In Financial Year (FY) 2017/18, the approved budget totaled Tanzanian Shillings (TZS) 1.087 trillion (US$483 million) which is a 29% increase in total expenditures in nominal terms or 26% in real terms.[13]

Table 1: Summary Statistics of some Macro-microeconomic Indicators, 2014 -2018

Sector	GDP at Market Prices (% shares)				
	2014	2015	2016	2017	2018
Gross Domestic Product (GDP) at constant price growth rates (%)	6.4%	6.2%	5.8%	7.7%	7.1%
GDP per capital at 2015 constant prices (TZS' 000)	1,609	1,666	1,712	1,750	1,823
GDP per capital at 2015 constant prices (USD)	806	834	857	876	913
Gross Domestic Product (GDP) [TZS]		2.31Bn.	2.63Bn.	2.7Bn.	3.6Bn.

Source: UNICEF and RGoZ (2018);RGoZ (2017); RGoZ (2019).[14]

[13] UNICEF and RGoZ (2018), National Budget Brief, Zanzibar

The services sector continues to be the lead contributor to the economic growth in the Isles followed by agriculture, although its contribution to GDP has slightly declined from 22.2% in 2014 to 21.3% in 2018. The industry sector is the third contributor with a contribution of 17.8% in 2018 (Table 2).

Table 2: Gross Domestic Product by Activity, 2014 -2018 (% shares)

Sector	GDP at Market Prices (% shares)				
	2014	2015	2016	2017	2018
Agriculture, Forestry and Fishing	22.2%	22.2%	21.9%	21.5%	21.3%
Industry	17.8%	18.4%	19.2%	19.6%	17.8%
Services	49.6%	49.8%	48.7%	48.6%	51.3%
Taxes on Products	10.5%	9.8%	10.1%	10.3%	9.7%

Source: RGoZ (2019).[15]

3.2.2 Poverty and Socio-economic Services Indicators

Poverty status

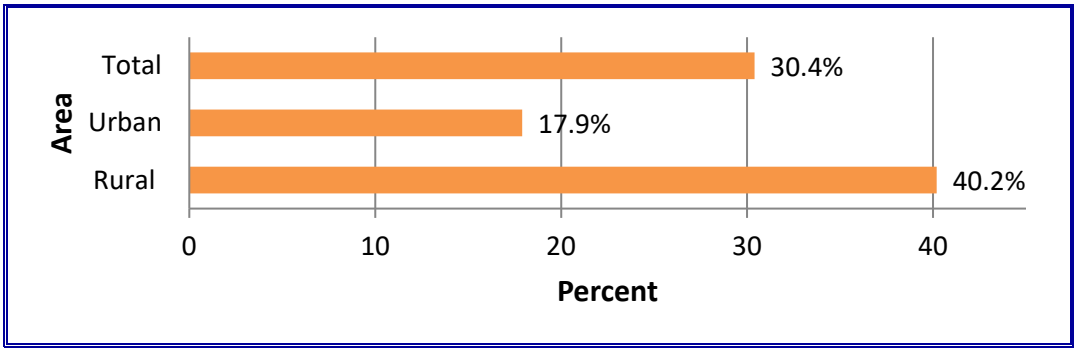
The latest Household Budget Survey (HBS) in the Isles was done in 2014/15. The findings from HBS showed that poverty is still pervasive. Basic needs poverty rate declined from 34.9% in 2009/10 to 30.4% 2014/15, while food poverty declined only marginally from 11.7% reported in 2009/10 to 10.8% during the same period.[16] Food poverty measures the inability to afford basic dietary requirements (recommended calorie intake) while basic needs poverty takes into account additional resources expended on non-food items such as shelter and clothing. Poverty in Zanzibar is largely characterized by higher poverty incidence in rural than in urban areas respectively. About 40.2% of people in the rural areas live below the basic needs poverty line as compared to 17.9% in urban areas. Similarly, 15.7% of people live below the food poverty line in the rural areas as compared to one third of those (4.5%) in the urban areas (Figures 2 and 3).

[14] UNICEF and RGoZ (2018), National Budget Brief, Zanzibar; RGoZ (2017), Zanzibar Statistical Abstract (2016), OCGS, Zanzibar; RGoZ (2019), Zanzibar Statistical Abstract (2018), OCGS, Zanzibar

[15] Ibid.

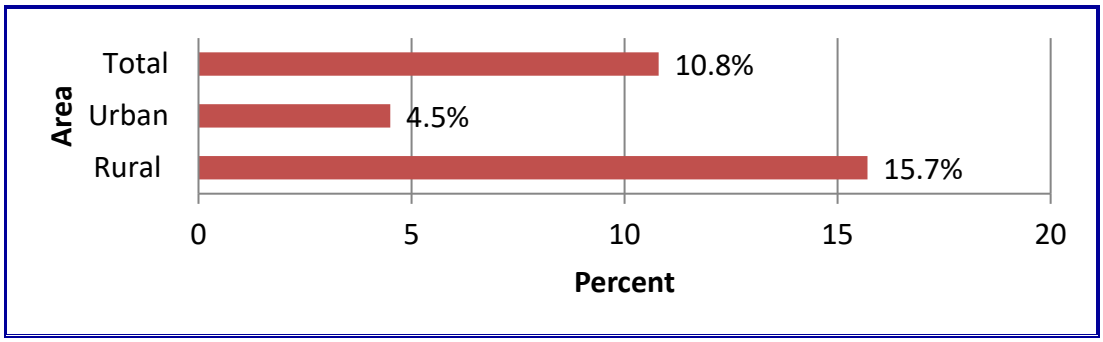
[16] RGoZ (2016), Household Budget Survey 2014/15, OCGS, Zanzibar.

Figure 2: Proportion of Population below Basic Needs Poverty Lines by Area, 2014/15



Source: RGoZ-HBS (2016).

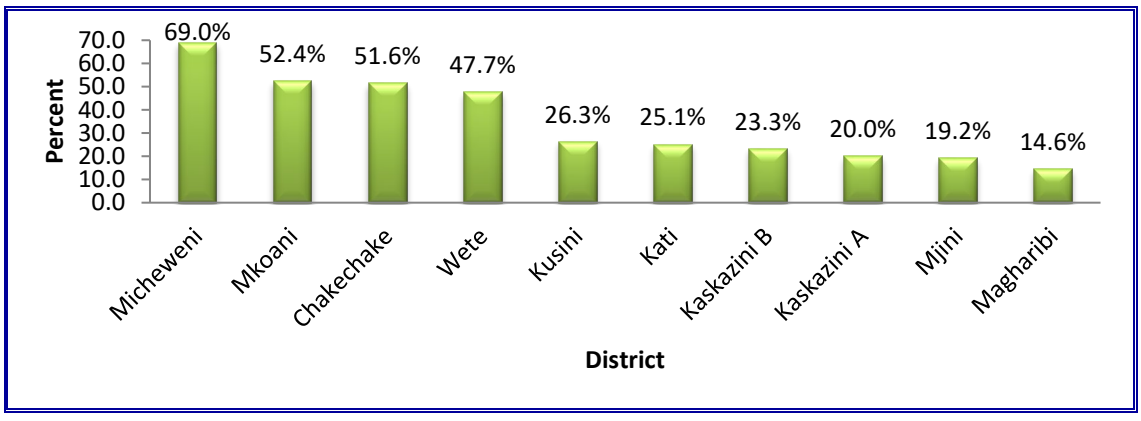
Figure 3: Proportion of Population below Food (extreme) Poverty Headcount Rates by Area, 2014/15



Source: RGoZ-HBS (2016).

The economy is somehow unequal with a Gini coefficient estimated to be 0.30 in the 2014/15 HBS. There is more inequality among the individuals in urban areas compared to rural areas (0.31 and 0.27 respectively). There is large disparity in poverty levels across districts. In 2014/15, the proportions of the poor (using basic needs poverty) ranged between 14.6% in Magharibi district to 69% in Micheweni district (a range of 54.4 percentage points). Districts in Pemba have highest poverty rates – on both basic needs and food poverty compared to districts in Unguja (Figure 4).

Figure 4: Proportion of Population below Basic Needs Poverty Line by District, 2014/15



Source: RGoZ-HBS (2016).

Water

The overall objective of the water and sanitation sector in Zanzibar is to improve water supply and sanitation systems to both rural and urban communities. The RGoZ has put emphasis in the supply of clean and safe water. Consequently, access to water has improved over time as shown by data from HBS 2014/15. Access to improved source of drinking water has improved slightly from 89.5% in 2009/10 to 90.5% in 2014/15. Majority of households in both rural and urban areas reside in less than 1 km to the water point during the dry season - overall improvement from 77.7% in 2009/10 to 96.9% in 2014/15 (Table 3). Further, data show that majority of the households (85.8%) spend less than 15 minutes fetching drinking water. The mean time is reported to be 6.9 minutes, while less than 1 % of the total population in Zanzibar collects water from more than 2 km from their residence. The reduced time spent in fetching water allows more time for the women and other family members to be engaged in economic activities and generate income.

Table 3: Performance of Indicators on Access to Improved Water Sources

Year	2004/05	2009/10	2014/15
Access to improved water sources			
Rural	79.5%	85.9%	86.8%
Urban	95.8%	95.4%	96.3%
Total	85.8%	89.5%	90.5%
Distance to the source of drinking water during dry seasons < 1km			
Rural	73.2%	81.9%	95.3%
Urban	85.5%	90.4%	99.0%
Total	77.7%	85.4%	96.9%

Source: RGoZ-HBS (2016).

Sanitation

Access to sanitation facilities is still a problem as only close to 56.5% of the population has access to improved sanitation facilities. It is important to note that Kaskazini Pemba region has the highest percentage of households with no toilet facilities (52.6%) followed by Kusini Pemba region (42%).[17]

Health

About 97% of the population in Zanzibar lives within 5 km from a health facility (mainly Primary Health Care Units). The urban/rural and regional differences are not significantly high. Currently, the facilities are documenting a disease shift patterns from infectious to Non-Communicable Diseases (NCDs) with malaria being not in the top leading diseases as was documented in earlier years. In 2017, the top ten lading diseases documented in Outpatient Department (OPD) include: Upper Respiratory Tract Infections (URTI) that accounted for

[17] URT (2014), Basic Demographic and Socio-economic Profile: Key Findings from the 2012 Population and Housing Census

27.3% of all OPD diagnosis and has been the leading diagnosis for three consecutive years. This was followed by other skin diseases (9%) and Ear, Nose and Throat [ENT] (8.7%), Urinary Tract Infection [UTI] (8.4%) and other diarrhea diseases with the magnitude of (8.1%). NCDs has shifted to sixth position while Conjunctivitis was not among the top ten diseases in 2015 and 2016, but appeared at ninth position in 2017. Also noted were the high maternal mortalities and the motor traffic accidents.

According to Tanzania Demographic Health Survey – Malaria Indicators Survey (TDHS-MIS) 2015-2016, Zanzibar has made remarkable progress in reducing infant mortality from 54 deaths/1000 live births in 2010 to 45 deaths/1000 live births in 2015. Neonatal mortality has reached 28 deaths/1000 live births in 2015/2016 from 29 deaths/1000 live births in 2010. Under-five mortality rate has been reduced to 56 deaths/1,000 from 73 deaths/1000. Institutional (facility based) Maternal Mortality Ratio (MMR) decreased to 191 per 100,000 live births in 2017, a decrease from 277 deaths per 100,000 live births reported in 2016 and 236 deaths per 100,000 live births reported in 2015.

Access to Education

According to Zanzibar Education Policy 2006, every child is given the right to start pre-primary education at the age of four years and six years is the eligible age for standard 1 of primary schooling to standard 6 which is followed by four years of ordinary secondary education. However, there is a big challenge in reaching this objective due to some parents resisting enrolling their children at the eligible age (4 years) for starting pre-primary and age of 6 for primary. They perceive that their children are too young to start both pre and primary schooling. This tendency affects Net Enrollment Ratio (NER) of primary education; it slightly increased from 87.5% in 2014 to 88.3% (92.1% girls and 84.4% boys) in 2018. At ordinary level of secondary education the Gross Enrollment Ratio (GER) increased from 59.9% (65.9% girls and 54.1% boys) to 85.6% (93.6% girls and 77.6% boys) while NER was 45.1% in 2014 and only 40.1% in 2018. Gender Parity as measured by Gender Parity Index (GPI) has been reached at pre-primary and primary education and it is close to been reached at secondary education.

3.2.3 Road Infrastructure

Zanzibar has roughly 1,234 km of main, urban and rural roads. About 70% of the Zanzibar's roads are located in Unguja Island, which contains the main urban centre and main port and plays host to a large tourism industry. Although this road network makes Unguja one of the most dense road networks in Africa, most of the roads were constructed after the revolution in 1964[18] Thus, the major challenge is updating the rather old road network and construction of feeder roads. Table 4 below shows the roads condition in Zanzibar.

[18]Shufaa et al., (2018) PPT on Rehabilitation of Zanzibar Roads Project, Zanzibar.

Table 4: Roads Condition, Zanzibar

Road Status (Kms)	Very Good	Good	Fair	Poor	Very Poor	Total
Paved	169.4	84.7	32	18.2	14.7	318.9
Unpaved	0	0	0	0	33.8	33.8
Paved	212	74.2	18.6	23.8	23	351.6
Unpaved	0	15.7	55.9	52	74.5	198.1
Paved	24.5	12.7	3.1	11.8	3.5	55.5
Unpaved	0	0	0.9	4.3	6.9	12
Paved	36	12	0	0.8	0.8	49.37
Unpaved	0	5.9	74.6	93.3	68.7	242.5
Paved	441.9	183.6	53.7	54.6	42	775.37
Unpaved	0	21.6	131.4	149.6	183.9	486.4

Source: RGoZ (2018)[19]

In 2015, the RGoZ introduced the infrastructure levy and tax with the primary purpose of strengthening the road maintenance mechanism in rural and urban areas. These taxes were targeted to be collected at points of service i.e. at the hotels and airports/seaports[20].
The levy and tax include the following:

i. Infrastructure Levy: USD$ 1 per person per night to be paid direct by guest at his/her hotel in Zanzibar.
ii. Infrastructure Tax: TZS 2,000 (USD $1) per person to be paid direct by passenger on departure at the airports/seaports in Zanzibar to any destination within the United Republic of Tanzania.

3.3 Health Care System

3.3.1 Infrastructure and Capacity

The overall objective of the health sector is to improve the health and well-being of the people of Zanzibar with particular attention to women and children. Zanzibar health care system is composed of primary, secondary and tertiary care with a total of 246 health facilities by the end of 2017, of which 166 are publicly owned and 83 are owned by the private sector (Non-Governmental Organizations (NGOs), Faith Based Organizations (FBOs) and private for profit). Health care services in Zanzibar are provided and managed at five levels (Table 5).

i. Referral Hospital:
National Referral Hospital Mnazi Mmoja is the only referral facility in Zanzibar.

ii. Regional Hospital:
Mkoani Hospital has been updated in 2016 to be the regional hospital as well as to serve as a referral hospital in Pemba.

iii. District Hospitals:

[19]RGoZ (2018), Zanzibar Socio-Economic Survey – 2017, OCGS.

[20]https://www.tripadvisor.com/ShowTopic-g482884-i9487-k8673270
The_Government_of_Zanzibar_has_recently_announced_NEW-Zanzibar_Island_Zanzibar_Archipelago.html

Makunduchi and Kivunge hospitals have been upgraded to district hospitals especially after meeting the requirements (both Human Resource for Health (HRH) and infrastructure) to be termed as so which made the total number of district hospitals in Zanzibar to be four .

iv. General/Specialized Hospitals:
There are two special hospitals namely, Mwembeladu Maternity Home (34 beds) and KidongoChekundu Mental Hospital (135 beds), both located in Unguja Island.

v. 1st and 2nd Primary Health Care Facilities: These include Primary Health Care Centers (PHCCs) and Primary Health Care Units (PHCUs).

Table 5: Health Care Facilities by Type and Region

Region	Public Medical Facilities							Private Medical Facilities	
	Primary Level			Secondary Level		Tertiary Level		Primary and Secondary Level	
	PHCU	PHCU+	PHCC	District Level	Regional Level	Special	Referral	Disp.	Hospital
KaskaziniUnguja	20	6	0	1	0	0	0	6	0
KusiniUnguja	30	6	0	1	0	0	0	5	0
MjiniMagharibi	18	9	0	0	0	2	1	51	5
Kaskazini Pemba	27	6	1	1	0	0	0	7	0
Kusini Pemba	24	7	1	1	1	0	0	9	0
Total	**119**	**34**	**2**	**4**	**1**	**2**	**1**	**78**	**5**

Source: RGoZ (2018)[21]

3.3.2 Decentralization of Health Care System

In order to facilitate smooth provision of health services at grassroots level, the government has decentralized health service provision to be managed by districts and is done through the District Health Management Teams (DHMTs) with zones being the mediator between the key ministries. The Zonal level of health care management is geographically represented by the two islands of Unguja and Pemba. The DHMTs are under the custodian of District Councils in both zones of Unguja and Pemba. These Health Management Teams fulfill the following six key functions:

i. Supervisory support and coordination at District level
ii. Health planning and program monitoring
iii. Co-ordination of public and NGOs health activities
iv. Formulation of health expenditure budgets
v. Logistical support, and

[21]RGoZ (2018), Zanzibar Socio-Economic Survey – 2017, OCGS

vi. Monitoring public health staff.

At community level PHCCs and PHCUs are located in Shehia/Ward subdivision of the administrative structure in Zanzibar. In each primary health care facility there is a Community advisory board/committee. The team includes the healthcare worker in charge of the health facility (s/he serves as the head of the team) and selected community members from the Shehia.

4.0 NASA METHODOLOGY

4.1 NASA Tools and Classifications

National AIDS Spending Assessment (NASA) is a framework that calls for the embodiment and resource tracking of HIV & AIDS related activities occurring in all sectors (not only health sector) 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. The process follows a harmonized framework of several classifications around HIV & AIDS activities, interventions and programmatic areas. The framework was produced in 2006 and revised in 2009 to incorporate comments from the stakeholders. Further reviews have been conducted since then to capture lessons learnt in almost a decade of implementing NASA in various countries. The latest NASA classifications were produced in 2018 and they have been used in this study.[22]

NASA seeks to answer the following questions:

1. **Where does the money come from? Who provides the funds?**
    a. Financial Entities

2. **Who pools the funds?**
    a. Revenues

3. **What mechanism allows payment?**
    a. Financing schemes

4. **Which entity manages the funds? Who makes the decision of what services or goods to purchase?**
    a. Financing Agents - Purchasers

5. **Who provides the services or the goods?**
    a. Services and goods providers

6. **How are the services provided?**
    a. Service Delivery Modalities

7. **What does a provider buy to produce the AIDS Spending Categories?**
    a. Production factors e.g. medical supplies, time of health providers (by paying salaries and other incentives), office rent, utilities, catering services, etc.
8. **What does a provider deliver?**

[22] See UNAIDS (2018), NASA Data Consolidation Tool (DCT) and NASA RTT Software, Geneva.

a. AIDS Spending Categories (ASC): e.g. Prevention services, treatment services, etc.

9. Who are the recipients of the services and goods?

- Beneficiaries of the services or target groups

These NASA classifications can be summarized in three dimensions: ***financing, provision, and utilization.*** The classification of the three dimensions and nine categories comprise the framework of the NASA system. These dimensions incorporate nine categories:

(A) Financing HIV & AIDS Services

1. Financing Entities (FE) are entities that provide money to financing agents (see Table A1a, Annex 1).
2. The funds are sourced from various pools (Revenues), e.g. transfer from government domestic revenue, transfers distributed by government from foreign origin etc.(see Table A1b, Annex 1).
3. Financing Schemes (SCH) are the main types of financing arrangements through which people obtain health services. Health care financing schemes include direct payments by households for services and goods and third-party financing arrangements e.g. through compulsory contributory health insurance schemes, transfer through social health insurance etc. (see TableA1c, Annex 1).
4. Financing Agents – Purchasers (FAP) are entities that pool financial resources to finance service provision programs and also make programmatic decisions (purchaser-agent)[see Table A1d, Annex 1].

(B) Provision of HIV & AIDS Services

1. Providers of Services (PS) are entities that engage in the production, provision, and delivery of HIV & AIDS Services (see Table A1e, Annex 1).
2. The health providers provide services using various Service Delivery Modalities (SDMs) e.g. inpatient care, outpatient care, community outreach programs etc. (see Table A1f, Annex 1).
3. Production Factors (PF)/resource costs are inputs (labor, capital, workshop facilities, promotion materials, travel etc.) that are used by providers to provide services [see Table A1g, Annex 1].

(C) Utilization of HIV & AIDS Services

1. AIDS Spending Categories (ASC) are HIV-related interventions and activities, what is done in order to reach the expected achievements in addressing the pandemic (see Table A1h, Annex 1).

2. Beneficiary segments of the population (BP), e.g., men who have sex with men, injecting drug users, general population, pregnant women etc. (see Table A1i, Annex 1).

4.2 NASA Process in Zanzibar

The following approaches and methods were used in engaging the stakeholders, data collection, processing, analysis, and reporting.

4.2.1 Planning

A stakeholders NASA sensitization workshop was convened in April 2019 to seek and build ownership of both the process and the final NASA results. Participants represented seven key organizations that guide the national response in Zanzibar [ZAC, MoH (ZIHHTLP), ZAPHA+, UNAIDS, Office of the Second Vice President (OSVP), Ministry of Education and Ministry responsible for labor]. Participants assumed the role of key informants and they were tasked to facilitate access of requisite data from their organizations and other organizations they are working with. This workshop was considered as a first step towards institutionalization of NASA in Zanzibar as it enhanced the capacity of key institutions to systematically monitor HIV & AIDS financing flow using the NASA methodology, the knowledge that trickled down to more than 100 organizations that were physically visited for data collection.

