# TANZANIA PUBLIC EXPENDITURE REVIEW
# MULTI-SECTORAL REVIEW: HIV-AIDS
# DECEMBER 2007

**FINAL REPORT, FEBRUARY 2008**

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| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AMREF | African Medical and Research Foundation |
| ARV | Antiretroviral |
| BCC | Behavioural Change Communication |
| CARF | Community AIDS Response Fund |
| CBO | Community Based Organisation |
| CHAC | Council HIV/AIDS Coordinator |
| CIDA | Canadian International Development Agency |
| CMAC | Council Multi-sectoral Aids Committee |
| CDC | (US) Centre for Communicable Diseases |
| CHMT | Council health management Team |
| CMO | Chief Medical Officer |
| COMATA | Tanzanian acronym for a specific community-based approach to planning |
| COP | Country Operational Plan (PEPFAR) |
| CSO | Civil Society Organisation |
| CSSC | Christian Social Science Council |
| CTC | Care and Treatment Centre |
| DAC | District AIDS Coordinator |
| DMO | District Medical Officer |
| DOT | Directly Observed Therapy |
| DP | Development Partners |
| EDP | External Development Partner |
| FBO | Faith-Based Organisation |
| GDP | Gross Domestic Product |
| GFATM | Global Fund against AIDS, TB and Malaria |
| GOT | Government of Tanzania |
| GTZ | German Agency for International Development |
| HAART | Highly Active Antiretroviral Therapy |
| HIV | Human Immunodeficiency Virus |
| HSHSP | Health Sector HIV and Aids Strategic Plan |
| IEC | Information, Education and Communication |
| IMF | International Monetary Fund |
| LGA | Local Government Authority |
| LGRP | Local Government Reform Programme |
| M&E | Monitoring and Evaluation |
| MAC | Multisectoral Aids Committee |
| MAP | Multi-Sectoral AIDS Project |
| MC | Municipal Council |
| MCH | Maternal and Child Health |
| MDA | Ministry, Department or Agency of Government |
| MKUKUTA | Mkakati wa Kukuza Uchumi na Kuondoa Umaskini Tanzania (=NSGRP in English) |
| MNH | Muhimbili National Hospital |
| MOEC | Ministry of Education and Culture |
| MoF | Ministry of Finance |
| MoHSW | Ministry of Health and Social Welfare |
| MPEE | Ministry of Planning Economy and Empowerment |

| | |
|---|---|
| MCDGC | Ministry of Community Development, Gender and Children |
| MLYDS | Ministry of Labour, Youth Development and Sports |
| MSD | Medical Stores Department |
| MTEF | Medium Term Expenditure Framework |
| MUCHS | Muhimbili University College of Health and Science |
| NACP | National AIDS Control Programme |
| NGO | Non-Governmental Organisation |
| NHSP | National Health Sector Programme |
| NMSF | National Multisectoral Strategic Framework |
| NSGRP | National Strategy for Growth and Reduction of Poverty (=MKUKUTA in Swahili) |
| OI | Opportunistic Infection |
| OVCs | Orphans and Vulnerable Children |
| PE | Personal Emoluments |
| PEPFAR | (US) Presidents Emergency program for AIDS Relief |
| PER | Public Expenditure Review |
| PLWHA | People Living with HIV/AIDS |
| PMTCT | Prevention of Mother to Child Transmission |
| POPSM | President's Office, Public Service Management |
| PORALG | President's Office, Regional Administration & Local Government |
| RA | Regional Administration |
| RFA | Regional Facilitating Agency |
| RS | Regional Secretariat |
| SIDA | Swedish International Development Agency |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| TACAIDS | Tanzania Commission for AIDS |
| TB | Tuberculosis |
| THIS | Tanzania HIV/AIDS Survey |
| TOMSHA | Tanzania Output Monitoring System for HIV and AIDS |
| TMAP | Tanzania Multi-Sectoral AIDS project (World Bank) |
| TOT | Training of Trainers |
| UNDP | United Nations Development Programme |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| USG | United States Government |
| VCT | Voluntary Counselling and Testing |
| VMAC | Village Multisectoral HIV/AIDS Committee |
| WHO | World Health Organization |
| WMAC | Ward Multisectoral HIV/AIDS Committee |
| WPI | Work Place Intervention |
| ZAC | Zanzibar AIDS Commission |

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The authors alone are responsible for errors of fact or interpretation in the use of the material, and for the opinions expressed.