In order to map out all Financial Entities, Financial Agents-Purchasers and Service Providers, all participants in the stakeholders' workshop were asked to fill information in Form 1. The purpose of this Form was to identify all key actors for data collection process, whether they are Financing Entities, Agents-Purchasers or Providers. The Form has been organized around AIDS Spending Categories and all organizations that participate in the national response to AIDS should be registered here. Identification of all Financing Entities, Agents-Purchasers and Providers is a prerequisite for data collection exercise. The workshop participants were also asked to list other potential stakeholders including businesses that contribute strongly to the HIV & AIDS response.

4.2.2 The Sample and Sampling Strategy

Financing Entities

The main financing entities are the RGoZ and Development Partners. With support from the workshop participants, all Development Partners (bilateral and multilateral organizations) operating in Zanzibar and supporting HIV & AIDS interventions were mapped and included in the sampling frame. Some businesses and business organizations perceived to support the fight against HIV & AIDS were also sampled.

Financing Agents-Purchasers

Some Development Partners, Ministries, Departments and Agencies (MDAs), and Civil Society Organizations (CSOs) have dual role of managing and spending funds on their own rights. Thus, the role of financing and managing the finances was explored from all sampled Development Partners, MDAs, and CSOs.

Service Providers

NASA requires that all spending units are captured in tracking the resources. Thus, MDAs that spend significant resources on HIV & AIDS were included in the sampling frame. These include Ministries responsible for Finance and Planning, Health, Education and , Agriculture, Local Government, Legal and Constitution Affairs, Tourism and Trade, Information and Communication, Youth, Culture and Sports, Labor and Women, Transport, and Water; Office of the Second Vice President (OSVP); and public Agencies such as ZAC.[23]

We also sampled health facilities/providers for interviews from: Public hospitals, Primary Health Care Centers (PHCCs), Primary Health Care Units + (PHCU+) and Primary Health Care Units (PHCU) perceived to provide HIV & AIDS services and Care and Treatment Centers (CTC).[24]However, it was difficult to get financial data from the health facilities. Thus, the study team estimated the expenditures for the health facilities as detailed in section 4.5 below. Other service providers included CSOs (mainly NGOs and FBOs) providing HIV-related services in the country, and regions and district offices. Table 6 provides the sample size for this study.

NASA Beneficiaries

NASA beneficiaries were not sampled. These were captured from the providers of services.

Table 6: NASA Zanzibar: The Sample

Sn.	Sampled organizations	Number	Organizations with HIV & AIDS Interventions	Number
1.	Development Partners:UNICEF, UNFPA, UNAIDS, UNODC, UNESCO, WHO, UNDP, ZGFCCM SECRETARIAT, DANIDA, EU, SIDA, ILO and DTREE.	13	Development Partners:UNICEF, UNFPA, UNAIDS, UNESCO, UNDP, ZGFCCM SECRETARIAT, CDC and European Commission.[25]	8
2.	Ministries responsible for Finance and Planning, Health, Education, Agriculture, Local Government, Legal and Constitution Affairs, Tourism and Trade, Information and Communication, Youth, Culture and	13	Ministries responsible for Finance and Planning, Health, Education, Local Government, Labor and Women,Information and Communication, and OSVP.	7

[23] In Tanzania Mainland, there is a budgetary code called Objective A. This is meant for HIV & AIDS interventions. All districts budget funds under this code. So it is easy to pull out all funds allocated through this code and activities. It is also possible to distill the list of beneficiaries from this code.
[24] See Annex 3 for the sampled health facilities.
[25] As presented in the Findings Chapter, several other development partners provided funds to CSOs but they do not have offices in Zanzibar.

Sn.	Sampled organizations	Number	Organizations with HIV & AIDS Interventions	Number
	Sports, Labor and Women, Transport, and Water; and OSVP.			
3.	Public Agencies and Parastatals – ZIHTLP, ZAC, Public Health Laboratory, Zanzibar Food and Drugs Authority (ZFDA), Zanzibar Bureau of Standards (ZBS), OCGS, SUZA (School of Health), and Central Medical Stores (CMS).	8	Public Agencies and Parastatals – ZIHTLP, ZAC, ZFDA, ZBS, OCGS, CMS.	6
4.	Civil Society Organizations – local NGOs and FBOs[26]	33	Local NGOs and FBOs: AYAHIZA, ZAYEDESA, UMATI, ZANGOC, SOS, ZYF, JUKAMKUM, THESODE, JUMAZA, BIO, ZAPHA+, ANGLICAN, ZANA, THPS, LEGAL SERVICES FACILITY, PIRO	16
5.	International NGOs: Save the Children, Milele Foundation, Action Aid, AMREEF, ZANZASP, Engender Health, JHPIEGO, PHARMACCES, PATH, and JSI.	10	International NGOs: Save the Children, AMREEF, ZANZASP, ICAP.	4
6.	Businesses: Sea Cliff Hotel; Serena Hotel; Kendwa Hotel; AZAM Company; Mahonda Sugar Factory; Zanzibar Insurance Cooperation; Zanzibar AIDS Business Coalition ; Zanzibar Chamber of Commerce Industry and Agriculture; Private Health Insurance Companies – Strategies; Private Health Insurance Companies – AAR	10	SOGEA SATOM, ZLSC[27]	2
7.	Regions (Regional HIV & AIDS Offices	5		1
8.	Districts (HIV & AIDS Offices)	11		1
9.	Health Facilities with CTC[28]	13	Estimated cost for: MnaziMmoja, Mwembeladu, Al-Rahma, Bububu, Micheweni, Makunduchi, Kivunge, Wete, Mkoani, and ChakeChake hospitals; Fuoni PHCU+; ZAYADESA CTC; and MAT.	13
10.	Health facilities - 120 PHCUs	120	Estimated cost for 120 PHCUs	120
	Total	**224**		**163**

4.3 Data Collection

[26] See Annex 2 for the list of sampled NGOs.
[27] These businesses were not sampled but they were reported on the ground by service providers - SOGEA SATOM (a construction company) and ZLSC (legal services company).
[28] See Annex 3 for the sampled health facilities.

NASA data collection tools have been designed to allow for standardization of the data collection process. These were adapted and used in this assignment. Data collection forms were organized as presented in Table 7.

Table 7: Data Collection Forms

Sn.	Name	Purpose of the Form
1.	Form 1	The purpose of this Form was to identify all key actors for data collection process, whether they are Financing Entities, Agents-Purchasers or Providers. The Form is organized around AIDS Spending Categories/Interventions and all organizations that participate in the national response to AIDS should be registered here. This Form was completed at the beginning of the NASA exercise, together with national stakeholders, NASA researchers and with ZAC.
2.	Form 2a	As much as relevant, this Form was used to obtain information from Financial Entities. It was used to report mainly information on institutions where the funds have been transferred to – Financial Agents – Purchasers or Providers.
	Form 2b	As much as relevant, this Form was used to obtain information from Financial Agents – Purchasers. It was used to report mainly information on institutions where the funds have been transferred to - Providers.
3.	Form 3	This Form was used to obtain information from Providers mainly on non-medical expenditures. It was used to collect information on institutions where the funds have been spent on, by AIDS Spending Categories, Production Factors and Beneficiary Population.
4.	Form 4	This Form was meant to obtain necessary data that would have allowed for calculations of actual expenditure of providers related to AIDS Spending Categories on outpatient care (e.g. Improving management of Sexually Transmitted Infections (STI), Post Exposure Prophylaxis, Treatment of Opportunistic Infections (OIs), Anti-retroviral Treatment etc.). However, this information was not readily available from the sampled health facilities. Estimations on ARV treatment and treatment of OIs expenditures was done using data from the central level.
5.	Form 5	This Form was meant to obtain necessary data to be used for actual expenditure estimation, from providers of inpatient care relating to HIV & AIDS and related patients. However, this information was not readily available from the sampled health facilities. Estimation on time spent by health providers on HIV & AIDS related interventions was estimated using data from the central level.

4.4 Data Processing and Analysis

Collected expenditure data were captured in UNAIDS NASA Data Consolidation Tool (DCT) and imported to NASA-RTT3 Software for analysis. The software has provisions for importing data captured in DCT (which is in excel format) for systematic analysis and production of requisite tables and figures automatically. NASA matrices (ross-tabulation of relevant classifications) e.g. financing entities and beneficiaries; and AIDS Spending Categories and beneficiaries to show which groups benefit most from the HIV interventions has been done in order to provide relevant information for decision makers.

4.5 Assumptions on Expenditure Estimations

Several assumptions were made to facilitate the NASA exercise in Zanzibar. Where expenditure data are missing, costing methods were applied or data were estimated as proxy from the central level sources.

(A): Reporting Finances on Financial against Calendar Years:

i. Data collection was done for two years; FY 2016/17 and FY 2017/18. To easy data capturing and entry process, data for each FY were recorded in separate data collection forms.
ii. While sources of data from the RGoZ are reported in financial years, those from some Development Partners and some recipient institutions have been reported in calendar years. In this assignment, we reported the funds per source as obtained at the source, that is, reporting by financial or calendar year depending on the source of information. Thus, funds spent in 2016 and 2017 were included in the 2016/17 financial year and funds spent in 2018 were included in the 2017/18 financial year. This might have in some instances elevated the expenditures for the 2016/17 financial year.

(B): Working Population

General population and population for specific groups

i. The assessment used the projected population of1,568,312 from the 2012 Population and Housing Census.
ii. Projected population estimate of 686,493 was used for those aged 0 - 14 years of age.
iii. Young population aged 15-24 years was estimated at 313,584.

Out of school children

i. Out of school children were obtained from the working assumption that 10% among those aged 6- 14 years were out of school hence our out of school estimate was 137,299 children.

CSOs coverage

i. CSOs were noted not to have same covering capacity, acceptability and community coverage and/or convincing skills. In lieu of this it was assumed that each CSO will cover 3,000 people in a given community per year. Hence if a CSO trains 30 people, these are supposed to reach and cover 3,000 people as a spillover effect of the training.

(C): Expenditure on ARVs

i. All ARVs in Zanzibar are procured by Zanzibar Integrated HIV, Hepatitis, TB and Leprosy Progress (ZIHHTLP). Thus, expenditures on ARVs was obtained from this source. All ARVs are procured using the funds from Global Fund.
ii. The expenditure includes 6% for distribution that is channeled through the Central Medical Store (CMS).
iii. Disaggregation by first, second and third lines, Prevention of Mother to Child Transmission (PMTCT), and pediatrics ARVs was not available.
iv. Zanzibar has adopted a "treat all" policy. Despite this policy, some HIV+ pregnant women are not on treatment because of various reasons.

(D): HIV Testing and TB Screening

i. Expenditure on procurement of testing medical supplies and equipment such as CD4 machine and gene expert was obtained from ZIHHTLP. These costs were covered using the funds from Global Fund.
ii. Procurement costs for medical equipment and supplies were included in ASC.06.05.01 – procurement and supply chain management which is under ASC.06 (Program enablers and systems strengthening) and sub-category ASC.06.05 (public systems strengthening).

(E): Hospitalizations for HIV & AIDS – make requisite assumptions

- Assumptions: it was assumed that based on the current universal access to care and treatment services, and the marked levels of those initiated on care and treatment as well as to those placed under Opportunistic Infections (OI) coverage there has been a marked reduction of HIV & AIDS related hospitalizations. With this background out of the estimated 6,269PLHV in 2016; only 5-10% gets admitted per year. In addition, the current review on patient management policies particularly the test and treat is a strategic decision; reliable availability of drugs with minimal stock outs coupled with low clinically observed drug resistance at level 1; social protection interventions e.g. for income generation; PLHIVs have contingent plans – living normal life in terms of eating habits, patterns of life etc. have all contributed to less hospitalization and deaths.

(F): Health Facilities' Labor Cost

- As noted above, data on expenditures by health facilities on in-patient and out-patient care were not available. Thus, central data were used for estimations as shown above. Some assumptions were also made in estimating the cost of labor spent on HIV & AIDS related.

Service levels

i. HIV & AIDS, STI, TB and other related services are being rendered based on the level of the facility. The higher ranked the facility, the more likelihood of finding comprehensive services being offered within the same facility/under the same roof and it will have a well-defined referral structure.
ii. Services that do not call for advanced monitoring system are being offered even at lower levels namely PHCU+ and PHCU. Such services include: HIV counselling and testing services, sputum diagnosis, management of opportunistic infections and ARV refills (in selected PHCU+ facilities).
iii. Most facilities offer Antenatal Care (ANC) services; hence PMTCT services are widely accessed and the coverage is around 80%.
iv. Level II PHCU have laboratories hence can undertake both TB and HIV diagnosis.
v. Cottage, District, Regional and Tertiary (referral) hospitals have good infrastructure to provide comprehensive integrated services with high laboratories capacities and even offer admissions to serious cases that require close observations and advanced management.
vi. Based on these facts, the human resource needs at each facility vary based on the level and complexity of services rendered.

Available human resource for HIV & AIDS service provision

i. All health facilities offer ANC services and do screen for PMTCT services. Hence ANC staff allocate 15% of their daily time to support HIV education and promotional campaigns, HIV Testing and Counselling (HTC) and referral of clients to CTC and other related services.
ii. Facilities with admission capacity have staff who allocate their time to undertake HIV interventions in particular the Provider Initiated Testing and Counselling (PITC) services, and other HIV, STI and TB management services. General wards staff allocate an average 0f 10-15% of their time to attend to HIV issues especially diagnostic and prevention education.
iii. Staff who are in HIV clinics, programs and counselling units use 100% of their time on HIV interventions.
iv. Laboratory staff in major hospitals spend 10-25% of their time (depending on patient load) to undertake HIV services.
v. Annex 4 provides detailed estimations on the cost of time spent on HIV & AIDS services by health facilities (mainly prevention and CTC) activities.

(G): Other Data Issues/Assumptions

1. The following are global AIDS Spending Categories (ASC) but they are not significant in the Zanzibar context:
    a. Voluntary male circumcision – not an issue in Zanzibar.
    b. Pre-exposure prophylaxis is on the table now; it has not been discussed in the past.
    c. Transgender Sex (TGS): The Global Fund expenditure and reporting Template has a category named “Prevention for Men who have Sex with

Men (MSM) and TGS." Nevertheless, in Zanzibar, TGS KP category has not been isolated and dealt with. Thus, all the funds allocated under this group were captured as MSM expenditures.

2. Some Financing Entities (FEs) were not mapped during the mapping exercise as they were not known. These were captured at provider level e.g. Japanese Trust Fund, European Commission, UBRAF etc.
3. Data collation was done - especially the data transferred from ZAC to CSOs or from ZIHHTLP to ZAC and then to CSOs in order to avoid double counting.
4. Many public institutions (MDAs) assumed dual roles of Financing Agents-Purchaser (FAP) and Providers of Services (PS).
5. In collecting data, cash flow accounting principle was used (not accrual principle). Thus, expenditures were accounted at the moment of the expenditure (cash flow) not at the moment when the services were provided and commodities used/distributed (accrual).
6. Please indicate if you would need further clarification on these accounting terms.
7. People Who Inject Drugs (PWID): note that other forms of drug users are also common in Zanzibar e.g. sniffing and smoking. Kichupa and shisha styles are also emerging; note that marijuana is not included as a drug.
8. Expenditures by health facilities on capital investment e.g. buildings (mainly improvement of the storage facilities) and procurement of vehicles, motorcycles, and medical equipment were obtained from central level (ZIHHTLP).
9. We did not capture Out of Pocket (OOPs) expenditures from households. The only area where OOPs has been reported is expenditures from Al-Rahma hospital (a private health facility) and benefits from pilgrimages (HIJAJ) whereby households returning from Makah after HIJAJ contribute to JUMAZA (a HIV & AIDS based NGO).
10. All M&E and supportive supervision funds have been included under PF named "travel." An assumption is that individuals do travel to conduct these activities.
11. For PMTCT, beneficiaries are assumed to be pregnant and breast feeding women (as provided in the NASA classification). However, a woman may be on ARV program if pregnant but not necessarily breast feeding.
12. Where funds have been spent on MSM and sex-workers in lump sum the following ratio was used to allocate these funds per specific KP; 60% for sex-workers and 40% for MSM.
13. Exchange rate used in the study: 1 USD=TZS 2,200; 1 EURO = TZS 2400.
14. In-kind supports have not been captured.

4.6 Verification of Data

Verification and validation of revenues and revenue sources against expenditures was done through:

1. Revisiting bank statements or income from the partners or the Ministry of Finance.
2. Revisiting annual auditing reports and audit certificates and clearances.
3. Cross checking funds transferred from the source to the beneficiary or recipient.

4.7 NASA Challenges

Although the NASA exercise was accomplished successfully in Zanzibar, it faced some few challenges especially in getting relevant data from some organizations and verification of the data.

1. Accessing finance data: Willingness to reveal financial expenditures especially on overheads and remuneration were among the major challenge encountered by this study.
2. Verification of the data: it was difficult to access bank statements and audited reports from some organizations.
3. Missing/underestimated or overestimated expenditures: the capturing of expenditures on procurement of ARTs is not consistent. As such, these expenses might have been overestimated in 2016/17 or underestimated in 2017/18.
4. Cost of Treating Opportunistic Infections: In estimating the cost of treating the opportunistic infections, one has to consider several categories of cases: those on ARV, their immunity system is stable and suffers less opportunistic infections; those enrolled but not on ARV (their immunity system will deteriorate quite rapidly); those with AIDS; those screened for cervical cancer and hepatitis infection as a result of their sero status; TB clinics; any opportunity cost. Data on these categories were not readily available. Furthermore, information on patients treated for OIs in the years of study was also not available.
5. Allocating time for clinical staff who are outside HIV clinics in line with the number of consulted clients was challenging.
6. Some international NGO have finalized their operational time in Zanzibar. Thus, we had to work with them through electronic media or we missed their financial inputs.
7. Detailed NASA classifications while organizations do not record and keep data in such detailed level e.g. recoding data according to NASA AIDS Spending Categories (ASC).
8. Out of pocket expenditure has not been calculated; this may have resulted to underestimation of expenditures on HIV & AIDS.
9. NASA requires information on actual consumption and not purchases. However, information on consumption was not available. Data is based on projected purchase due to low volume on the amount of ART needed compared to other countries. Bulk procurement is done for some commodities and drugs especially for OIs or procurement is based on need and through case by case requirements. It is important to note that the change in policy to diagnose and treat may have a negative impact on projected stock - stock out will have notable repercussion on the longevity and adherence to CTC clients.

5.0 EXPENDITURE FOR HIV & AIDS

5.1 Introduction

This Chapter presents trends of public expenditure on HIV & AIDS as recorded for financial years 2016/17 and 2017/18 using the current NASA classifications. Table 8 shows the overview of the collected data for both Financial Years (FYs). As shown in the table, most of data were collected from the primary sources. As explained in chapter 4, estimations were made for expenditures at health facilities mainly for the salaries of health care workers.

While a total of 59 organizations participated in the national response in 2016/17 as financing source, purchaser or service provider, a total of 55 organizations were recorded in 2017/18; thus four organizations left the scene due to various program implementation reasons (Annex 5). These include but not limited to program finalization and close out, change of support and change of operational guidelines from financing entities leading to operations in other areas in the country (Tanzania mainland). Noted financing entity that was no longer operating on HIV & AIDS arena in Zanzibar is Tanzania Health Program Support (THPS). As presented in section 5.2 below, response to the pandemic has been dynamic with new financing entities and providers entering and others leaving in line with the program longevity and agreed operational period. This has to a remarkable extent created a significant financial gap.

Table 8: Data Overview

Source Type	Number of Transactions		Total Expenditures (TZS)	
	2016/17	2017/18	2016/17	2017/18
Adapted on primary source	77	79	13.45Bn.	6.52Bn.
Estimation or imputation	23	25	3.78Bn.	4.30Bn.
Personal information	0	0	0	0
Primary source certificate	0	0	0	0
Not Available	0	0	0	0
Based on budgets	0	2	0	99.46Mn.
Based on expense reports	75	69	13.24Bn.	5.72Bn.
PxQ	25	33	3.00Bn.	5.00Bn.
Not Available	0	0	0	0.00

Note: Bn. = Billion; Mn. = Million

The findings are organized per 3major NASA vectors and variables under each vector as shown in Figure 5 below. Annexes 6 and 7 show the complex cob-web of financial flows from the financing entity, to pools/revenues, financing schemes, agents-purchasers and finally service providers for 2016/17 and 2017/18 financial years respectively. The financial flow process is discussed under each vector as deemed appropriate.

(A): HIV & AIDS Financing

1. Financing Entities (FE) – who pays?
2. Revenues (REV) – the payment is from which pool?
3. Financing Schemes (SCH) - what mechanisms allow for payment?
4. Financing Agents – Purchasers (FAP) – who purchases the services?

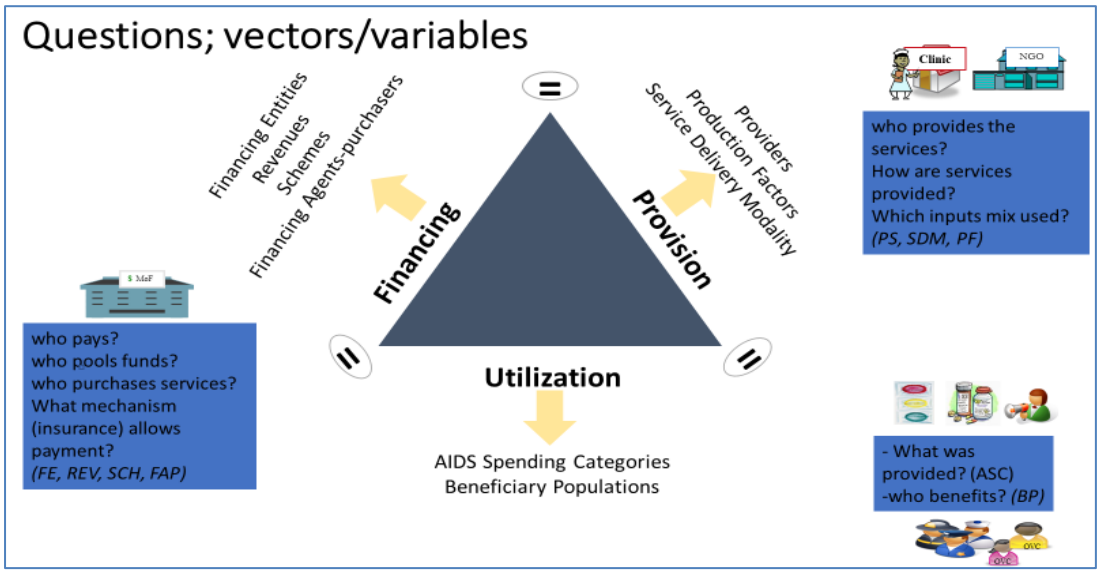
(B): Provision of HIV & AIDS Services

1. Providers of Services (PS) – who provides the services?
2. Service Delivery Modalities (SDM) – how are services provided?
3. Production Factors (PF) – which input mix are used?

(C): Utilization of HIV & AIDS Services

1. AIDS Spending Categories (ASC) – what was provided?
2. Beneficiary segments of the population (BP) – who benefited?

Figure 5: NASA Vectors



5.2 HIV & AIDS Financing

5.2.1 HIV & AIDS Financing Entities

A total of TZS 17.24Bn and 10.82Bn were spent on HIV & AIDS by various local and international organizations in 2016/17 and 2017/18 financial years respectively, a decline of 32.74% (Table 9). This spending is equivalent to 0.61% and 0.30% of the GDP in 2016/17 and 2017/18 respectively. With this level of spending, HIV spending per people who live with HIV & AIDS was TZS 28,585 in 2016/17 but it declined to TZS 17,122 in 2017/18 (a decline of 40.10%) as a result of decline of overall funding given the departure of some prominent financial entities and decline of funds from Global Fund.

Table 9: Summary of Key HIV & AIDS Financing Variables

Sn.	Variables	Value (2016/17)	Value (2017/18)
1.	Total HIV spending (TZS)	17.24Bn	10.82Bn
2.	Public spending on HIV (TZS)	5.06Bn	5.21Bn
3.	Public spending as a share of total HIV spending (%)	29.35%	48.11%
4.	International on HIV (TZS)	11.76Bn	5.10Bn
5.	International spending as a share of total HIV spending (%)	68.21%	47.10%
6.	Private spending on HIV (TZS)	420.69Mn	518.30Mn
7.	Private spending as a share of total HIV spending (%)	2.44%	4.79%
8.	HIV spending as a share of GDP (%)	0.61%	0.30%
9.	Per capita spending (TZS)	1,143,425	684,909
10.	HIV spending per people who live with HIV & AIDS (TZS)	28,585	17,122
11.	Total spending on prevention interventions (TZS)	3.39Bn	1.14Bn
12.	Prevention as a % share of total spending	19.69%	10.57%
13.	Total spending on care and treatment (TZS)	4.32Bn	2.13Bn
14.	Care and treatment as a % share of total spending	25.09 %	19.65%
15.	Total spending on HIV testing and counseling (TZS)	790.71Mn	273.49Mn
16.	HIV testing and counseling as % share of total spending	4.59%	2.53%
17.	Total spending on programs' management (TZS)[29]	7.30Bn	6.67Bn
18.	Management as a share of total spending (%)	42.34%	61.62%
19.	Total spending on Antiretroviral therapy (TZS)[30]	1,611.46Mn	730.28Mn
20.	Antiretroviral therapy as a % share of total spending	9.35%	6.75%
21.	Antiretroviral therapy as a % share of total care and treatment spending	37.25%	34.34%

Note: Bn = Billion; Mn = Million

The observed decline definitely affected service delivery to PLHIV, Key and Vulnerable Populations (KVPs), and general population on prevention and testing and counseling aspects (e.g. see below on interventions that were supported by THPS). The decline is markedly contributed by:

- Finalization of the program duration and/or close out of some programs.
- Re-allocation of the program operators to other zones and reintroduction of new operators who won the country operation mechanism especially through United States Government support. For example, there was a time lapse from the finalization of THPS as operators in Zanzibar to the take off by AMREF as the new

[29] Management cost is defined crudely to include PF.01.01.01.01(labor costs – direct service providers); PF.01.01.01.02 (fringe benefits – direct service providers); PF.01.01.01.04 (consultants - external); PF.01.01.02 (program management personnel costs); PF.01.01.02.01 (labor costs - program management); PF.01.01.02.02 (fringe benefits - program management); PF.01.01.02.04 (program management consultants - external); PF.01.01.02.98 (program management personnel not disaggregated); PF.01.01.98 (personnel not disaggregated); PF.01.02 (other operational and program management current expenditures); PF.01.02.01 (office rental costs); PF.01.02.02 (office utilities costs - electricity, water, heating, etc.); PF.01.03.05(office supplies); and PF.01.02.04 (administrative and program management costs).

[30] This includes procurement of ART, adherence and retention on ART support (including nutrition and transport) and monitoring and specific ART-related laboratory monitoring. Nutritional support was part of food for prescription especially for children from the destitute and marginalized populations, the pregnant women and those who were debilitated due to advanced conditions of the AIDS related complications.

operators as it has to recruit human resources and ensure that its introduction and establishment in both islands of Zanzibar is sound and solid.

Support from the Global Fund has also declined. This can be attributed to several reasons:

- Principally the Global Fund complements the Government funding efforts in certain defined projects and programs. One of the Global Fund conditions is contribution from the Government of around 5% of the total grant as part of Government's commitment. This is important in ensuring sustainability of set systems (systems strengthening using government coffers) and operational needs in the ministerial budget and plans. Failure to realize the 5% from the Government results to some penalties which may entail reduction of the tranches. However, it is important to note that the Global Fund support covers a fraction of the human resource recruitment, deployment carrier path development and other resources needed to deliver services within the health sector. Apart from recruiting and maintaining the human resource for health, the Government also provides premises and utilities such as safe water supply and electricity. Interpretation of this is that though the Government might not have provided the 5% in cash, this is more than covered in the areas detailed here.
- The Global Fund disbursement requires clearance from Local Funding Agent (LFA) and at times there are delays due to embedded challenges within the programmatic and financial reporting systems. These contribute markedly to the Global Fungsaving system as funds are cut/deducted hence budget reduction.
- Limited ability of principal and sub-recipients to timely absorb allocated funds also affects disbursements. Delays in reporting and requesting of funds contribute to late releases or no release of funds at all which in turn results to low absorption of funds.

Figures 6a and 6b show the total HIV & AIDS expenditures by financing entities in 2016/17 and 2017/18 FYs respectively. International financing entities were the main source of funds for HIV & AIDS response in Zanzibar in 2016/17 followed by the public entities but the trend reversed in 2017/18 where public entities became the main financing entities. Notably, in 2016/17 international financing entities accounted for 68.21% of the total national response but it declined to 47.10% in 2017/18, mainly attributed by the reasons mentioned above viz. finalization of project duration and time lapse for the introduction of new program operators and substantial decline of finances from the Global Fund. Part of the left financial gap was filled by the public entities which resulted to substantial increase of finances from this source from 29.35% in 2016/17 to 48.11% in 2017/18. In both years, only a small amount of expenditure was covered by domestic private entities including households (2.44% in 2016/17 and 4.79% in 2017/18).

The low contribution from private entities including households reflects the fact that out of pocket expenditure for HIV & AIDS related expenses is low. This is attributed to low purchasing power of the infected and affected population as well the guidance from both the National HIV & AIDS as well as the National Health Sector Policies of ensuring that those living with HIV & AIDS are accessing health and related services free of charge. The country's free treatment

Policy coupled with the low participation of the private sector in the national HIV & AIDS response has notably contributed to the observed low documented private HIV& AIDS expenditures in the country.

Figure 6a: HIV & AIDS Financing Entities (2016/17)

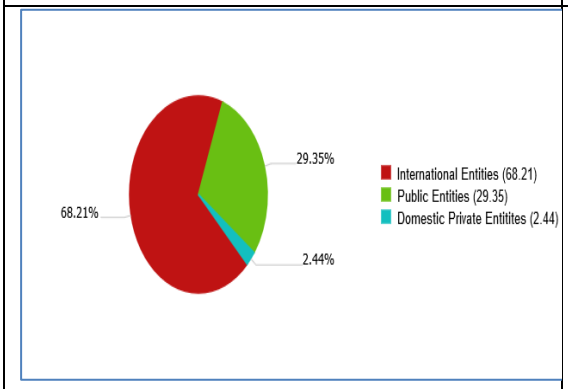
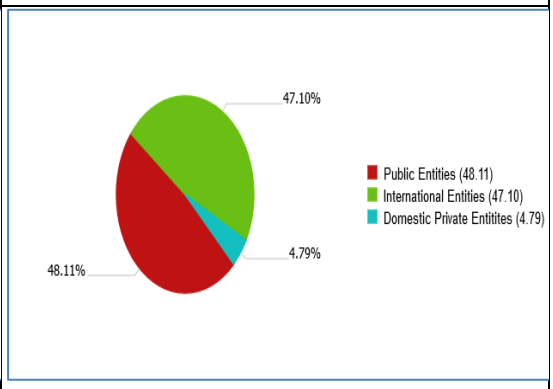


Figure 6b: HIV & AIDS Financing Entities (2017/18)



For both years, most of the funds from the international financing entities were from multi-lateral organizations (51.95% in 2016/17 and 38.99%). The funds in form of bilateral aid were 9.62% of the total international spending in 2016/17 but it declined to 6.37% in 2017/18 (Figures 7a and 7b), possibly reflecting the departure of THPS which was funded by the United States Government through Centre for Disease Control (CDC). No improvement is noted on the funds from international not-for profit organizations and foundations; the funds from this source declined by 71.71% during the study period.

Figure 7a: Types of International Financing Entities (2016/17)

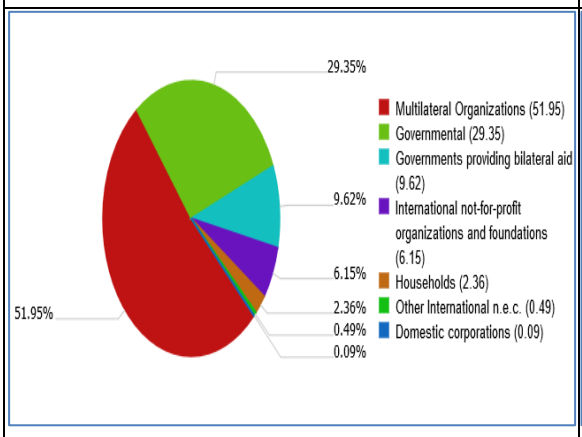
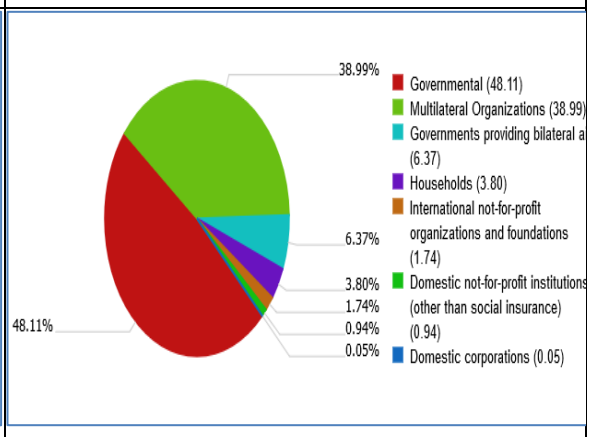


Figure 7b: Types of International Financing Entities (2017/18)



For both financial years, the main international financing entity was the Global Fund to Fight AIDS, Tuberculosis and Malaria (Table 10). Relative to other international sources, its contribution in terms of percentage of the total national response was 71.11% in 2016/17 but it declined substantially to 52.76% in 2017/18. In absolute terms, the support declined from TZS 8,362Mn in 2016/17 to 2,688Mn, a 67.85% decline. Infact, Global Fund funded close to

half of the national response in 2016/17 (48.50%) but it declined to 24.85% in 2017/18. This raises an issue of too much dependence on one source of funding. If the operations of this source cease to exist, the national response will suffer.

The US Government mainly through the THPS was the second major financing entity in 2016/17 but in absolute terms, the support declined substantially from TZS 1,636Min in 2016/17 to TZS 671.76Min in 2017/18, a 58.95% decline. As noted above, THPS HIV & AIDS activities which were funded by the United States Government through CDC have been phased out in Zanzibar which has left a significant gap in the national response. Among the major areas of interventions provided by THPS include:

(i) Community sensitization and mobilization campaigns.
(ii) Door to door and moonlight services targeting Key and Vulnerable Populations (KVPs).
(iii) Strengthening of laboratory services in capacity enhancement and mentorship programs, quality assurance of rendered services, support to peer educators' interventions at all levels and in all CTCs. The later has largely contributed to user friendly service provision among those in need.
(iv) Tracing ART defaulters and ensuring that they are put back to right HIV management including treatment.
(v) Strengthening linkages between diagnosing HTC centers to CTC and HBC services. This was done through the client's escort services where peer educators escorted the newly diagnosed HIV clients to the nearest CTC sites.
(vi) Support and strengthen the operationalization of MAT sites.
(vii) Scale up TB HIV intervention by supporting and recruiting, training, mentoring the required human resource for health.
(viii) Procurement of advanced laboratory reagents and assists in sample transportation for Early Infant Diagnosis (EID).
(ix) Supporting and strengthening reporting systems between the public and non-public actors (in particular the M&E system).
(x) Supported the accreditation process of major laboratories in Zanzibar.
(xi) Set up sites that either conducted or supported cervical cancer screening, training and early management among people living with HIV &AIDS and to the general population at large.
(xii) THPS was among the lead agency that drove the designing and overall implementation of The Tanzania HIV Impact Survey and the obtained results showed a decline in HIV magnitude and provided light on HIV incidence rate (new infections).

The United Nations Children's Fund (UNICEF)has a significant contribution (an increase from 2.00% support in the national response in 2016/17 to 19.01%). The United Nations Population Fund (UNFPA) also had a significant presence in Zanzibar in 2017/18. Other international not for profit organizations and foundations that are not classified in NASA e.g. Save the Children and Stefan Lewis Foundation (SLF) also contributed in the national HIV &AIDS response although the support declined in 2017/18 (9.01%vs 3.70% respectively).It is interesting to note

a new form of funding which is "contributions from HIJAJ." This means that households are channeling their charitable contributions to the national response.

Table 10: Contributions by International Financial Entities, 2016/17 & 2017/18

FE Categories	2016/17		2017/18	
	TZS (Mn)	%	TZS (Mn)	%
FE.03.01.19: Government Norway	23.11	0.20%	17.08	0.34%
FE.03.01.30: Government of United States	1,636.33	13.91%	671.76	13.18%
FE.03.02.02: European Commission	-	-	55.55	1.09%
FE.03.02.07: The Global Fund to Fight AIDS, Tuberculosis and Malaria	8,362.46	71.11%	2,688.93	52.76%
FE.03.02.08: UNAIDS Secretariat[31]	92.90	0.79%	35.17	0.69%
FE.03.02.09: United Nations Children's Fund (UNICEF)	235.38	2.00%	973.85	19.10%
FE.03.02.11: United Nations Development Program (UNDP)	-	-	20.82	0.41%
FE.03.02.12: United Nations Educational Scientific and Cultural Organization (UNESCO)	-	-	50.13	0.98%
FE.03.02.17: United Nations Population Fund (UNFPA)	265.66	2.26%	394.98	7.75%
FE.03.03.99: Other international not for profit organization and foundations, e.g. Save the Children and Stefan Lewis Foundation	1,059.72	9.01%	188.66	3.70%
FE.03.99: Other International Organizations (Japan Trust Fund)	84.07	0.71%	-	-
Total	**11,759.65**	**100.00%**	**5,096.92**	**100.00 %**

A big worry is the disappearance of the once big financing entity from the picture. In the mid to late 2000s, significant donors in Zanzibar included PEPFAR, World Bank TMAP, WHO, and Action AID SIPAA project among others but they are no longer in the picture.[32] Without firm commitments of funding, Zanzibar is at risk of interruptions or sudden unanticipated drops in funding which would be difficult to compensate for and could be detrimental on the national efforts to keep prevalence rates below 1% and curb new infections. The current noted declining HIV financing trend is a threat to the national response particularly taking in account the bridging nature of sexual relationship between the general population and the KPs. This calls for an intense investment on prevention services given that the nature of the epidemic is known.

Despite the fact that the epidemic is matured having been there for more than30 years, private entities have not fully joined the fight in a significant way. Only two private organizations were found to have active HIV & AIDS interventions– one was a road construction company which may mean that the program has been initiated as a way of

[31]Note that UNAIDS pools resources e.g. through Unified Budget Results Accountability Framework (UBRAF) which is UNAIDS instrument to maximize coherence coordination and impact of UN response to AIDS – combining efforts of UN consortium with UNAIDS.

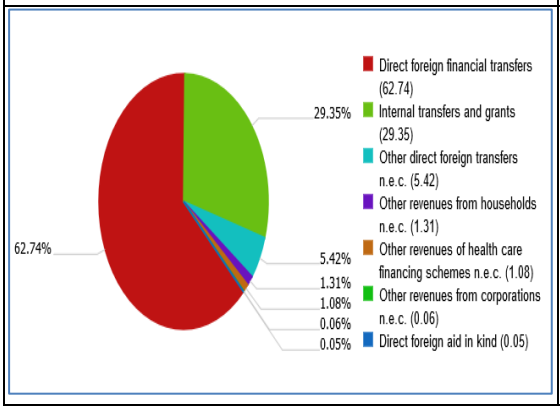
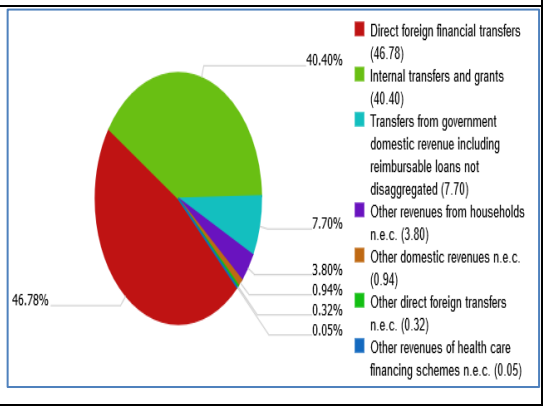
[32]Ramsa, N., O. Sultan, A. Seha, and S. Juma (2007), HIV & AIDS Resource Tracking in Zanzibar, Zanzibar.

complying with HIV & AIDS work place interventions as required by HIV & AIDS policy. The sampled businesses were found not to deal with HIV & AIDS issues even the ones in the tourism sector. AIDS Business Coalition of Zanzibar (ABCZ) was formed in 2005 with the aim of organizing and coordinating the private sector so that it can join hands in the fight. However, it has lost momentum due to the decline of HIV funding. It is now operationalized from the support of a number of volunteers and it has not received HIV funding to support its HIV activities based on its Strategic Plan - for two consecutive years (2016/17 &2017/18). This implies that it has not been able to mobilize the private sector substantially to contribute funds even for its own operations. Few members of ABCZ like Hotels and Zanzibar Social Security Fund (ZSSF) provide irregular support, for example, in 2016/17 it received TZS 4,000,000 from Hotels and ZSSF to procure 200 pieces of ZAC t-shirts for the commemoration of the world HIV day.

5.2.2 HIV & AIDS Revenues

NASA provides classifications on how the funds are pooled from the financing entities/sources. Although the financial flow is between the economic agents (FE, FAP and PS), resource tracking allows us to identify what type of pools/resources are transferred and how the financing mechanism is organized for guaranteeing access, according to the legal provisions in force in the country. Examples of such pools/resources include: transfers from government domestic revenue including reimbursable loans allocated to HIV purposes (REV.01); transfers distributed by government from foreign origin (REV.02); social insurance contributions (REV.03), direct foreign transfers (REV.07) etc. (see Table A1b, Annex 1 for REV classifications).

Given that the big chunk of funds came from international sources, the dominant resource/pool was direct foreign financial transfers for both years (62.74% and 46.78% respectively) and it was followed by internal transfers and grants from the government (29.35% and 40.40% respectively) as shown in Figures 8a and 8b.The transfers from the government pool increased from 29.35% in 2016/17 to 40.40% in 2017/18. In terms of financial flows, the direct multilateral financial transfer pool (REV.07.01.02) pooled 52.86% of the transfers in 2016/17 but this declined to 36.18% in 2017/18 echoing the decline of the support from the Global Fund. The transfers from the government financing pool (REV.01) increased from 29.35% in 2016/17 to 48.11% in 2017/18.