# Executive Summary

**Overview**

Total Government plus donor spending on HIV/AIDS increased by 76% in 2006/7, a real increase of 66% after adjusting for inflation (Table ES1). The most remarkable feature is the continued rapid growth in donor HIV/AIDS spending, now expected to reach TSh568bn in 2007/8 and accounting for 95% of total Government plus donor funding. The increase has been from off-budget sources of finance, and only 23% of expected aid in 2007/8 is included in the budget.

## Table ES1 Total HIV/AIDS Expenditure and Financing

| TSh Billions | Actual 2005/6 | Budget 2006/7 | Actual 2006/7 | Budget 2007-8 |
|---|---|---|---|---|
| 1. Total Budget expenditure on HIV/AIDS | 119.9 | 71.7 | 62.0 | 157.2 |
| 2. Of which, ODA financed | 98.1 | 47.4 | 40.6 | 129.7 |
| 3. Off-budget ODA for HIV/AIDS | 106.1 | 283.2 | 337.2 | 438.5 |
| 4. Total ODA for HIV/AIDS (=2+3) | 204.2 | 330.6 | 377.8 | 568.2 |
| Estimated Total Public & Donor Expenditure on HIV/AIDS (=1+3) | 226.0 | 354.9 | 399.2 | 595.7 |
| ODA as % of HIV/AIDS expenditure | 90.4 | 93.2 | 94.6 | 95.4 |
| % of HIV/AIDS aid included in Govt budget | 48.0 | 14.3 | 10.8 | 22.8 |

Sources: Table 2.1

As a result of the sustained increases in aid, total Government plus donor spending on HIV/AIDS in 2007-08 is expected to equal over 10% of public expenditure, over 3% of GDP, and a staggering one third of all aid to Tanzania[1].

## Table ES2: HIV/AIDS Expenditure relative to Government spending, GDP, and total aid flows 2005/06-2007/08

| **Total HIV spending as a % of:-** | Actual 2005/6 | Budget 2006/7 | Actual 2006/7 | Budget 2007/8 |
|---|---|---|---|---|
| Total Govt Spending | 5.8 | 7.4 | 8.3 | 10.9 |
| GDP | 1.6 | 2.2 | 2.5 | 3.3 |
| HIV aid as % of total aid | 15.1 | 21.8 | 24.9 | 32.9 |

Source: Table 2.1

[1] Aggregate public expenditure, GDP and aid data from IMF (July 2007). These percentages include off-budget donor aid.

Table ES3 shows recent trends in Government budget spending on HIV/AIDS.

## Table ES3 Budget Spending on HIV/AIDS TSh Bns 2005/6-2007/8

| | 2005/6 Actual | Budget 2006/7 | Actual 2006/7 | Budget 2007-8 |
|---|---|---|---|---|
| MDA Recurrent | 21.8 | 24.0 | 21.4 | 21.6 |
| MDA Development | 96.9 | 36.8 | 29.3 | 107.0 |
| -Of which, GOT funded | | 0.3 | 0.0 | 5.9 |
| Transfers to regions and Districts | 1.2 | 10.9 | 11.3 | 28.6 |
| Total Budget expenditure on HIV/AIDSS | 119.9 | 71.7 | 62.0 | 157.2 |

Recurrent expenditure on HIV/AIDS is falling in real terms. Some of this may reflect recurrent costs being shifted onto donor programmes, understandable given the massive resources now available. However, some of the reduction is a real one, including the proposed reduction in the recurrent budget for TACAIDS over the coming MTEF. This merits reconsideration, given the need to expand the TACAIDS role in a number of areas. These include identifying priorities and persuading donors to fund them, further strengthening monitoring and evaluation, and identifying, producing, and disseminating best practice guidance on behaviour change communication (BCC) and economic and social support.