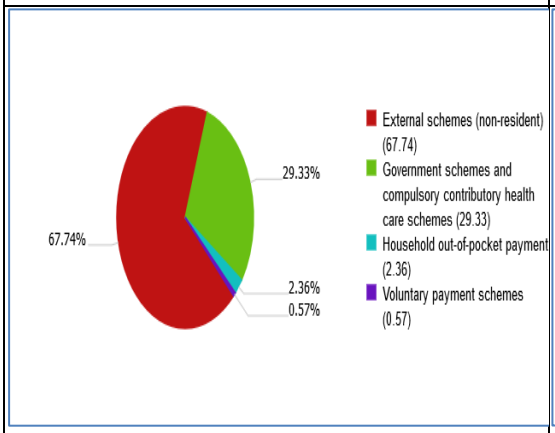
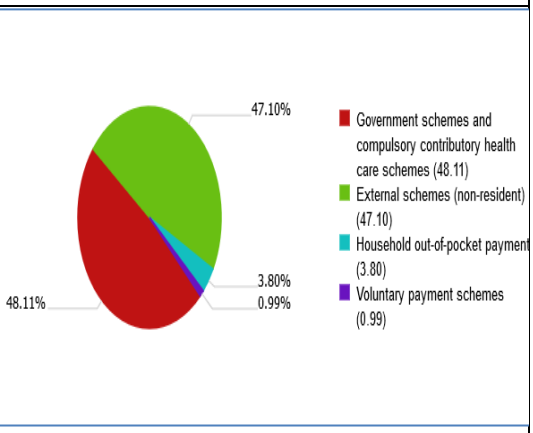
Figure 8a: Revenues/Pools (2016/17)	Figure 8b: Revenues/Pools (2017/18)
	

5.2.3 HIV & AIDS Financing Schemes

NASA classifies the schemes from which HIV & AIDS expenditures come from. Financing Schemes (SCH) are financing modalities through which the population has access to HIV & AIDS goods and services. SCHs mobilize and allocate resources within the system to satisfy the needs of individuals and collective populations, both current and future. They are a set of rules or laws that regulate the modality of participation, the right to access health services and how to obtain and pool resources. Financing schemes are classified according to the following criteria: mode of participation, benefit entitlement, basic method for fund-raising and pooling. SCHs include direct payments by households for services and goods and third-party financing arrangements.An example of the third party scheme is where the services are provided for free at the health facility but certain organizations have paid for the services e.g. the government or any international organization.

Given the nature of the national response (largely funded by the international organizations in 2016/17), external schemes (non-resident) were mostly used (67.74%). This was followed by the government schemes and compulsory contributory health care schemes (29.33%). However, this changed with government schemes and compulsory contributory health care schemes pooling more funds in 2017/18 (48.11%) compared to external schemes (47.10%).Households' contributions were minimal and this reflects the sampled private health facility and the contributions from HIJAJ (Figure 9a and 9b).

Further disaggregation shows that foreign development agencies schemes (SCH.04.02.02.02) had the highest contribution in 2016/17 (62.73%) followed by central government scheme (29.33%) but this was reversed in 2017/18 where central government schemes contributed 48.11% followed by foreign development agencies schemes (46.78%). It is important to note this turning point in the financial flow where government started to take the lead in financing national HIV & AIDS response. This is important for sustainability of HIV & AIDS interventions.

Figure 9a: Financing Schemes (2016/17)	Figure 9b: Financing Schemes (2017/18)
	

5.2.4 HIV & AIDS Financing Agents – Purchasers

As expected, large amount of fund in both years (72.85% and 69.32% respectively) has been managed by the Ministry of Health through the Zanzibar Integrated HIV & AIDS, TB and Leprosy Program (ZIHHTLP). MoH is also responsible in managing salaries for health providers; salaries for health providers command a significant share of HIV & AIDS expenditures. Funds from Global Fund (the largest international financing entity in the two years) are channeled through ZIHHTLP for implementation of interventions in the following thematic areas:

1. TB/HIV collaboration interventions
2. Treatment and care support
3. Prevention of Mother to Child Transmission (PMTCT)
4. Prevention for:
    a. Men who have Sex with Men (MSM) and Transgender Sex (TGS)
    b. People Who Inject Drug (PWID)
    c. Sexual workers
    d. General population
    e. Program management.

Not-for-profit institutions (other than social insurance) also manage significant amount of funds given that several financing entities use non-governmental organizations for execution of HIV & AIDS interventions followed by ZAC (Table 11). In 2016/17 a significant amount of fund was channeled through central government authorities that are not defined in NASA. Examples of these authorities are agencies such as Zanzibar Food and Drugs Authorities (ZFDA) and Office of the Chief Government Statistician (OCGS). This was done as part of ensuring health sector system strengthening aiming at long term sustainability of designed interventions. Some entities were both the FAP and providers of services e.g. NGOs that received funds directly from the Financing Entity. Some money from Global Fund passed through ZIHHTLP and then transferred to ZAC for transference to service providers (NGOs). This shows multiple intermediate layers. NASA principles provides for the most proximate FAP to the actual contracting of the services or purchase of the commodities.

The major financing scheme in 2016/17 was foreign development agencies schemes (SCH.04.02.02.02) – 62.73%. In this category of scheme of financing, Global Fund dominated (48.50%). In 2017/18 central government financing schemes (SCH.01.01.01) dominated (48.11%), meaning that more money were pooled through the public financing schemes compared to international schemes.

Table 11: Financing Agents – Purchasers, 2016/17 & 2017/18

FAP Categories	2016/17		2017/18	
	TZS (Mn)	%	TZS (Mn)	%
AP.01.01.01.01 Ministry of Health (or equivalent sector entity)	12,561.06	72.85%	7,500.30	69.32%
FAP.01.01.01.02 Ministry of Education (or equivalent sector entity)	2.01	0.01%	60.79	0.56%
FAP.01.01.01.06 Ministry of Labor (or equivalent sector entity)	60.42	0.35%	181.85	1.68%
FAP.01.01.01.08 Other ministries (or equivalent sector entities)	5.65	0.03%	3.50	0.03%
FAP.01.01.01.09 Prime Minister's or President's office	4.49	0.03%	2.35	0.02%
FAP.01.01.01.10 National AIDS Commission	1,304.36	7.57%	1,222.33	11.30%
FAP.01.01.02.99 State/provincial/regional entities	4.19	0.03%	37.20	0.34%
FAP.02.06 Corporations other than providers of health services (non-parastatal)	15.07	0.09%	5.26	0.05%
AP.02.05 Not-for-profit institutions (other than social insurance)	2,245.81	13.03%	1,346.03	12.44%
FAP.02.99 Other private financing agents e.g. Al Rahma Hospital	202.52	1.17%	405.05	3.74%
FAP.03.02.16 United Nations Population Fund (UNFPA)	-	-	13.41	0.12%
FAP.01.01.01.99 Central or federal authorities' entities includes ZFDA and OCGS	827.52	4.80%	4.93	0.05%
FAP.03.99 Other international financing agents e.g. RFE	8.38	0.05%	-	-
FAP.03.03.99 Other International not-for-profit organizations e.g. AMREEF and ICAP.	-	-	37.51	0.35%
Total	**17,241.49**	**100.00%**	**10,820.52**	**100.00%**

5.3 Provision of HIV & AIDS Services

5.3.1 Providers of Services

A number of service providers participated in the HIV & AIDS national response during the review period (Table 12). The main service provider (provided53.66% and about 35.72% of all HIV & AIDS related services in 2016/17 and 2017/18 respectively) is ZIHHTLP (a Unit in the Preventive Service Department of the Ministry of Health) which is reflecting the role of the program in provision of HIV & AIDS services using the funds from the Global Fund. It is important to note that ZIHHTLP participates in delivering an array of services from prevention (including reaching the KVPs) to procurement of ARVs and major equipment such as Gene

Expert for diagnosing TB infection through the Government set procurement mechanism. This is followed by public sector providers who have not been classified (12.51% and 20.51%in 2016/17 and 2017/18 respectively) reflecting the service provision by Fuoni PHU+ and 120 PHUs based on the estimates made on personnel emoluments.

Public hospitals are another major provider rendering testing and counselling, care and treatment services given that they all have CTCs. It is important to note the participation of non-health departments which is reflecting the multi-sectoral nature of the pandemic. Notably, the Ministry responsible for Finance provided services equivalent to 4.75% of the HIV & AIDS expenditures in 2016/17.

Civil society organizations (private non-profit non-faith based) are also important partners in service provision landscape. This sector is dynamic with establishment of new NGOs and phasing out of others. For example, while Zanzibar against AIDS Infection and Drug Abuse (ZAIADA) was a strong NGO focusing on one of the MARPs in 2000s, it has lost momentum over time irrespective of the persistent problem of drug abuse in Zanzibar. Other CSOs that are no longer strong/almost disappearing from the picture include WAMATA, ZASO, ZAMASO, COWPZ and ZAFFIDE. This is a result of phasing out of the Africare program which used to channel funds through these NGOs. Phasing out of Action Aid SIPAA program also left some NGOs without funds. Thus, the change of NGOs landscape reflects dependency of donor funding which results to discontinuity of activities and fading of organizations that harbor those activities.

Table 12: Service Providers, 2016/17 & 2017/18

PS Categories	2016/17		2017/18	
	TZS (Mn)	%	TZS (Mn)	%
PS.01.01.01: Hospitals (public)	1,424.04	8.26%	1,676.06	15.49%
PS.01.01.13.01: National AIDS Coordinating Authority (NACs)	1,004.13	5.82%	1,078.53	9.97%
PS.01.01.13.02: Departments inside the Ministry of Health or equivalent	9,251.57	53.66%	3,865.50	35.72%
PS.01.01.13.03: Departments inside the Ministry of Education or equivalent	2.01	0.01%	60.79	0.56%
PS.01.01.13.07: Departments inside the Ministry of Labor or equivalent	60.42	0.35%	159.87	1.48%
PS.01.01.99: Government organizations not disaggregated	12.25	0.07%	6.97	0.06%
PS.01.99: Public sector providers including PHCs and PHCs+	2,156.86	12.51%	2,218.77	20.51%
PS.02.01.01.14: Civil society organizations (private non-profit non-faith based)	2,214.03	12.84%	1,267.40	11.71%
PS.02.02.98: Profit-making private sector providers not disaggregated	5.26	0.03%	3.76	0.03%
PS.02.98: Private sector providers not disaggregated	-	-	1.50	0.01%
PS.02.01.01.01: Hospitals (private non-profit non-faith based)	202.52	1.17%	405.05	3.74%
PS.02.01.01.11 Orphanages (private non-profit non-faith based)	17.83	0.10%	-	-

PS Categories	2016/17		2017/18	
	TZS (Mn)	%	TZS (Mn)	%
PS.02.01.01.13 Self-help and informal community-based organizations (private non-profit non-faith based)	5.40	0.03%		
PS.01.01.13.06: Departments inside the Ministry of Finance or equivalent	819.19	4.75%	34.58	0.32%
PS.02.01.02.13: Civil society organizations (private non-profit faith based)	62.57	0.36%	35.31	0.33%
Total	**17,241.49**	**100.00%**	**10,820.52**	**100.00%**

Other NGOs e.g. ZANGOC are still operational amidst declining capacity and funding sources[33]. Emergency of new, strong, and stable NGOs has also been observed in Zanzibar. Notable ones are ZAYEDESA and PIRO which deal with MARPs. The emerging young NGOs that have centered their roles to cover the young population, vulnerable and key population have attracted more resources and have strengthened their capacity.

According to the CSOs mapping exercise conducted by ZAC in mid 2000s, there were approximately 87 CSOs carrying out HIV & AIDS activities in Unguja and Pemba. This number has declined to less than 40 CSOs currently. Change in the funding modality by international financing entities including the Global Fund is another reason that affected the operations of NGOs. While in the 2000s many international financing entities preferred to work with NGOs which resulted to proliferation of many NGOs, currently the preference is to work with government institutions. The main reason is the sub-optimal capacity by most of the CSOs but also sustenance of the interventions. The government has capacity to sustain the interventions when the program is phased out.

THPS is another program which has been phased out. THPS isa national NGO that used to operate by zones allocated by CDC as a funder. Currently through CDC PEPFAR funding THPS is operating in Pwani and Kigoma regions of mainland Tanzania.

5.3.2 Production Factors

Production factors have been classified under two broad classifications – the current direct and indirect expenditures and capital expenditures. Current expenditures are defined as expenditures on goods and services consumed within the current year, which need to be made recurrently to sustain the production of the services by the organization while capital expenditures record the value of the non-financial assets that are acquired, disposed of or have experienced a change in value during the period under study. Given the nature of HIV interventions as stipulated in the Zanzibar National Strategic Plan III for HIV & AIDS,[34]recurrent

[33]A sub-recipient of Global Fund and other funding envelopes.

[34]Given that about 99% of the population in Zanzibar is not infected and it needs to be protected, key interventions stipulated in the Zanzibar National Strategic Plan III for HIV & AIDS focus on HIV prevention, care and treatment programs and programs targeting KPs and vulnerable population given their heterosexual interactions with the general population.

expenditures consumed largest share of the funds in both years (96.83% and 96.17% respectively) [Figures 10a and 10b]. The 3.83% capital expenditures in 2017/18 were on construction/renovation of storage facilities and procurement of vehicles as part of enhancing and strengthening the health systems.

Figure 10a:Current vs Capital Spending (2016/17)

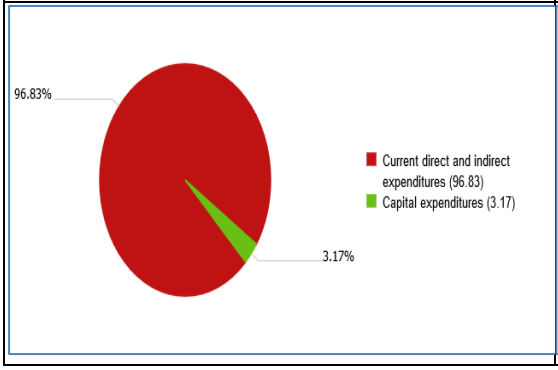
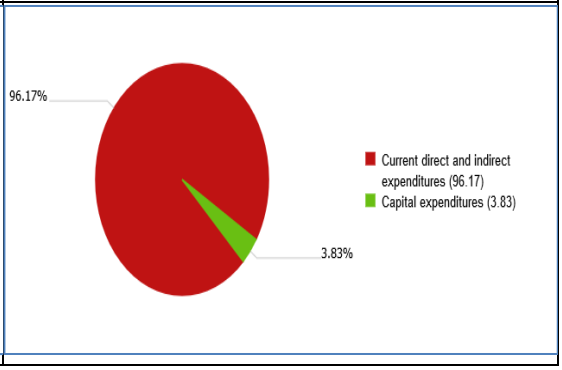


Figure 10b: Current vs Capital Spending (2017/18)



Labor cost was the major production factor recorded in the period of study. Labor cost is composed of both labor cost for direct service providers (providers that are dealing directly with the clients) and labor cost for program management. Labor cost for direct service providers had highest expenditure in both years (23.72% and 43.10% in 2016/17 and 2017/18 respectively) possibly reflecting the estimations for the salaries of health providers in 13 CTCs, Fuoni PHCU+ and all PHCs in Zanzibar (Table 13). The labor cost for program management staff costed 6.87% and 10.42% of the total HIV & AIDS expenditure in 2016/17 and 2017/18 respectively. Program service providers include those working with public HIV & AIDS programs and CSOs programs.

Logistics of events, including catering services also commanded large share of expenditure. These are expenditures related to meetings for various reasons including meetings to discuss various guidelines such as TB guidelines, advocacy meetings with key populations etc. It is important to note that most of prevention activities for various groups and for the general population involve gathering in meetings. Travel costs are also significant in both years. Program service providers do travel for various interventions out of their workplace including monitoring and evaluation and supportive supervision. Training also consumed a significant amount of funds especially in 2016/17. Training costs are related to per diems, transport, and other costs necessary for conducting trainings.

The pattern of expenditure on ARVs, diagnostic test for TB and HIV tests screening/diagnostics was different in the two years of study. While in 2016/17 9.35% of HIV & AIDS expenditures were directed to procurement of ARVs, only 2.37% was used in 2017/18. The same goes for procurement of TB screening/diagnostics equipment. In 2016/17 heavy diagnostics equipment such as Gene Expert were procured.

Expenditures on construction and renovations that were made in 2017/18 were meant to strengthen the supply chain in terms of storage facilities. Expenditures on logistics are also significant signifying the fact that most of prevention activities are done in form of meetings, workshops etc. Travelling is also apparent – travelling to various meetings and workshops (some workshops are held to sharpen/refresh capacities of service providers), monitoring and evaluation and supportive supervision. It also covers venue and round air trip for participants and facilitators to and from the two islands and their daily subsistence allowances.

Table 13: Production Factors, 2016/17 & 2017/18

PF Categories	2016/17		2017/18	
	TZS (Mn)	%	TZS (Mn)	%
PF.01.01.01.01: Labor costs - Direct service providers	4,090.29	23.72%	4,663.62	43.10%
PF.01.01.01.02: Fringe Benefits - Direct service providers	103.08	0.60%	189.46	1.75%
PF.01.01.01.04: Consultants (external)	232.64	1.35%	45.59	0.42%
PF.01.01.02.01: Labor costs - Program management	1,184.17	6.87%	1,127.60	10.42%
PF.01.01.02.02: Fringe Benefits - Program management	110.64	0.64%	321.78	2.97%
PF.01.01.02.04: Program Management Consultants (external)	72.54	0.42%	234.64	2.17%
PF.01.02.02: Office utilities cost (electricity, water, heating, etc.)	90.78	0.53%	120.09	1.11%
PF.01.02.03: Travel expenditure	844.14	4.90%	872.06	8.06%
PF.01.02.04: Administrative and program management costs	1,313.09	7.62%	136.73	1.26%
PF.01.03.01.01: Antiretrovirals	1,611.46	9.35%	299.01	2.76%
PF.01.03.02.02: Condoms	78.44	0.45%	245.26	2.27%
PF.01.03.03.01: HIV tests screening/diagnostics	591.06	3.43%	559.70	5.17%
PF.01.03.03.05: Diagnostic tests for TB (including rapid testing)	1,598.87	9.27%	-	-
PF.01.03.04.01: Food and nutrients	115.74	0.67%	123.61	1.14%
PF.01.03.04.02: Promotion and information materials	132.01	0.77%	124.05	1.15%
PF.01.03.05: Office Supplies	91.07	0.53%	59.28	0.55%
PF.01.04: Contracted external services	-	-	52.62	0.49%
PF.01.08: Training- Training related per diems/transport/other costs	1,263.30	7.33%	333.28	3.08%
PF.01.09: Logistics of events, including catering services	925.29	5.37%	714.63	6.60%
PF.01.98 Current direct and indirect expenditures not disaggregated	102.22	0.59%	-	-
PF.02.01.02: Construction and renovation	-	-	123.34	1.14%
PF.02.02: Vehicles	315.86	1.83%	246.11	2.27%
PF.02.03.01: Information technology (hardware and software)	116.04	0.67%	-	-

PF Categories	2016/17		2017/18	
	TZS (Mn)	%	TZS (Mn)	%
Others (e.g. medical equipment and supplies, non-medical equipment, lubricants, indirect expenditures not disaggregated etc.)	2,258.74	13.10%	228.03	2.11%
Total	**17,241.49**	**100.00%**	**10,820.52**	**100.00**

Trainings are conducted for institutional capacity enhancement based on the noted capacity shortages that affect quality of service delivery. In addition, training aims at filling up noted gaps during supportive supervision and are done as mentoring and/or practicum. Furthermore, trainings are also conducted in addressing the updates on revised guidelines and or standard operating procedures.

Expenditures on procurement of condoms were very low in both years. Condom access and use in Zanzibar is extremely low as depicted by low modern contraceptive rate. Access to condom by youth and young population has been very difficult practically attributed by judgmental health care worker's attitude, negative society perceptions and misconceptions. During the review period, there were challenges of accessing low cost condoms from vendors and the only available condoms were those which were branded and very expensive costing about TZS 3,500per packet of three.

In a nutshell, management cost which is roughly comprised of labor cost (both for direct service providers and providers in programs), fringe benefits, office utilities and supplies cost, cost of hiring consultants and administrative cost is less than 50% in 2016/17 (42.34%) but more than 50% in 2017/18 (61.62%). This means that more than 50% of the expenditures were directed to service delivery in 2016/17 and less in 2017/18. More needs to be done in ensuring that more funds are channeled to interventions rather than program management. Further, more needs to be done in ensuring laboratory commodities for diagnosis of various HIV/STI disease conditions and monitoring reagents and supplies are in place at all levels. Also there is a need to scale up access to viral load machines and diagnostic services to exposed infants and children inclusive of Early Infant Diagnosis (EID).

5.3.3 Service Provision Modalities

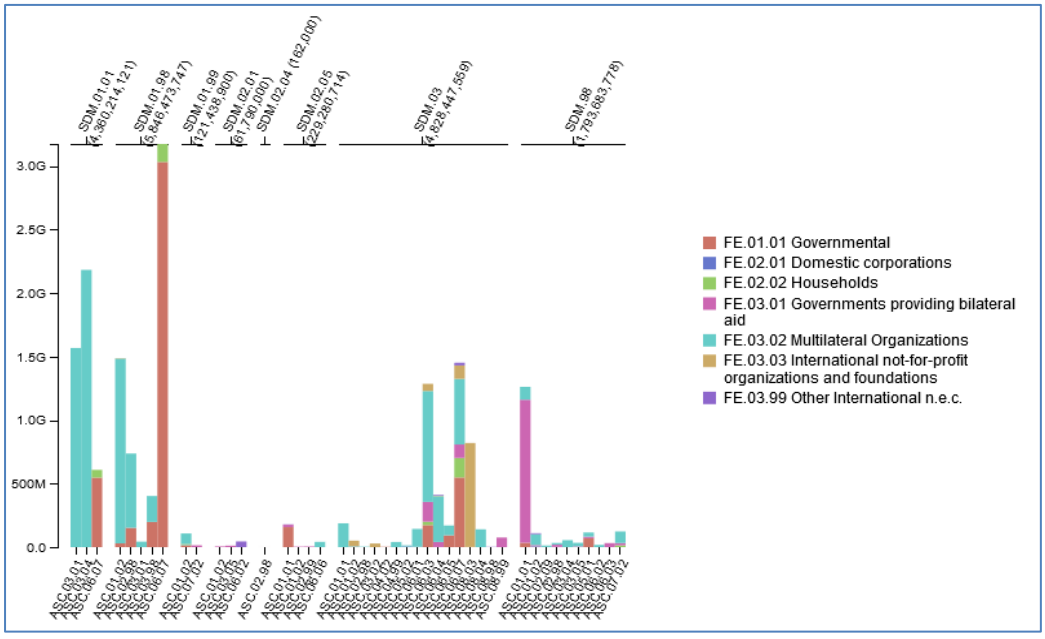
Service providers do use various modes of service delivery as defined in NASA Classifications (see Annex 1, Table A1f). Nevertheless, most of collected data are not disaggregated by Service Delivery Modalities (SDMs). Furthermore, most of the interventions do not have a defined SDM e.g. advocacy meetings, trainings, monitoring and evaluation etc. Thus, Table 14 shows a snapshot of few SDMs that were captured in this study. In 2016/17, 37.87% of the expenditures were spent using the facility based modalities mainly HIV care and treatment (24.34% of the 2016/17 expenditures). Less expenditures using this SDM were recorded in 2017/18 (19.28%). Home based care SDM was minimally used in both years.