The reduction in budgeted development spending in 2006/7 was not the result of any actual decline in Government spending. It is entirely due to MOHSW not including any of the HIV/AIDS funding they receive from donors in their budget in that year, although several major donor programmes were included in 2005/6 and in 2007/8.

**Aid for HIV/AIDS**

Aid is forecast to continue at levels of more than TSh500bn p.a. -far above the 'best case' scenario of the 2007 NMSF financial assessment (Table ES4). This assumes that the proposed increase in the PEPFAR budget to US$300mn will be confirmed, and that funding will continue at that level. Other assumptions are relatively conservative. The forecast does not include future GFATM rounds, any TMAP successor, or any block grant support beyond present commitments. The forecast decline in aid from 2007/8 is therefore likely to prove too pessimistic

## Table ES4 ODA is Exceeding The 'Best Case' NMSF Forecast

| | Expected | Actual | Estimate | Forecast | | |
|---|---|---|---|---|---|---|
| | 2006/7 | | 2007/8 | 2008/9 | 2009/10 | 2010/11 |
| **NMSF 'Best case'** | 292.9 | | 318.1 | 351.2 | 382.3 | 413.5 |
| **Our Forecast** | 330.6 | 377.8 | 568.2 | 532.2 | 507.4 | 463.8 |

Sources: NMSF financial assessment and PER estimates (See Annex 1).

The US and the Global Fund account for 86% of donor support expected in 2007/8, and may reach more than 90% of the total in 2008/9. The analysis shows that care and treatment represented 64% of combined US and Global Fund spending in 2006/7. Prevention was just 15% of total expenditure; economic and social support about 8%. Spending on care and treatment by these two donors alone represents 55% of all expenditure on HIV/AIDS in 2006/07. Although the standardised targets under Objective A should permit a similar analysis of budget spending, most MDAs are not using these targets appropriately but are allocating most spending to 'cross-cutting' or 'other.' Our best estimate is that care and treatment accounts for 60-70% of all spending on HIV//AIDS in Tanzania

**Local Government Expenditure on HIV/AIDS**

With 95% of the finance coming from aid, and three quarters of spending off-budget, it is difficult for Government to exercise effective leadership. We recommend that a **donor** expenditure review be undertaken. This would focus on understanding better what is being financed, how it is managed, and what impact it is having. It would aim to make recommendations on how Government can exercise effective leadership and can have a positive influence on how funds are allocated and managed.

Health-related HIV/AIDS expenditure at LGA level is mostly off budget except for some health basket funding. ARV drugs are supplied direct and free of cost, PEPFAR partners are working directly with service providers. GFATM provides about half of central funding for LGAs, but less than half of LGAs benefit[2]. Progress on health interventions has been better than on the multi-sectoral aspects, although there have been serious procurement problems .ARV drug supply was maintained, but there have been some worrying shortages via MSD including e.g. drugs for STIs. Prompt treatment of STIs is a key intervention for prevention, and it should be unacceptable for an HIV/AIDS programme spending TSh500bn per annum to run out of antibiotics.

Despite massive resources for care and treatment, lack of central funding again prevented implementation of planned LGA prevention and impact mitigation programmes in 2006/7– because the HIV/AIDS block grant was cut from the final budget due to late signing of the CIDA grant. Part of the 2007/8 HIV/AIDS grant was paid in November, but 4 from 5 LGAs had not yet received it in early December (banking delays). We recommend that the LGA grant should be seen as a core programme within the Government budget, de-linked from specific earmarked donor funding, and with disbursements concentrated early in the year to facilitate implementation.

We reviewed 18 LGA performance budgets for their HIV/AIDS content, and visited 5 additional LGAs. Most LGAs are planning a range of interventions in prevention and in economic and social support for affected households, as well as supporting action at village and ward level. Lack of budget has confined many activities to a relatively small

[2] Expected to increase to more than 90 of the 133 LGAs in 2008/09.

scale, but the proposed programmes for the most part seem to reflect reasonable responses to the HIV/AIDS problems being experienced.