Table 14: Service Delivery Modalities by ASC, 2016/17 & 2017/18

ASC/SDM	SDM.01 Facility-based Service Modalities (Mn.)		SDM.02 Home and Community Based Service Modalities (Mn.)	
	2016/17	2017/18	2016/17	2017/18
ASC.01 Prevention	1,596.07	259.55	188.62	171.02
ASC.02 HIV testing and counselling (HTC)	737.10	18.19	5.07	4.91
ASC.03 HIV Care and Treatment Care	4,197.59	1,809.09	11.40	12.90
Total	**6,530.76**	**2,086.84**	**205.09**	**188.83**
% of Expenditures	**37.87%**	**19.28%**	**1.03%**	**1.53%**

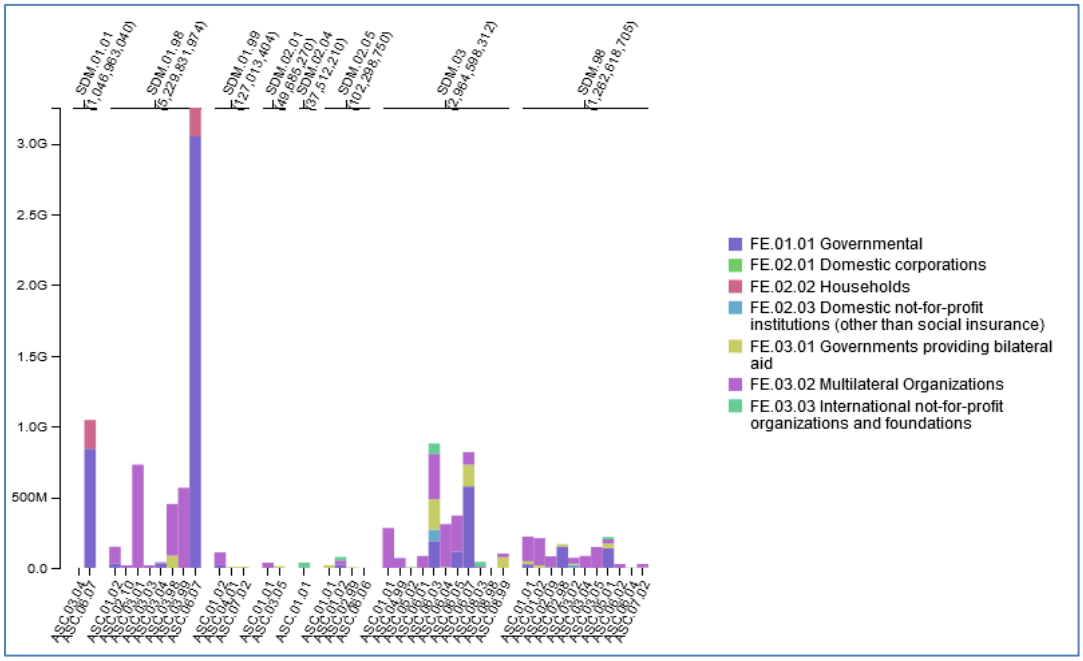
Figures 11a and 11b show the cross-tabulation of FE-SDM-ASC for FY 2016/17 and 2017/18 respectively. For both years, human resources for health (ASC.06.07) commanded the largest share of public expenditures using facility-based not disaggregated service delivery modality (SDM.01.98). This category includes the salaries of health care workers. ASC without specific SDMs (SDM.03) also took large share of expenditures reflecting activities like training, M&E, supportive supervision which do not have a specific pre-defined SDM.

Figure 11a: Linkage between FE, SDM and ASC (2016/17)



Note: See Annex 8 for definitions of ASCs and SDMs in Figures 11a & 11b.

Figure 11b: Linkage between FE, SDM and ASC (2017/18)



5.4 Utilization of HIV & AIDS Services

5.4.1 AIDS Spending Categories

Figures 12a and 12b show the expenditures by NASA AIDS Spending Categories (ASCs). For both years, program enablers and systems strengthening (ASC.06) had highest expenditures (42.85% and 62.78% for FYs 2016/17 and 2017/18 respectively) followed by other ASCs as discussed below.

Figure 12a: Expenditures by AIDS Spending Categories, 2016/17

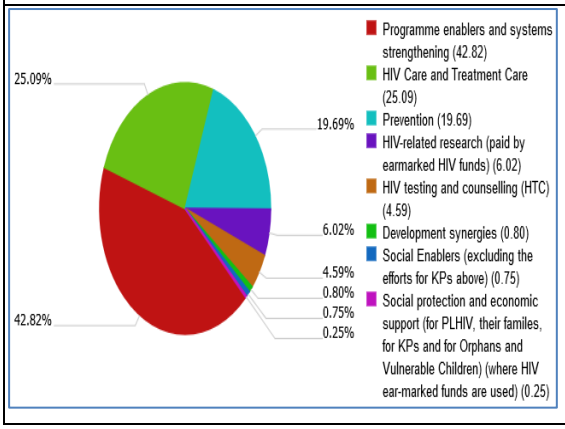
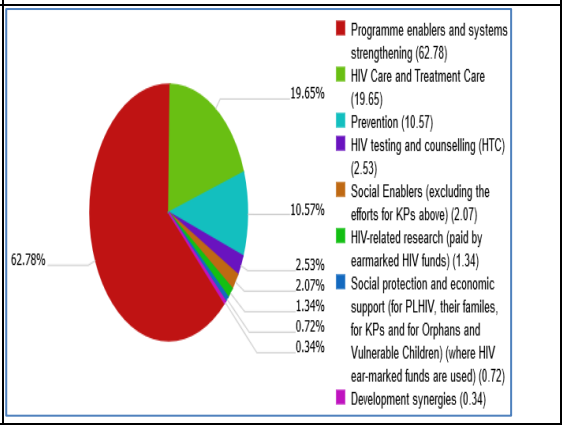


Figure 12b:Expenditures by AIDS Spending Categories, 2017/18



Program enablers and systems strengthening

Program enablers and systems strengthening ASC has several sub-categories as shown in Table 15 (only first level disaggregation). The expenditure trigger in program enablers and systems strengthening is recruitment, retention and scale-up of health workers, excluding for community health workers (ASC.06.07 sub-category ASC.06.07.02) which includes salaries for health providers (as estimated for all hospitals and PHUCs) – 25.53% and 46.43% in 2016/17 and 2017/18 respectively. This is followed by TB screening, case detection and diagnosis (ASC.03.04.01.02) in 2016/17 (12.66%). Other expenditure triggers in 2016/17 include HIV-related research - paid by earmarked HIV funds (ASC.08) – 6.02% and program administration and management costs (ASC.06.03) which also include salaries for staff in programs such as ZIHHTLP and ZAC (7.64%). In 2017/18, program administration and management costs (ASC.06.03) accounted for 8.13% of the total expenditures.

Table 15: Program and Systems Strengthening Sub-Categories

ASC.06	Program enablers and systems strengthening
ASC.06.01	Strategic planning, coordination and policy development
ASC.06.02	Building meaningful engagement for representation in key governance, policy reform and development processes
ASC.06.03	Program administration and management costs (above service-delivery level)
ASC.06.04	Strategic information
ASC.06.05	Public systems strengthening
ASC.06.06	Community system strengthening
ASC.06.07	Human resources for health
ASC.06.98	Program enablers and systems strengthening not disaggregated
ASC.06.99	Program enablers and systems strengthening n.e.c

HIV care and treatment

The next ASC with highest expenditure is HIV care and treatment which commanded 25.09% and 19.65% of HIV & AIDS spending in this category in 2016/17 and 2017/18 respectively. Disaggregation of this expenditure category shows quite a different pattern of expenditure in both years. While prevention of co-infections and opportunistic infections (prevention and treatment for PHLIV and KPs) commanded 51.74% of the expenditures in 2016/17, in 2017/18 the share of expenditure on this ASC was only 5.94%. Procurement of ARVs commanded 37.25% of total expenditures in this category in 2016/17 but it slightly decreased to 34.34% in 2017/18 (Figures 11a and 11b). This level of expenditure on procurement of ARVs may be reflecting the change in treatment approach from CD4 based treatment Standard Operating Procedure (SOP) to diagnose and treat policy approach which is the new HIV management guideline. This has shifted the total amount of needed ARV amongst PLHIV put on treatment. It is important to note that the change in policy to diagnose and treat may have a negative impact on projected stock - stock out will have notable repercussion on the longevity and adherence to CTC clients.

Knowing whether ART treatment is a first-line or second-line, for adults or children, is very important to manage HIV strategy and the purchasing processes. This information is not ready available in Zanzibar, possibly because the information systems cannot provide such data. Nevertheless, majority (nearly 98%) of all ART clients are on first line management with few on second line. There is no clinical or laboratory indication that there is a major shift of ART beneficiaries to be moving to second line treatment even though there are cases within the first line where some drugs have to be changed as they cause some reactions or un-comfortability/inconvenience to benefitting clients.

Figure 13a:Expenditures on Care and Treatment Components (2016/17)

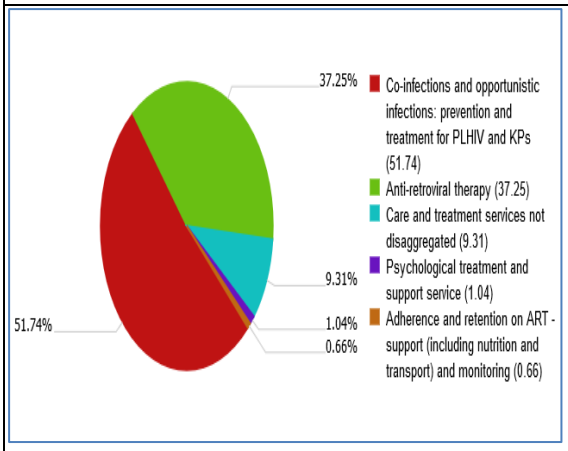
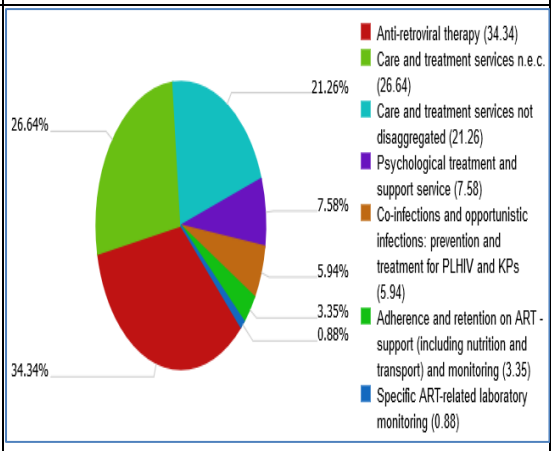


Figure 13b: Expenditures on Care and Treatment Components (2017/18)



HIV Testing and counseling

Overall, HIV Testing and Counseling (HTC) interventions commanded low share of HIV & AIDS expenditures (4.59% and 2.53% in 2016/17 and 2017/18 respectively). NASA provides classifications on HIV testing and counselling for various population groups e.g. sex workers (ASC.02.02), MSM (ASC.02.03), HIV testing and counselling for pregnant women as part of PMTCT program (ASC.02.07), voluntary HIV testing and counselling for general population (ASC.02.10), Provider Initiated Testing and Counselling (PITC) [ASC.02.11] etc. However, collected data are not disaggregated to these levels. Thus, the dominant mode of expenditure for both years is HIV testing and counseling activities not disaggregated (97.77% and 61.53% respectively) [Figures 14a and 14b]. We see an increase in expenditure on voluntary HIV testing and counselling for general population from 1.61% in 2016/17 to 30.2% in 2017/18. This may be interpreted as actual increase in service for this group or these findings are reflecting better reporting in 2017/18.

Figure 14a: Expenditures on HIV Testing and Counselling, 2016/17

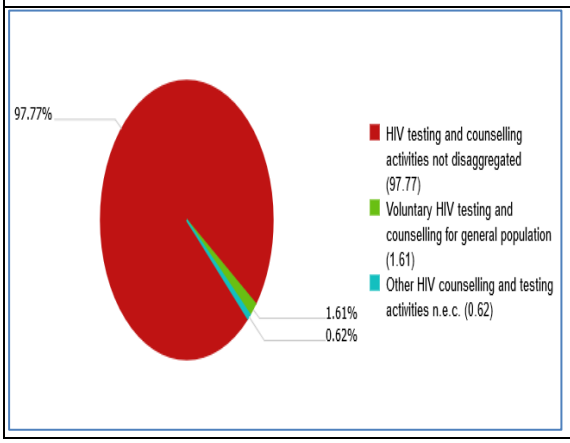
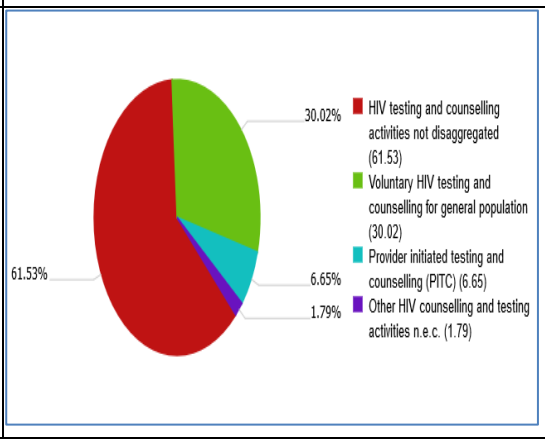


Figure 14b:Expenditures on HIV Testing and Counselling, 2017/18



Prevention

Getting back on track to reducing new infections to 500,000 by 2020 requires continued progress towards the 90–90–90 target and intensive focus on five prevention pillars delivered through a people-centered, combination approach. These include:

1. Combination prevention, including comprehensive sexuality education, economic empowerment and access to sexual and reproductive health services for young women and adolescent girls and their male partners in high-prevalence locations.
2. Evidence-informed and human rights-based prevention programs *for Key Populations*, including dedicated services and community mobilization and empowerment.
3. Strengthened national condom programs, including procurement, distribution, social marketing, private-sector sales and demand creation.
4. Voluntary medical male circumcision in priority countries that have high levels of HIV prevalence and low levels of male circumcision, as part of wider sexual and reproductive health service provision for boys and men.
5. Pre-exposure prophylaxis for population groups at higher risk of HIV infection.

While these pillars are relevant for Zanzibar, as noted in chapter 4, voluntary male circumcision is not an issues in Zanzibar. Thus, prevention activities covered some aspects of these pillars plus other prevention interventions.

Overall, 19.69% and 10.57% of the total HIV & AIDS funds were spent on prevention activities in 2016/17 and 2017/18 respectively. Of these, about 52% were spent on the five prevention pillars in each year (Figures 15a and 15b). Huge expenditures on the five prevention pillars (93.84% and 61.63in 2016/17 and 2018/18 respectively) were made on the Key Populations which is a reflection of the commitment made in the ZNSP III KRA2 – enhancing initiatives that will increase access by KPs to HIV services including promoting innovative ways of engaging KPs in the HIV prevention and care will. Establishment of the center that provides Methadone Assisted Therapy (MAT) could be termed as one of such initiatives. Also, use of ARV for

discordant couples as well as amongst MSM could help in reducing viral copies amongst HIV positive individuals and reduce the chances of escalated new infections

Other prevention activities that commanded large share of expenditures include ASC.01.02.05 (prevention for children and youth), ASC.01.02.05.98 (prevention activities for children and youth not disaggregated by type and ASC.01.02.10 (STI prevention and treatment programs for populations other than key populations).

Figure 15a:Expenditures on Prevention, 2016/17

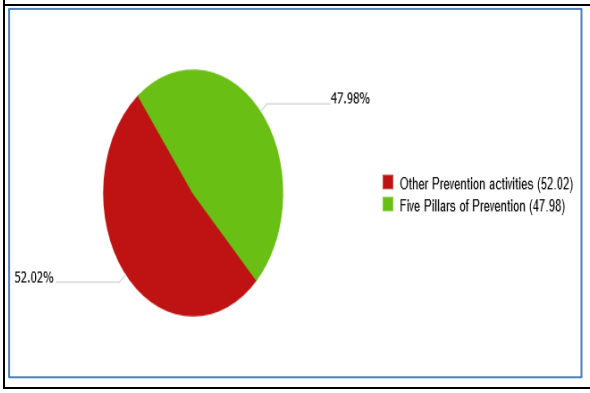
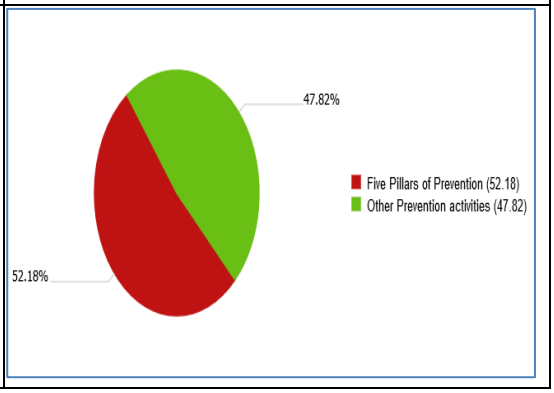


Figure 15b: Expenditures on Prevention, 2017/18



Figures 16a and 16b shows the NASA matrix of ASC vs FE. All financing entities funded ASC.01 (prevention activities) in 2016/17 and only one financing entity did not fund an element of ASC.06 (program enablers and systems strengthening) in that year. In 2017/18, some financing entities that funded prevention activities in 2017/18 phased out e.g. European Commission. In 2016/17 research activities (ASC.08) were heavily funded by international non-profit organizations/foundations that have not been classified while in 2017/18 they were funded by the Government of Norway. The Government of Norway also supported some social protection and economic activities for PLHIV, KPs and orphans and vulnerable children in 2017/18.

Figure 16a: Financing Entities vs AIDS Spending Categories, 2016/17

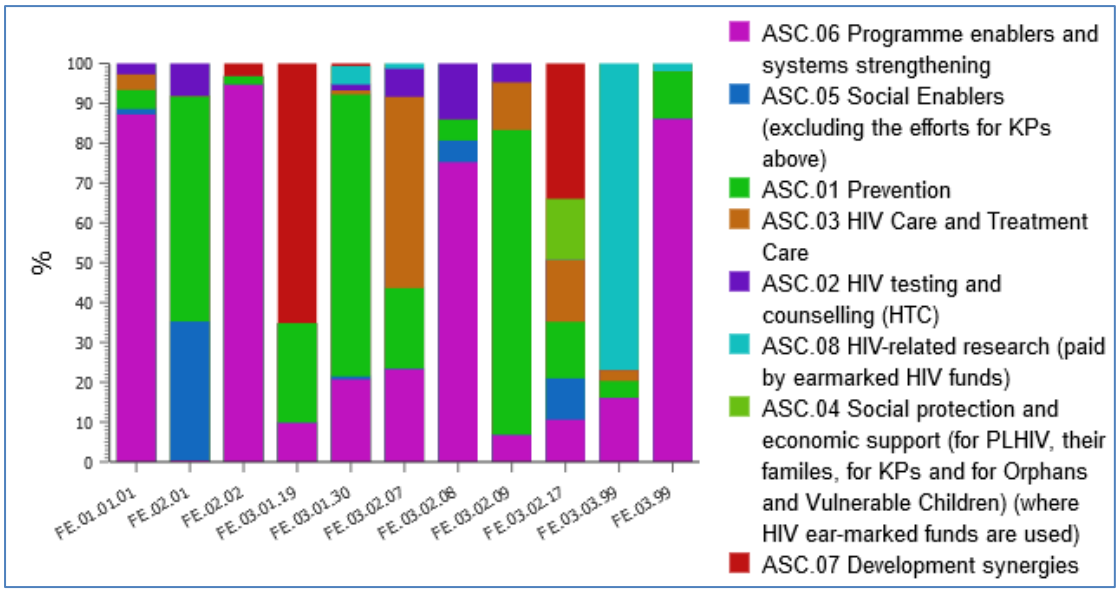
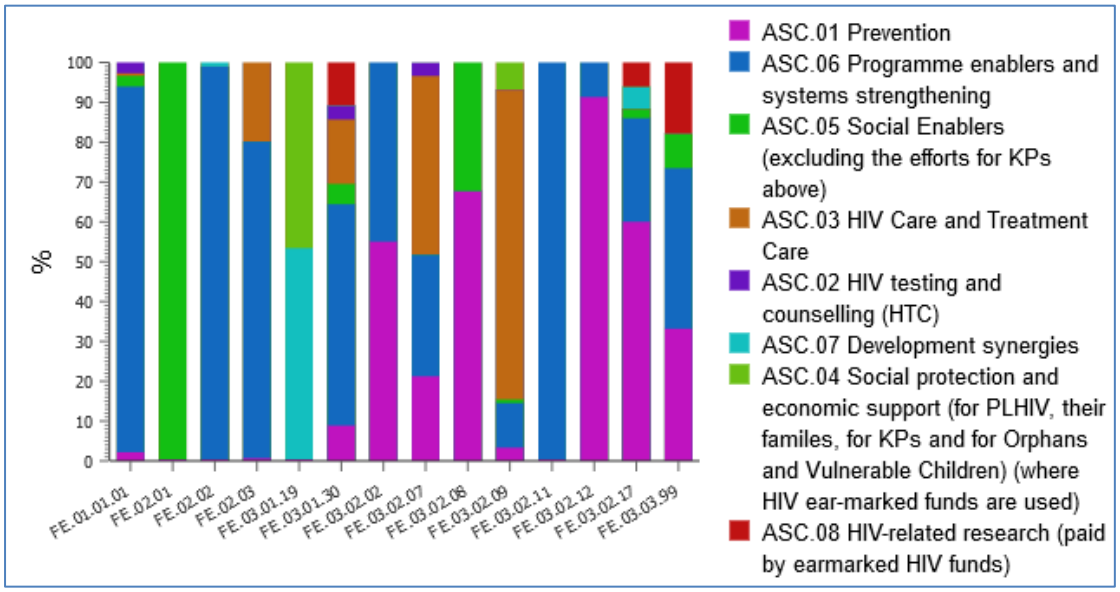


Figure 16b: Financing Entities vs AIDS Spending Categories, 2017/18



Note: **Legend:**

FE.01.01.01:	Central government
FE.02.01:	Domestic corporations
FE.02.02:	Households
FE.02.03:	Domestic not-for-profit institutions (other than social insurance)
FE.03.01.19:	Government of Norway
FE.03.01.30:	Government of United States
FE.03.02.02:	European Commission
FE.03.02.07:	The Global Fund to Fight AIDS, Tuberculosis and Malaria
FE.03.02.08:	UNAIDS Secretariat

FE.03.02.09:	United Nations Children's Fund (UNICEF)
FE.03.02.11:	United Nations Development Program (UNDP)
FE.03.02.12:	United Nations Educational, Scientific and Cultural Organization (UNESCO):
FE.03.02.17:	United Nations Population Fund (UNFPA)
FE.03.02.99:	Other Multilateral organizations e.g. ICAP
FE.03.03.99:	Other International not-for-profit organizations and foundations e.g. AMREEF

The linkage between SPs and ASCs shows that ZIHHTLP (a department inside the Ministry of Health - PS.01.01.13.02) spent about 53.65% of the total expenditures in 2016/17 and 35.72% in 2017/18. These were spent on major ASCs such as SC.03.04.01.02 (TB screening, case detection and diagnosis), ASC.03.01.98 (Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT), and ASC.06.03 (program administration and management costs). This decline reflects the decline of Global Fund support which is channeled through ZIHHTLP. PS.02.01.01.14 (Civil society organizations - private non-profit non-faith based) also spent significant amount on KPs e.g. SC.01.01.02.02.98 (programmatic activities for MSM not disaggregated), ASC.01.01.02.04.06.98 (drug substitution treatment and social support not disaggregated) and ASC.01.01.02.04.98 (other programmatic activities for PWID, not disaggregated by type).Public health facilities (PS.01.01.01 – public hospitals and PS.01.99 - public sector health providers e.g. PHCs and PHCs+) spent 20.77% and 35.99% of the expenditures in form of recruitment, retention and scale-up of health workers, excluding for community health workers (ASC.06.07.02) in 2016/17 and 2017/18 respectively.

5.4.2 Beneficiary Population

Various beneficiaries were reached by the implemented HIV & AIDS interventions. While NASA classifications are very rich in terms of disaggregation (e.g. vulnerable, accessible and other target populations category has 26 sub-categories), the collected data do not allow for disaggregation of Beneficiary Population (BP) to the desired levels. Thus, we have captured only 5/6 types of beneficiaries in both years (Figures 17a and 17b). General population was the dominant beneficiary of HIV & AIDS expenditures in both years (39.31% and 59.42% respectively). This was followed by non-target interventions in both years (21.97% and 13.83% respectively).

The general adult population (aged older than 24) [BP.04.01] benefited mostly from prevention interventions in 2016/17 (41.22%) while in 2017/18 the general population not broken down by age or gender [BP.04.98] benefited most from prevention related ASCs (33.08%). Non-targeted interventions include ASCs such as advocacy meetings (ASC.05.01) such as the ones held during the world AIDS day, monitoring and evaluation activities, training of health workers on several aspects including the use of guidelines, research activities etc. This reflects the major challenge in NASA – lack of expenditure information broken down to the desired level.

Figure 17a:Beneficiary Population, 2016/17

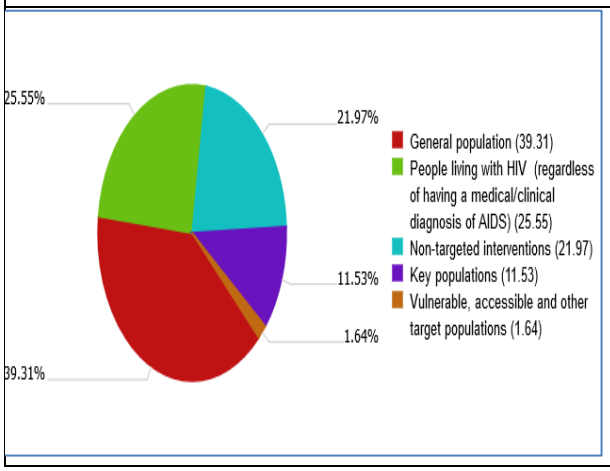
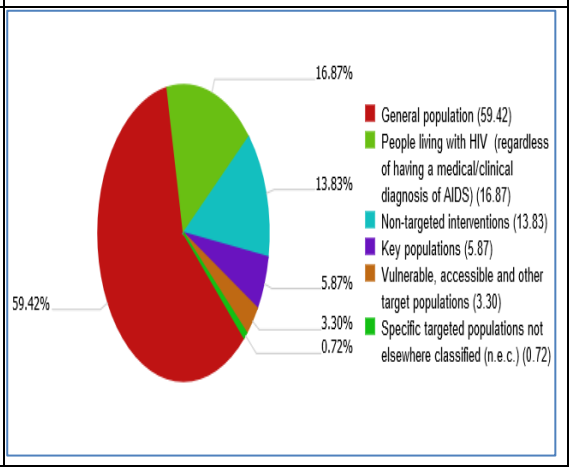


Figure 17b:Beneficiary Population, 2017/18



PLHIV was the next group that benefited most (25.55% in 2016/17 and 16.86% in 2017/18). NASA classifications allow for disaggregation by four types of the KPs (PWID, sex workers, MSM, and TGS). These benefited from the interventions targeting the KPs as follows:

i. BP.02.01 – PWID and their sexual partners (6.65% and 36.34% of the total expenditures on KPs in 2016/17 and 2017/18 respectively).
ii. BP.02.02.98 - Sex workers, not broken down by gender, and their clients (3.29% and 7.06% of the total expenditures on KPs in 2016/17 and 2017/18respectively).
iii. BP.02.03 - Gay men and other men who have sex with men [MSM](`8.32% and 14.05% of the total expenditures on KPs in 2016/17 and 2017/18respectively).
iv. BP.02.98 “Key populations” not broken down by type (81.74% and 42.54% of the total expenditures on KPs in 2016/17 and 2017/18respectively).

Data also show that 37.47% and 11.10% of the prevention expenditures in 2016/17 and 2017/18 respectively were spent on prevention activities for key populations not broken down by type (BP.02.98), again echoing the lack of data disaggregated to the lowest levels. The following are some examples of KPs related ASCs that benefited from the HIV & AIDS expenditures in 2016/17 and 2017/18:

- ASC.01.01.02.04.06 (drug substitution treatment and social support as part of programs for people who inject drugs).
- ASC.01.01.02 Services for key populations
- SC.01.01.02.02 Programmatic activities for gay men and other men who have sex with men (MSM)
- ASC.01.01.02.01 Programmatic activities for sex workers and their clients
- ASC.01.02.01.98 PMTCT not disaggregated by activity etc.

Figures 18a and 18b shows the NASA matrix of BP vs FE. Majority of financing entities funded interventions that benefited multiple beneficiaries while others funded interventions specific for PLHIV e.g. UNAIDS Secretariat in 2016/17 and Government of Norway in 2017/18.

Figure 18a: Financing Entities vs Beneficiary Population, 2016/17

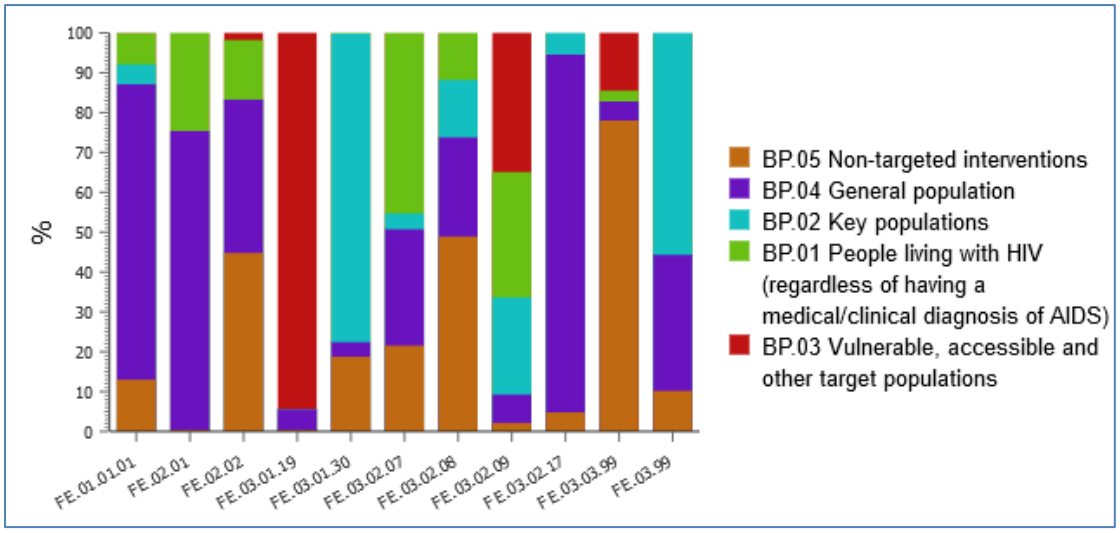
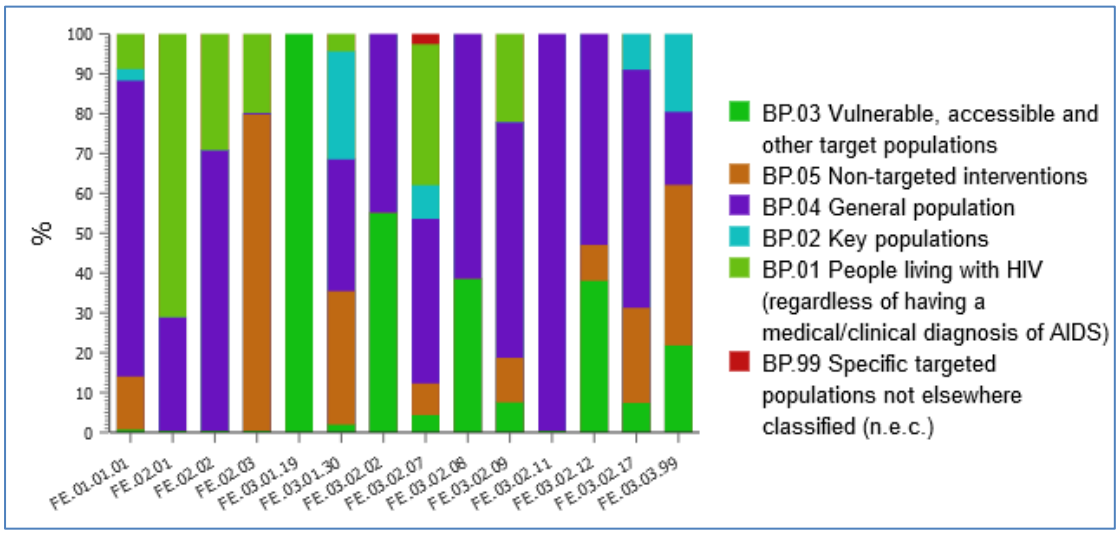


Figure 18b: Financing Entities vs Beneficiary Population, 2017/18



Note: Legend:

FE.01.01.01: Central government
FE.02.01: Domestic corporations
FE.02.02: Households
FE.02.03: Domestic not-for-profit institutions (other than social insurance)
FE.03.01.19: Government of Norway
FE.03.01.30: Government of United States
FE.03.02.02: European Commission
FE.03.02.07: The Global Fund to Fight AIDS, Tuberculosis and Malaria
FE.03.02.08: UNAIDS Secretariat
FE.03.02.09: United Nations Children's Fund (UNICEF)
FE.03.02.11: United Nations Development Program (UNDP)
FE.03.02.12: United Nations Educational, Scientific and Cultural Organization (UNESCO)
FE.03.02.17: United Nations Population Fund (UNFPA)
FE.03.02.99: Other Multilateral organizations e.g. ICAP
FE.03.03.99: Other International not-for-profit organizations and foundations e.g. AMREEF.

Although several ASCs do not have pre-defined SDMs, a linkage can be made between BP and SDM – where all services provided to the beneficiary population are delivered (see NASA matrices 9a and 9b). For instance, 36.89% and 66.87% of the services delivered to the general population - not broken down by age or gender(BP.04.98) in 2016/17 and 2017/18 respectively were delivered using facility-based service modalities (SDM.01). So are the majority of the services for people living with HIV - not broken down by age or gender (BP.01.98).Home and community based service modalities (SDM.02) was used to reach some KPs notably gay men and other men who have sex with men (MSM) [BP.02.03]. Some sex workers and their clients (BP.02.02) were also reached by community-based – outreach service delivery modality (SDM.02.05).

5.5 NASA Matrices

One of authentic features of the new RTT software is the ability to produce cross-tabs of various NASA classifications (NASA matrices) which are important in understanding the nature of the national response. Thus, NASA matrices have been produced for various NASA vectors as deemed necessary and these are submitted as extra annexes to this report. For each financial year (2016/17 and 2017/18), the following NASA matrices have been produced and submitted as separate deliverables:

- → 1a. Financing Entities (FE) vs AIDS Spending Categories (ASC) – 2016/17
- → 1b. Financing Entities (FE) vs AIDS Spending Categories (ASC) – 2017/18
- → 2a. Financing Entities (FE) vs Production Factors (PF) – 2016/17
- → 2b. Financing Entities (FE) vs Production Factors (PF) – 2017/18
- → 3a. Financing Entities (FE) vs Providers of Services (PS) – 2016/17
- → 3b. Financing Entities (FE) vs Providers of Services (PS) – 2017/18
- → 4a. Financing Entities (FE) vs Beneficiary Population (BP) – 2016/17
- → 4b. Financing Entities (FE) vs Beneficiary Population (BP) – 2017/18
- → 5a. Financing Entities (FE) vs Type of Revenue (REV) – 2016/17
- → 5b. Financing Entities (FE) vs Type of Revenue (REV) – 2017/18
- → 6a. Financing Entities (FE) vs Financing Schemes (SCH) – 2016/17
- → 6b. Financing Entities (FE) vs Financing Schemes (SCH)– 2017/18
- → 7a. AIDS Spending Categories (ASC) vs Beneficiary Population (BP) – 2016/17
- → 7b. AIDS Spending Categories (ASC) vs Beneficiary Population (BP)– 2017/18
- → 8a. Financing Entities (FE) vs Financing Agents – Purchasers (FAP) – 2016/17
- → 8b. Financing Entities (FE) vs Financing Agents – Purchasers (FAP) – 2017/18
- → 9a. Service Delivery Modalities (SDM) vs Beneficiary Population (BP) – 2016/17
- → 9b. Service Delivery Modalities (SDM) vs Beneficiary Population (BP) – 2017/18
- → 10a. Revenues (REV) vs Financing Schemes (SCH) – 2016/17
- → 10b. Revenues (REV) vs Financing Schemes (SCH) – 2017/18
- → 11a. AIDS Spending Categories (ASC) vs Production Factors (PF) -2016/17
- → 11b. AIDS Spending Categories (ASC) vs Production Factors (PF) -2017/18
- → 12a. Financing Schemes (SCH) vs Beneficiary Population (BP) – 2016/17
- → 12b. Financing Schemes (SCH) vs Beneficiary Population (BP) – 2017/18
- → 13a. Financing Schemes (SCH) vs Financing Agents – Purchasers (FAP)– 2016/17

→ 13b. Financing Schemes (SCH) vs Financing Agents – Purchasers (FAP)– 2017/18
→ 14a. AIDS Spending Categories (ASC) vs Service Delivery Modalities (SDM) – 2016/17.
→ 14b. AIDS Spending Categories (ASC) vs Service Delivery Modalities (SDM) – 2017/18.
→ 15a. Providers of Services (PS) vs AIDS Spending Categories (ASC) – 2016/17.
→ 15b. Providers of Services (PS) vs AIDS Spending Categories (ASC) – 2017/18.
→ 16a. Providers of Services (PS) vs Production Factors (PF) – 2016/17.
→ 16b. Providers of Services (PS) vs Production Factors (PF) – 2017/18.

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

This study tracked expenditures on HIV & AIDS in Zanzibar using the NASA methodology. NASA methodology has standard classifications of tracking funds from financing entities through financial agents-purchasers to providers of services, types of services provided, types of resources/inputs used in provision of services and the beneficiary population. Having detailed classifications as those provided by NASA methodology will provide stakeholders with much-needed evidence to decide on how to best finance the response to the epidemic in a sustainable manner. It will also inform resource allocation decisions in a way that responds to Zanzibar National Strategic Plan III for HIV & AIDS.

Key observations noted in relation to the 2016/17 & 2017/18 NASA exercise in Zanzibar include:

1. **Decline in funding for HIV & AIDS interventions**: there is a marked decline from 17.24Bn in 2016/17 to 10.82bn in 2017/18, a 32.74% decline. This is a result of declining of the international financing from 68.21% in 2016/17 to 47.10% in 2017/18. Worth noting is the turn-around in 2017/18 where the public spending surpassed the international spending (48.11% vs 47.10%).

2. **High donor dependence on HIV & AIDS financing** which poses risk for sustainably financing the Zanzibar National Strategic Plan III for HIV & AIDS and ensuring coverage of services; international financing was 68.21% and 47.10% of the total HIV & AIDS expenditures in 2016/17 and 2017/18 respectively.

3. **Dependence on one major source** of financing poses a risk to the national response; Global Fund funded 48.50% of the national response in 2016/17 but declined to 24.85% in 2017/18. Relative to other international sources, its contribution in terms of percentage of the total national response was 71.11% in 2016/17 but it declined substantially to 52.76% in 2017/18.

4. The potential of **private sector** and other complementary financial sources in addressing the HIV & AIDS resources gap remains underexplored. After more than three decades of the national response, the business community has not fully joined the suit.

5. Given the nature of the national response (largely funded by the international organizations in 2016/17), **external schemes** were mostly used (67.74%). However, this changed with **government schemes and compulsory contributory health care schemes** pooling more funds in 2017/18 (48.11%) compared to external schemes (47.10%) which is a good sign of sustainability.

6. In both years, **households' contributions** were minimal; this reflects the sampled private health facility, contributions from HIJAJ and failure to capture out of pocket expenditures (OOPs).

7. Large amount of fund in both years (72.85% and 69.32% respectively) **has been managed by the Ministry of Health through the Zanzibar Integrated HIV & AIDS, TB and Leprosy Program (ZIHHTLP)**, reflecting the support from the Global Fund. Not-for-profit institutions (other than social insurance) also managed significant amount of funds given that several financing entities use non-governmental organizations for execution of HIV & AIDS interventions.

8. There is no standard registry that keeps national financing record of HIV &AIDS finances. Record keeping reflects the reporting procedures as required by different financing entities and these are not necessarily in line with NASA classifications.

9. Expenditure tracking does not yet appear to be systematic for HIV & AIDS. In addition, data at a disaggregated level is not yet fully available that can enable organizations such as ZAC to make informed decisions about resource allocations and to monitor spending against priorities.

Despite these challenges, significant efforts have been made by the Government and other implementing agencies in reaching the KPs and other vulnerable and marginalized populations. This is of great importance in combating the pandemic given the alarming HIV prevalence in some of the KP groups and the obvious risk of these groups acting as "bridging populations" for HIV to cross over into the general population. The following are seen as innovative ways of engaging KPs in the HIV prevention and care:

i. Establishment of the Methadone Assisted Therapy (MAT) clinic.
ii. Use of ARVs for discordant couples as well as amongst MSM could help in reducing viral copies amongst HIV positive individuals and reduce the chances of escalated new infections.
iii. Formation of NGOs focusing on KPs such as ZYF, ZAYEDSA, THPS, ZIADA and ZAPHA+.
iv. Presence of Sober houses and the envisaged newly established detoxification Centre by the Drug Commission.

Other achievements include:

i. Review of treatment policy in line with Diagnose and Treat.
ii. Strengthened rehabilitation services among PLHIV and KVPs and enhanced income generating capacities.
iii. Increased capacities of service providers and strengthened one umbrella comprehensive service approach including the wide active engagement of peer educators as part of ensuring meaningful involvement of People living with HIV and AIDS.

6.2 Recommendations

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

Implementation of the Zanzibar National Strategic Plan III for HIV & AIDS will require a significant amount of resources (throughout the five years ZNSPIII period). This is in a context of a somewhat precarious financial position where there is high dependence on external financing but where that financing stream is showing a declining trend. This increases the need to find more stable sources of financing domestically in order to protect the continuation of goods and services for HIV &AIDS. Financing from central government, local government and the private sector are potential sources of domestic financing which could be further developed. The threat of decreased financing from international sources does not only affect the total resources available for HIV &AIDS but may also threaten specific interventions which these sources significantly contribute to e.g. KVPs interventions. Such decline will also negatively affect the three decades' achievements of sustaining the HIV prevalence and burden in the general population to less than 1%. The prevention investment cost is high as it calls for primary prevention as well as secondary prevention strategies inclusive of persistent use and adherence to ART. Thus we recommend to:

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

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

III. Advocate for the establishment of national HIV fund **(Zanzibar HIV & AIDS Trust Fund)** in ensuring sustainability of services

Improving data collection to facilitate regular tracking of HIV & AIDS spending by institutionalizing NASA

Based on the experience gained by the HIV & AIDS authorities in Zanzibar notably officials from ZAC and ZIHHTLP, institutionalization of NASA methodology is possible. This can be effected by further training these officials to become Training of Trainers (ToTs). Then they will be tasked with the responsibility of training beneficiary institutions on NASA methodology in particular on disaggregating data into relevant NASA classification. This will enhance better (effective and efficient) tracking of resources by thematic areas which is important for programmers to understand how spending is aligned with priorities in the Zanzibar National Strategic Plan III for HIV & AIDS. With this background, it is of paramount importance to re-introduce and strengthen Zanzibar HIV & AIDS Program Monitoring System (ZAPHMOS) to all

MDAs and ensure the incorporation of financial elements within the ZAPHMOS monitoring tools.

Improving the NASA RTT further

The NASA RTT software has significantly simplified the analysis of NASA data. The software can be improved further to allow for production of more 3 vectors' matrices. Currently the software could only produce a 3 vectors matrix on FE-SDM-ASC only.

Strengthening implementation of HIV & AIDS interventions at local levels

Among the strong notable successes during the implementation of ZNSPI and ZNSPII was the remarkable level of community engagement and comprehensive ownership of HIV related interventions at community level through District AIDS Coordinating Committees (DACCOMS) and Shehia AIDS Coordinating Committees (SHACCOMS). In view of this and in line with the ongoing decentralization efforts there is need to reintroduce and scale up efforts that will help to address and de-bridge potential new infections at community level. These include spearheading primary and secondary prevention, mitigating stigma and violence against women and children and promoting Income Generating Activities (IGAs) among PLHIV and KVPs. The active and full engagement of DACCOMS and SHACCOMS is undisputable and if the epidemic is not owned by the communities and or if left unabated there are higher chances of documenting a full blown generalized epidemic in Zanzibar.

Intense investment on prevention services

Knowing the nature of the epidemic, the current noted declining HIV financing trend is a threat to the national response particularly taking into account the bridging nature of sexual relationship between the general population and the KPs. More needs to be done in ensuring laboratory commodities for diagnosis of various HIV/STI disease conditions and making sure that supplies and reagents are in place at all levels. Also there is a need to scale up access to viral load machines and diagnostic services to exposed infants and children inclusive of Early Infant Diagnosis (EID).

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ANNEXES

Annex 1: Examples of NASA Classifications

Table A1a: Financial Entity (FE) Classifications

NASA Codes	Financing Entities
FE.01	Public Entities
FE.01.01	Governmental
FE.01.02	Social security institutions
FE.01.99	Other public (not elsewhere classified [n.e.c]).
FE.02	Domestic Private Entities
FE.02.01	Domestic corporations
FE.02.02	Households
FE.02.03	Domestic not-for-profit institutions (other than social insurance)
FE.02.99	Other Private financing n.e.c.
FE.03	International Entities
FE.03.01	Governments providing bilateral aid
FE.03.02	Multilateral Organizations
FE.03.03	International not-for-profit organizations and foundations
FE.03.04	International for profit organizations
FE.03.99	Other International n.e.c.
FE.99	Financial entity n.e.c.

Note: The classifications in Table 4.1a goes to second level of disaggregation. The detailed table in NASA DCT has disaggregations to level 3.

Table A1b: Revenue (REV)

NASA Codes	Revenues/Pools
REV.01	Transfers from government domestic revenue including reimbursable loans (allocated to HIV purposes)
REV.02	Transfers distributed by government from foreign origin
REV.03	Social insurance contributions
REV.04	Compulsory prepayment (other and unspecified, than REV.3)
REV.05	Voluntary prepayment
REV.06	Other domestic revenues n.e.c.
REV.07	Direct foreign transfers
REV.98	Revenues of health care financing schemes not disaggregated
REV.99	Other revenues of health care financing schemes n.e.c.

Note: The classifications in Table 4.1bare in first level of disaggregation. The detailed table in NASA DCT has disaggregations to level 4.

Table A1c: Financing Schemes (SCH)

NASA Codes	Financing Schemes
SCH.1	Government schemes and compulsory contributory health care schemes
SCH.1.1	Government schemes
SCH.1.2	Compulsory contributory health insurance schemes
SCH.1.3	Compulsory Medical Saving Accounts (CMSA)
SCH.1.98	Government schemes not disaggregated
SCH.1.99	Other government schemes n.e.c.
SCH.2	Voluntary payment schemes
SCH.2.1	Voluntary insurance schemes
SCH.2.2	Not-for-profit organization schemes
SCH.2.3	For-profit enterprise schemes
SCH.3	Household out-of-pocket payment
SCH.3.1	Out-of-pocket excluding cost-sharing
SCH.3.2	Cost sharing with third-party payers
SCH.3.98	Out-of-pocket not disaggregated
SCH.3.99	Out-of-pocket n.e.c.
SCH.4	External schemes (non-resident)
SCH.4.1	Compulsory schemes (non-resident)
SCH.4.2	Voluntary schemes (non-resident)
SCH.4.98	Compulsory schemes (non-resident) not disaggregated
SCH.4.99	Compulsory schemes (non-resident) n.e.c.

Note: The classifications in Table 4.1c goes to second level of disaggregation. The detailed table in NASA DCT has disaggregations to level 4.

Table A1d: Financing Agent – Purchaser (FAP)

NASA Codes	Financing Agents - Purchaser
FAP.01	Public sector
FAP.01.01	Territorial governments
FAP.01.02	Public social security
FAP.01.03	Government employee insurance programs
FAP.01.04	Parastatal organizations
FAP.01.99	Other public financing agents n.e.c.
FAP.02	Private sector
FAP.02.01	Private social security
FAP.02.02	Private employer insurance programs
FAP.02.03	Private insurance enterprises (other than social insurance)
FAP.02.04	Private households' (out-of-pocket payments)
FAP.02.05	Not-for-profit institutions (other than social insurance)
FAP.02.06	Corporations other than providers of health services (non-parastatal)
FAP.02.99	Other private financing agents n.e.c.
FAP.03	International purchasing organizations
FAP.03.01	Country offices of bilateral agencies managing external resources and fulfilling financing agent roles
FAP.03.02	Multilateral agencies managing external resources
FAP.03.03	International not-for-profit organizations and foundations
FAP.03.04	Projects within Universities
FAP.03.05	International for-profit organizations
FAP.03.99	Other international financing agents n.e.c.

NASA Codes	Financing Agents - Purchaser
FAP.99	FAP n.e.c.

Note: The classifications in Table 4.1d goes to second level of disaggregation. The detailed table in NASA DCT has disaggregations to level 4.

Table A1e: Providers of Services (PS)

NASA Codes	Service Providers
PS.01	Public sector providers
PS.01.01	Governmental organizations
PS.01.02	Parastatal organizations
PS.01.98	Public sector providers not disaggregated
PS.01.99	Public sector providers n.e.c.
PS.02	Private sector providers
PS.02.01	Non-profit providers
PS.02.02	Profit-making private sector providers
PS.02.98	Private sector providers not disaggregated
PS.02.99	Private sector providers n.e.c.
PS.03	Bilateral, multilateral entities, international NGOs and foundations – in country offices
PS.03.01	Bilateral agencies
PS.03.02	Multilateral agencies
PS.03.03	International NGOs and foundations
PS.03.98	Bilateral, multilateral entities, international NGOs and foundations – in country offices not disaggregated
PS.03.99	Bilateral, multilateral entities, international NGOs and foundations – in country offices n.e.c.
PS.04	International providers (activities undertaken outside the country)
PS.98	Providers not disaggregated
PS.99	Providers n.e.c.

Note: The classifications in Table 4.1e goes to second level of disaggregation. The detailed table in NASA DCT has disaggregations to level 5.

Table A1f: Service Delivery Modalities (SDM)

NASA Codes	Types of Service Delivery Modalities
SDM.01	Facility-based service modalities
SDM.01.01	Facility-based: Outpatient
SDM.01.02	Facility-based: Inpatient
SDM.01.03	Directly observed treatment (DOT)
SDM.01.98	Facility-based not disaggregated
SDM.01.99	Other facility-based n.e.c.
SDM.02	Home and community based service modalities
SDM.02.01	Community-based: center
SDM.02.02	Community-based: pick up points (CPUP)
SDM.02.03	Community-based: automated distribution unit/dispensing machine
SDM.02.04	Community-based: mobile unit
SDM.02.05	Community-based: outreach
SDM.02.06	Community-based: home-based (including door-to-door)
SDM.02.07	HIV self-testing
SDM.02.98	Home and community based not disaggregated
SDM.02.99	Home and community based n.e.c.

NASA Codes	Types of Service Delivery Modalities
SDM.03	Non applicable (ASC which does not have a specific SDM)
SDM.98	Modalities not disaggregated
SDM.99	Modalities n.e.c.

Table A1g: Production Factors (PF)

NASA Codes	Production Factors
PF.01	Current direct and indirect expenditures
PF.01.01	Personnel costs
PF.01.02	Other operational and program management current expenditures
PF.01.03	Medical products and supplies
PF.01.04	Contracted external services
PF.01.05	Transportation related to beneficiaries
PF.01.06	Housing/accommodation services for beneficiaries
PF.01.07	Financial support for beneficiaries
PF.01.08	Training- Training related per diems/transport/other costs
PF.01.09	Logistics of events, including catering services
PF.01.10	Indirect costs
PF.01.98	Current direct and indirect expenditures not disaggregated
PF.01.99	Current direct and indirect expenditures n.e.c.
PF.02	Capital expenditures
PF.02.01	Building
PF.02.02	Vehicles
PF.02.03	Other capital investment
PF.02.98	Capital expenditure not disaggregated
PF.02.99	Capital expenditure n.e.c.
PF.98	Production factors not disaggregated

Note: The classifications in Table 4.1g goes to second level of disaggregation. The detailed table in NASA DCT has disaggregations to level 4.

Table A1h: AIDS Spending Categories (ASC)

NASA Codes	AIDS Spending Categories on Prevention
ASC.01	Prevention
ASC.02	HIV testing and counselling (HTC)
ASC.03	HIV Care and Treatment
ASC.04	Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)
ASC.05	Social Enablers (excluding the efforts for KPs above)
ASC.06	Program enablers and systems strengthening
ASC.07	Development synergies
ASC.08	HIV-related research (paid by earmarked HIV funds)

Note: The classifications in Table 4.1fare in first level of disaggregation. The detailed table in NASA DCT has disaggregations to level 6.

Table A1i: Beneficiary Population (BP)

NASA Codes	Beneficiary Populations
BP.01	People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)
BP.01.01	Adult and young people (aged 15 and over) living with HIV
BP.01.02	Children (aged under 15) living with HIV
BP.01.98	People living with HIV not broken down by age or gender
BP.02	Key populations
BP.02.01	Persons who Inject drug (PWID) and their sexual partners
BP.02.02	Sex workers (SW) and their clients
BP.02.03	Gay men and other men who have sex with men (MSM)
BP.02.04	Transgender
BP.02.05	Inmates of correctional facilities (prisoners) and other institutionalized persons
BP.02.98	"Key populations" not broken down by type
BP.03	Vulnerable, accessible and other target populations
BP.03.01	Orphans and vulnerable children (OVC)
BP.03.02	Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns
….	…..
BP.03.24	Employees (e.g. for workplace interventions)
BP.04	General population
BP.04.01	General adult population (aged older than 24)
BP.04.02	Children (aged under 15)
BP.04.03	Youth (aged 15 to 24)
BP.04.98	General population not broken down by age or gender
BP.05	Non-targeted interventions
BP.99	Specific targeted populations not elsewhere classified (n.e.c.)

Note: The classifications in Table 4.1iare in first level of disaggregation. The detailed table in NASA DCT has disaggregations to level 3.

Annex 2: NASA Zanzibar: Sampled CSOs from Unguja and Pemba

SN.	NAME OF CSO	ADDRESS TEL No.	CONTACT PERSON	GEOGRAPHICAL COVERAGE
1.	ANGLICAN	0784 597847	Priscila Tayari	Kiungani
2.	ZANGOC	0777 426622	Wanu Bakari	Kwerekwe
3.	ZAYEA	0656 505152	Japhet Fumbuka	Mlandege
4.	AYAHIZA	0658 470797	Ahmed Abdurahmani	Mombasa
5.	YOSOA	0715 318903	Aziza	Mombasa
6.	ZAIADA	0773 482159	Mbarouk Saidi	Kwerekwe
7.	BIO6	0655 814121	Salum	Migombani
8.	ZAPHA+	0777 455312	Seif Abdulla	Welezo
9.	ZAYEDESA	0773 171818	Mgoli Mgoli	Mazizini
10.	DRUG FREE	0782 800426	Suleiman Mauly	Mpendae
11.	ZAMWASO	0777 871538	Fatma Juma	Kikwajuni
12.	ZANA	0777 419356	Abrahamani Kwaza	Mpendae
13.	ZYF	0777 852830	Maulid	Mlandege
14.	JUMAZA	0777 420612	Muhidin Zubeir	Mkunazini
15.	ZAFAYCO	0773 165549	Abdulla Ali Abeid	Mombasa
16.	ZANAB	0777 456210	Adil Mohd	Kikwajuni
17.	ZAFIDE	0777 456242	Soud Nahoda	Mwanakwerekwe
18.	ZAFELA	0777 47545	Jamila	Mpendae
19.	THESODE	0777 437518	Abdullah Mdoe	Mkunazini
20.	TUISHI	0777 483811	Jaku Ameir	Jambiani
21.	UMATI	0777 6354327	Mwajuma Salum	Mwanakwerekwe
22.	ZASO	0777 426565	Rukia Mohd	Mpendae
23.	ZACA	0777 434845	Kidawa Ramadhan	Mpendae
24.	YUNA	0779 665071	Mohd Hassan	Wete
25.	JUKAMKUM	0773 176527	Nassor Ali	Mkanjuni
26.	PIRO	0777528169	Alawi Bakari	Chake Msingini
27.	MPESO	0777 473089	Ali Abbass	Mkoani
28.	PESTA	0775 018532	Hafidh Mbarouk	Tibirinzi Chake
29.	PIYDO	0777 479566	Ali Jabu	Wete
30.	WAMATA			Chake
31.	ZLS			Unguja/Pemba
32.	SOS			Unguja/Pemba
33.	TAMWA			

Annex 3: Sampled Health Facilities

Sn.	Health Facility	Type	Location	Ownership
1.	Abdalla Mzee Regional	Hospital	MKOANI PEMBA	RGOZ
2.	Al-Rahma Hospital	private Hospital	URBAN UNGUJA	PRIVATE
3.	Al_Zahraa (Zanzibar/ University)	Dispensary	PRIVATE	PARASTATAL
4.	Ali Khamis Camp	Parastatal	PEMBA	PARASTATAL
5.	Bogowa PHCU+	PHCU+	PEMBA	PUBLIC
6.	BOT Dispensary	Dispensary	UNGUJA	PARASTATAL
7.	Chake Chake District Hospital	Hospital	CHAKE PEMBA	PUBLIC
8.	Farham Martenity Home	Home	UNGUJA	PRIVATE
9.	Fuoni PHCU+	PHCU+	UNGUJA	PUBLIC
10.	Gombani PHCU	PHCU	PEMBA	PRIVATE
11.	Jambiani PHCU+	PHCU+	UNGUJA	PUBLIC
12.	Kibweni KMKM	Parastatal	UNGUJA	PARASTATAL
13.	Kidongo Chekundu PHCU (MAT CLINIC)	PHCU	UNGUJA	PUBLIC
14.	Kitope Church Dispensary	Dispensary	UNGUJA	PRIVATE
15.	Kivunge Cottage Hospital	Hospital	UNGUJA	PUBLIC
16.	Kojani PHCU+	PHCU+	PEMBA	PUBLIC
17.	Konde PHCU+	PHCU+	PEMBA	PUBLIC
18.	Mafunzo PHCU	Parastatal	UNGUJA	PARASTATAL
19.	Mahonda PHCU+	PHCU+	UNGUJA	PUBLIC
20.	Makao Makuu JKU	JKU	UNGUJA	PARASTATAL
21.	Makunduchi Cottage Hospital	Hospital	UNGUJA	PUBLIC
22.	Marie Stopes Private Hospital	Hospital	UNGUJA	PUBLIC
23.	Micheweni Cottage Hospital	Hospital	PEMBA	PUBLIC
24.	Mina Hospital	Hospital	UNGUJA	PRIVATE
25.	Mnazi Mmoja Hospital	Hospital	UNGUJA	PUBLIC
26.	Mwembeladu Hospital	Hospital	UNGUJA	PUBLIC
27.	Mwera PHCU+	PHCU+	UNGUJA	PUBLIC
28.	Nungwi PHCU+	PHCU+	UNGUJA	PUBLIC
29.	Sebleni PHCU+	PHCU+	UNGUJA	PUBLIC
30.	Tasakhtaa Global Hospital	Private Hospital	UNGUJA	PRIVATE
31.	Tumbatu Gomani PHCU+	PHCU+	UNGUJA	PUBLIC
32.	Vitongoji Cottage Hospital	Hospital	PEMBA	PUBLIC
33.	Wete District Hospital	Hospital	PEMBA	PUBLIC
34.	Zanzibar Medical Group	private Hospital	UNGUJA	PRIVATE
35.	Zanzibar Military Hospital (JWTZ)	Parastatal	UNGUJA	PARASTATAL
36.	ZAYEDESA	NGO BASED CTC	UNGUJA	NGO

Annex 4: Assumptions on the Labor Cost for Health Providers Managing HIV & AIDS Related Cases

HEALTH FACILITY	NUMBER OF STAFF	ALLOCATED TIME TO HIV INTERVENTIONS	SALARY SCALE	RISK ALLOWANCE	ANNUAL GROSS SALARY	ESTIMATED POPULATION		
						PREVENTION	HTC	CTC
1. MNAZI MMMOJA HOSP.						**810,651**	**101,704**	**3,042**
MD	1	100%	1,004,000	75,000	12,948,000			
AMO	1	100%	557,000	75,000	7,584,000			
LAB SCIENTIST	1	100%	593,000	75,000	8,016,000			
LAB TECHNICIAN	2	100%	399,500	75,000	11,388,000			
NURSE (DEGREE)	1	100%	593,000	75,000	8,016,000			
NURSE OFFICERS	8	100%	593,000	75,000	64,128,000			
PHARMACEUTICAL TECHN	3	100%	399,000	75,000	17,064,000			
DATA CLERK	3	100%	363,000	75,000	15,768,000			
COUNSELOR	1	100%	474,500	75,000	6,594,000			
SOCIAL WORKER	1	100%	474,500	75,000	6,594,000			
WARDS								
MEDICINE	2	40%	1,004,000	75,000	10,358,400			
OBGY	4	15%	1,004,000	75,000	7,768,800			
PAEDIATRIC	2	5%	1,004,000	75,000	1,294,800			
TB	2	25%	1,004,000	75,000	6,474,000			
MAIN LABORATORY	4	25%	593,000	75,000	8,016,000			
TOTAL				75,000	**192,012,000**			
2. MWEMBELADU HOSP.						**17,129**	**21,901**	**300**
CLINICAL OFFICER	O1	100%	399,500	75,000	1,379,400			
LAB TECHNICIAN	2	100%	399,500	75,000	11,388,000			
NURSE OFFICERS	1	100%	593,000	75,000	8,016,000			
SOCIAL WORKER	1	100%	474,500	75,000	6,594,000			
DATA CLERK	2	100%	363,000	75,000	10,512,000			
COUNSELOR	1	100%	474,000	75,000	6,588,000			
MARTENITY	3	40%	1,004,000	75,000	15,537,600			
TOTAL					**60,015,000**			
3. AL-RAHMA HOSP.	**PRIVATE HOSPITALS HAVE THEIR OWN SALARY SCALES AND SALARY AGREEMENT BUT HERE WE ASSUMED SAME SALARIES AS PUBLIC EMPLOYEES**					**17,692**	**21,000**	**20**
CLINICAL OFFICERS	2	100%	399,500	75,000	11,388,000			
LABORATORY TECHNICIANS	1	100%	399,500	75,000	5,694,000			

HEALTH FACILITY	NUMBER OF STAFF	ALLOCATED TIME TO HIV INTERVENTIONS	SALARY SCALE	RISK ALLOWANCE	ANNUAL GROSS SALARY	ESTIMATED POPULATION		
						PREVENTION	HTC	CTC
NURSE OFFICERS	1	100%	593,000	75,000	8,016,000			
PHARMACEUTICAL TECHN	1	100%	399,500	75,000	5,694,000			
DATA CLERK	1	100%	363,000	75,000	5,256,000			
MATERNITY	3	40%	1,004,000	75,000	38,844,000			
WARDS								
MEDICINE	3	20%	1,004,000	75,000	38,844,000			
OBGY	3	10%	1,004,000	75,000	38,844,000			
PAEDIATRIC	2	5%	1,004,000	75,000	25,896,000			
MAIN LABORATORY	3	10%	593,000	75,000	24,048,000			
TOTAL					**202,524,000**			
4. MAT CLINIC								
MD	1	100%	1,004,000	75,000	12,948,000			
CO	1	100%	399,500	75,000	5,694,000			
LAB TECHN	1	100%	399,500	75,000	5,694,000			
NURSE OFFICER	2	100%	593,000	75,000	16,032,000			
PHARMACEUTICAL TECHNICIA	1	100%	399,500	75,000	5,694,000			
DATA CLERK	2	100%	36,300	75,000	2,671,200			
SOCIAL WORKERS	2	100%	474,000	75,000	13,176,000			
TOTAL					**61,909,200**			
5. MAKUNDUCHI HOSP.						**20,630**	**13,000**	**16**
AMO	2	100%	557,000	75,000	15,168,000			
NURSES	3	100%	593,000	75,000	24,048,000			
HEALTH OFFICER	1	100%	399,500	75,000	5,694,000			
DATA CLERK	1	100%	363,000	75,000	5,256,000			
PHARMACEUTICAL TECHN	1	100%	399,500	75,000	5,694,000			
LABORATORY TECHNICIAN	2	100%	399,500	75,000	11,388,000			
WARS								
MEDICINE	2	20%	1,004,000	75,000	25,896,000			
OBGY	2	10%	1,004,000	75,000	25,896,000			
PAEDIATRIC	1	5%	1,004,000	75,000	12,948,000			
MAIN LABORATORY	3	10%	593,000	75,000	24,048,000			
TOTAL					**156,036,000**			

HEALTH FACILITY	NUMBER OF STAFF	ALLOCATED TIME TO HIV INTERVENTIONS	SALARY SCALE	RISK ALLOWANCE	ANNUAL GROSS SALARY	ESTIMATED POPULATION		
						PREVENTION	HTC	CTC
6. KIVUNGE HOSP.						**38,327**	**32,000**	**41**
MD	1	100%	1,004,000	75,000	12,948,000			
AMO	2	100%	59,300	75,000	3,223,200			
NURSES	2	100%	557,000	75,000	15,168,000			
DATA CLERKS	1	100%	363,000	75,000	5,256,000			
PHARMACEUTICAL TECH	1	100%	399,500	75,000	5,694,000			
LAB TECH	2	100%	399,500	75,000	11,388,000			
WARS								
MEDICINE	2	20%	1,004,000	75,000	25,896,000			
OBGY	2	10%	1,004,000	75,000	25,896,000			
PAEDIATRIC	1	5%	1,004,000	75,000	12,948,000			
MAIN LABORATORY	3	10%	593,000	75,000	24,048,000			
TOTAL					**142,465,200**			
7. CHAKE CHAKE HOSP.						**44,548**	**41,000**	**19**
MD	1	100%	1,004,000	75,000	12,948,000			
AMO	1	100%	557,000	75,000	7,584,000			
CO	1	100%	399,500	75,000	5,694,000			
LAB TECHNICIAN	2	100%	399,500	75,000	11,388,000			
NURSE PHNB	2	100%	399,500	75,000	11,388,000			
NURSE OFFICER	2	100%	593,000	75,000	16,032,000			
PHARMACEUTICAL TECH	1	100%	399,000	75,000	5,688,000			
DATA CLERK	1	100%	363,000	75,000	5,256,000			
WARDS								
MEDICINE	2	25%	1,004,000	75,000	25,896,000			
OBGY	3	20%	1,004,000	75,000	38,844,000			
PAEDIATRIC	2	5%	1,004,000	75,000	25,896,000			
MAIN LABORATORY	4	20%	593,000	75,000	32,064,000			
MARTENITY	3	15%	1,004,000	75,000	38,844,000			
TOTAL					**237,522,000**			
8. WETE HOSP.						**35,994**	**32,000**	**22**
MD	2	100%	1,004,000	75,000	25,896,000			

HEALTH FACILITY	NUMBER OF STAFF	ALLOCATED TIME TO HIV INTERVENTIONS	SALARY SCALE	RISK ALLOWANCE	ANNUAL GROSS SALARY	ESTIMATED POPULATION		
						PREVENTION	HTC	CTC
AMO	3	100%	557,000	75,000	22,752,000			
CO	1	100%	399,500	75,000	5,694,000			
LAB TECHNICIANS	3	100%	399,500	75,000	17,082,000			
NURSE OFFICERS	1	100%	593,000	75,000	8,016,000			
PHARMACEUTICAL TECHN	1	100%	399,500	75,000	5,694,000			
NURSE CLERK	1	100%	399,500	75,000	5,694,000			
WARDS								
MEDICINE	2	25%	1,004,000	75,000	25,896,000			
OBGY	3	20%	1,004,000	75,000	38,844,000			
PAEDIATRIC	2	5%	1,004,000	75,000	25,896,000			
MAIN LABORATORY	4	20%	593,000	75,000	32,064,000			
MARTENITY	3	15%	1,004,000	75,000	38,844,000			
					252,372,000			
TOTAL								
9. BUBUBU	**HAVE THEIR OWN MILITARY RATED SALARY SCALES**					**19,879**	**13,000**	**79**
MD	1	100%	1,004,000	75,000	12,948,000			
NURSES	1	100%	593,000	75,000	8,016,000			
PHARM TECH	2	100%	399,500	75,000	11,388,000			
LAB TECHN	1	100%	399,500	75,000	5,694,000			
NURSE CLERK	1	100%	593,000	75,000	8,016,000			
WARDS								
MEDICINE	1	25%	1,004,000	75,000	12,948,000			
MAIN LABORATORY	1	20%	1,004,000	75,000	12,948,000			
MARTENITY	1	15%	1,004,000	75,000	12,948,000			
TOTAL					**84,906,000**			
10. MKOANI HOSP.						**6,503**	**8,500**	**3**
MD	1	100%	1,004,000	75,000	12,948,000			
CO	2	100%	399,500	75,000	11,388,000			
NURSES	3	100%	399,500	75,000	17,082,000			
PHARM TECH	1	100%	399,500	75,000	5,694,000			
LAB TECH	1	100%	399,500	75,000	5,694,000			
SOCIAL WORKER								

HEALTH FACILITY	NUMBER OF STAFF	ALLOCATED TIME TO HIV INTERVENTIONS	SALARY SCALE	RISK ALLOWANCE	ANNUAL GROSS SALARY	ESTIMATED POPULATION		
						PREVENTION	HTC	CTC
WARDS								
MEDICINE	3	20%	1,004,000	75,000	38,844,000			
OBGY	3	15%	1,004,000	75,000	38,844,000			
PAEDIATRIC	3	5%	1,004,000	75,000	38,844,000			
MAIN LABORATORY	4	15%	399,500	75,000	22,776,000			
MARTENITY	3	15%	1,004,000	75,000	38,844,000			
TOTAL					**230,958,000**			
11. MICHEWENI						**10,805**	**8,500**	**5**
MD	2	100%	1,004,000	75,000	25,896,000			
CO	2	100%	399,500	75,000	11,388,000			
LAB TECHN	2	100%	399,500	75,000	11,388,000			
NURSE OFFICERS	1	100%	399,500	75,000	5,694,000			
PHARM TECHNI	1	100%	399,500	75,000	5,694,000			
NURSE CLERK	1	100%	399,500	75,000	5,694,000			
TOTAL					**65,754,000**			
12. FUONI PHU+						**34,500**	**20,000**	**0**
CO	1	100%	399,500	75,000	5,694,000			
NURSES	2	100%	399,500	75,000	11,388,000			
PHARMAC TECH	2	100%	399,500	75,000	11,388,000			
LAB TECH	2	100%	399,500	75,000	11,388,000			
DATA CLERK	1	100%	363,000	75,000	5,256,000			
					45,114,000			
12. COUNSELLING SERVICES AT PHCU LEVELS: REPORTING PHCU : 120								
PHCU (GENERAL HCT & PMTCT	3	100	399,500	75,000	2,049,840,000	**720,000**		

Annex 5: Organizations/Institutions in the Zanzibar National HIV & AIDS Response

Table A5A: Organizations/Institutions in the Zanzibar National HIV & AIDS Response (2017/18)

Sn.	Sn.	Institution	Financing Entity	Purchaser
1.	AL-RAHMA HOSPITAL		x	x
2.	ANGLICAN			x
3.	AYAHIZA			x
4.	BENEFITS FROM HIJJAJ	x		
5.	BIO		x	x
6.	BUBUBU HOSPITAL			x
7.	CDC	x		
8.	CHAKE CHAKE HOSPITAL			x
9.	FUONI PHC+			x
10.	GLOBAL FUND	x		
11.	HOUSEHOLDS	x		
12.	ICAP	x		
13.	INTERNATIONAL HIV & AIDS ALLIANCE	x		
14.	JAPAN TRUST FUND	x		
15.	JUKAMKUM			x
16.	JUMAZA		x	x
17.	KIVUNGE COTTAGE HOSPITAL			x
18.	LEGAL SERVICES FACILITY		x	
19.	LOCAL CONTRIBUTIONS	x		
20.	MAKUNDUCHI HOSPITAL			x
21.	MAT			x
22.	MICHEWENI HOSPITAL			x
23.	MINISTRY OF COMMUNICATION		x	x
24.	MINISTRY OF INFORMATION, TOURISM AND ARCHIVES		x	x
25.	MKOANI HOSPITAL			x
26.	MLEEWC		x	x
27.	MNAZI MMOJA HOSPITAL			x
28.	MOEVT		x	x
29.	MOH		x	
30.	MWEMBELADU HOSPITAL			x
31.	NORAD	x		
32.	NOT REVEALLED	x		
33.	OCGS		x	x
34.	OFFICE OF THE SECOND VICE PRESIDENT		x	x
35.	OFISI YA MKUU WA WILAYA MJINI			x
36.	PHCU (120)			x
37.	RFE BASKET FUND	x	X	
38.	RGOZ	x		
39.	SAVE THE CHILDREN	x		

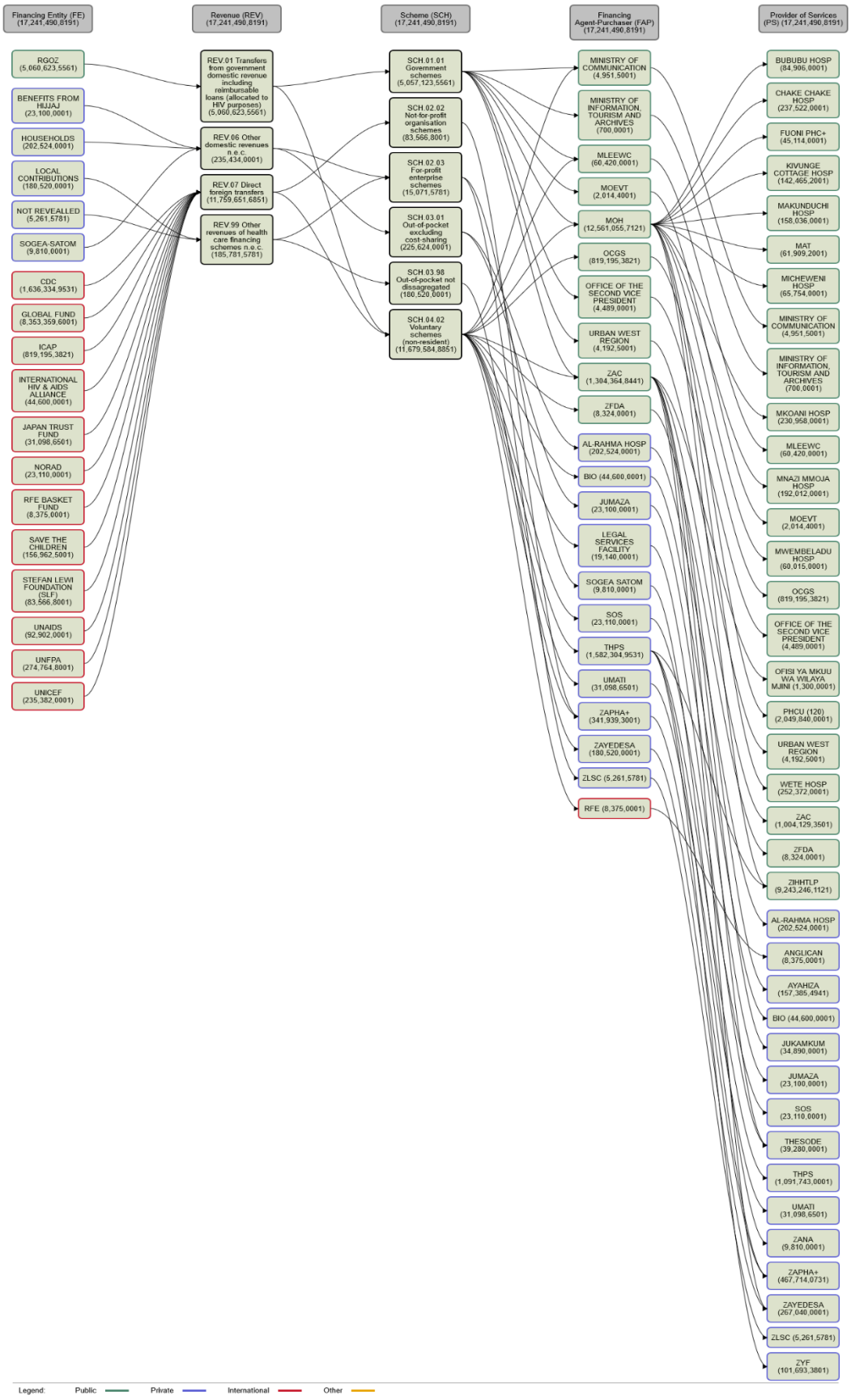
Sn.	Sn.	Institution	Financing Entity	Purchaser
40.	SOGEA SATOM	X	x	
41.	SOS		x	x
42.	STEFAN LEWI FOUNDATION (SLF)	x		
43.	THESODE			x
44.	THPS		x	x
45.	UNIFIED BUDGET RESULTS ACCOUNTABILITY FRAMEWORK (UBRAF)	x		
46.	UMATI		x	x
47.	UNAIDS	x		
48.	UNFPA	x		
49.	UNICEF	x		
50.	URBAN WEST REGION		x	x
51.	WETE HOSPITAL			x
52.	ZAC		x	x
53.	ZANA			x
54.	ZAPHA+		x	x
55.	ZAYEDESA		x	x
56.	ZFDA		x	x
57.	ZIHHTLP			x
58.	ZLSC		x	x
59.	ZYF			x

Table A5B: Organizations/Institutions in the Zanzibar National HIV & AIDS Response (2017/18)

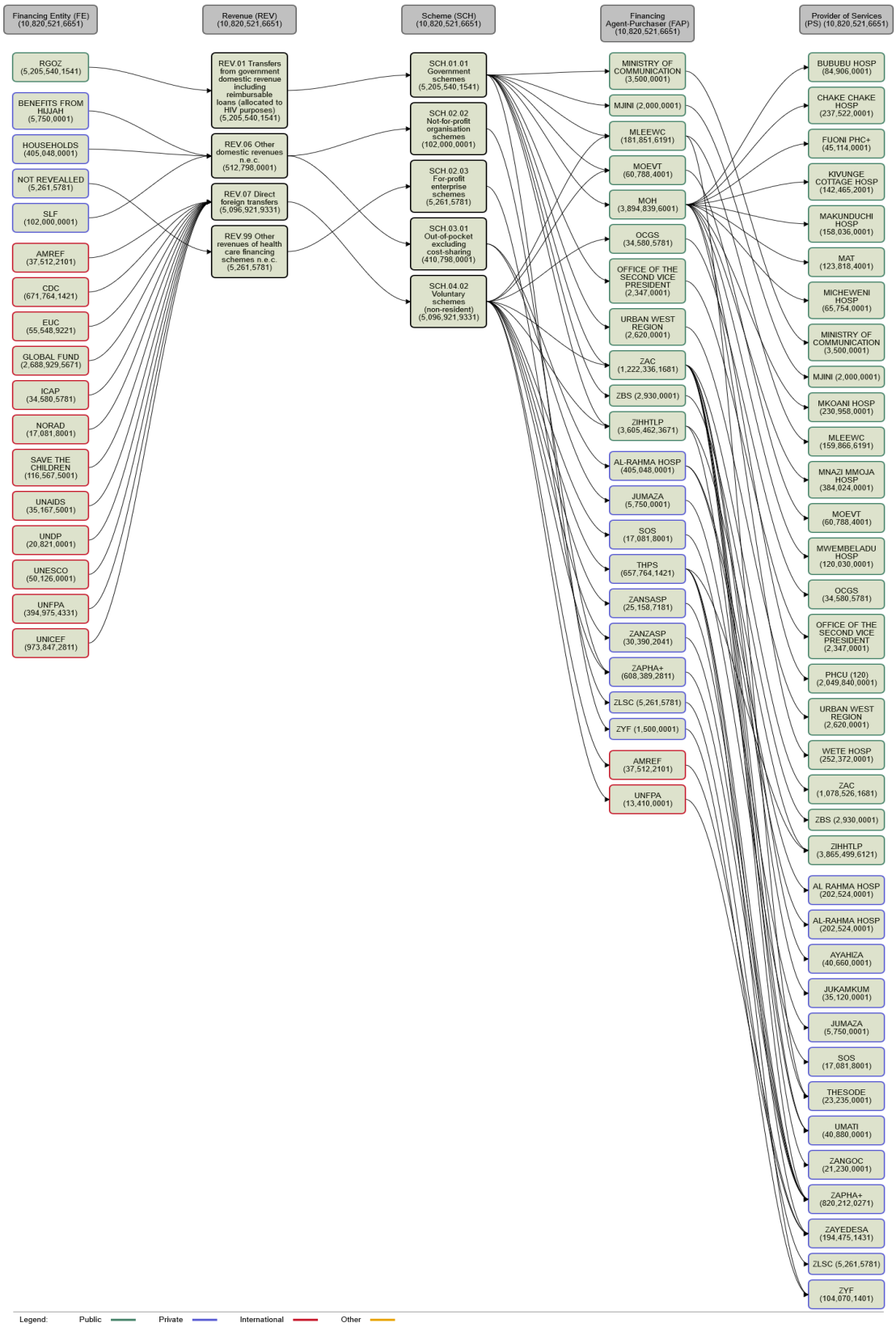
Sn.	Institution	Financing Entity	Purchaser	Provider
1.	AL-RAHMA HOSPITAL		x	x
2.	AMREEF	x	x	
3.	AYAHIZA			x
4.	BENEFITS FROM HIJJAH	x		
5.	BUBUBU HOSP			x
6.	CDC	x		
7.	CHAKE CHAKE HOSPITAL			x
8.	EUC	x		
9.	FUONI PHC+			x
10.	GLOBAL FUND	x		
11.	HOUSEHOLDS	x		
12.	ICAP	x		
13.	JUKAMKUM			x
14.	JUMAZA		x	x
15.	KIVUNGE COTTAGE HOSPITAL			x
16.	MAKUNDUCHI HOSPITAL			x
17.	MAT			x
18.	MICHEWENI HOSPITAL			x
19.	MINISTRY OF COMMUNICATION		x	x
20.	OFISI YA MKUU WA WILAYA MJINI		x	x
21.	MKOANI HOSPITAL			x
22.	MLEEWC		x	x
23.	MNAZI MMOJA HOSPITAL			x
24.	MOEVT		x	x
25.	MOH		x	
26.	MWEMBELADU HOSP			x
27.	NORAD	x		
28.	NOT REVEALLED	x		
29.	OCGS		x	x
30.	OFFICE OF THE SECOND VICE PRESIDENT		x	x
31.	PHCUs (120)			x
32.	RGOZ	x		
33.	SAVE THE CHILDREN	x		
34.	SLF	x		
35.	SOS		x	x
36.	THESODE			x
37.	THPS		x	

Sn.	Institution	Financing Entity	Purchaser	Provider
38.	UMATI			x
39.	UNAIDS	x		
40.	UNDP	x		
41.	UNESCO	x		
42.	UNFPA	x	x	
43.	UNICEF	x		
44.	UBRAF	x		
45.	URBAN WEST REGION		x	x
46.	WETE HOSPITAL			x
47.	ZAC		x	x
48.	ZANGOC			x
49.	ZANZASP		x	
50.	ZAPHA+		x	x
51.	ZAYEDESA			x
52.	ZBS		x	x
53.	ZIHHTLP		x	x
54.	ZLSC		x	x
55.	ZYF		x	x

Annex 6: Financial Flow, 2016/17



Annex 7: Financial Flow, 2017/18



Annex 8: Definition of SDMs & ASCs in Figures 11a and 11b

ASC.01.01	Five Pillars of Prevention
ASC.01.02	Other Prevention activities
ASC.02.09	Voluntary HIV testing and counselling for general population
ASC.02.10	Provider initiated testing and counselling (PITC)
ASC.02.98	HIV testing and counselling activities not disaggregated
ASC.02.99	Other HIV counselling and testing activities n.e.c.
ASC.03.01	Anti-retroviral therapy
ASC.03.02	Adherence and retention on ART - support (including nutrition and transport) and monitoring
ASC.03.03	Specific ART-related laboratory monitoring
ASC.03.04	Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs
ASC.03.05	Psychological treatment and support service
ASC.03.98	Care and treatment services not disaggregated
ASC.04.01	Social protection and economic support for OVC
ASC.04.02	Other social protection and economic support (non-OVC)
ASC.04.99	Social protection activities n.e.c
ASC.05.01	Advocacy
ASC.05.02	Human rights programs
ASC.06.01	Strategic planning, coordination and policy development
ASC.06.02	Building meaningful engagement for representation in key governance, policy reform and development processes
ASC.06.03	Program administration and management costs (above service-delivery level)
ASC.06.04	Strategic information
ASC.06.05	Public Systems strengthening
ASC.06.06	Community system strengthening
ASC.06.07	Human resources for health (above-site programs)
ASC.07.02	Reducing gender based violence
ASC.08.03	Epidemiological research
ASC.08.04	Socio-behavioural research
ASC.08.98	HIV and AIDS-related research activities not disaggregated by type
ASC.08.99	HIV and AIDS-related research activities n.e.c.
SDM.01.01	Facility-based: Outpatient
SDM.01.98	Facility-based not disaggregated
SDM.01.99	Other facility-based n.e.c.
SDM.02.01	Community-based: center
SDM.02.04	Community-based: mobile unit
SDM.02.05	Community-based: outreach
SDM.03	Non applicable (ASC which does not have a specific
SDM.98	Modalities not disaggregated