The essential minimum package for LGAs developed by TACAIDS and included in the 2007/8 budget guidelines has over 60 'must have' interventions, and is beyond the financial and institutional capacity of most LGAs to implement. We recommend that TACAIDS should provide further advice on prioritising within it, and support it with more detailed guidance and capacity building support. TACAIDS should invest even more heavily in researching good practice, and developing, disseminating, and updating guidance on 'what works' in each of the proposed intervention areas.

LGAs should become responsible for the role currently performed by the RFAs in providing financial support and some capacity building help to CSOs. The funds will need to be earmarked to CSO use, and CHACs will need operational guidance and professional support.

To enable LGAs to perform satisfactorily in both of these expanded roles, we recommend resourcing the RAs to provide supportive supervision and guidance, supplemented by providing a budget for contracting-in NGOs to provide capacity building services. There are some risks in expanding the LGA role as proposed, and it would make sense to pilot the approach before going to national scale, with appropriate and early attention to collecting the necessary information to ensure useful lessons can be learned. While the new approach to financing of CSOs is being developed it is suggested that continuity be preserved by extending the contracts of the better-performing RFAs.

**From Strategy to Implementation**

In order to overcome the challenges of turning the NHSP and the new health sector HIV/AIDS strategy into workable implementation plans, a decentralised approach is the only practical one, given the multiplicity of stakeholders and the decentralised and geographically specific nature of the epidemic. A critical role for the centre {TACAIDS and NACP) is to generate practical, evidence-based guidance to those implementing HIV/AIDS interventions. Resources to implement the strategy should then be allocated based on criteria of need, which will include for example developing a more specific geographical allocation formula for the HIV/AIDS grant, as well as reviewing the existing coverage and need for expansion of key interventions. The critical requirement is not for a detailed plan that will quickly become out of date, but to put in place the institutional mechanisms for reviewing progress with other stakeholders, identifying financing gaps and neglected areas, and directing Government and donor resources towards them. Some of this is already happening, with clear allocation of responsibilities for procuring drugs for ART and with some regional specialisation of service providers.

There are unlikely to be significant additional resources beyond the large sums already allocated, and the task is therefore to persuade external partners to allocate a larger share of HIV/AIDS spending to prevention and impact mitigation. This requires interventions that can be supported with evidence of their effectiveness, and institutions capable of delivering them on a larger scale.

Institutional arrangements need to operate at a number of levels. At the highest levels, TACAIDS and NACP may be engaged in discussing regional concentration and thematic responsibilities with the major stakeholders, as well as identifying interventions that need to be expanded or contracted, and the responsibility for doing so. At lower levels, more limited and technical forums may be needed to thrash out the details of individual interventions, for example what programmes will be implemented in schools and who will support which aspects from developing curricula and teaching materials for specific age groups through to working with teachers and pupils in specific regions. At district level, LGAs will coordinate district level plans with local CSOs, as several of the LGAs we reviewed already attempt to do.

With clear policies in place, and guidance and support available, MOF and TACAIDS need to ensure that promised funds are made available in full and on time, but allow more flexibility to local decision-makers to decide how to allocate the budget. The job of strategic allocation is difficult enough, and will require all of the capacity available to TACAIDS. They should withdraw from involvement in decisions on individual LGA activities or NGO projects, where decisions need a level of local knowledge that TACAIDS does not have and should not attempt to acquire. Instead of ex ante approval, the TACAIDS role should be to support operational research on a sample of on-going LGA and CSO programmes, and ensure that lessons are learned and disseminated widely.

**The HIV/AIDS Grant**

The HIV/AIDS grant is a potentially good instrument for providing predictable support to LGAs to enable them to plan and implement HIV/AIDS interventions, particularly in prevention and economic and social support.

The allocation formula needs to incorporate criteria more specifically related to HIV/AIDS than the existing health basket formula that is used. Unfortunately, HIV/AIDS prevalence is only available from the THIS at regional level, with big differences between LGAs within each region, with urban areas for example typically having much higher infection rates. One possibility proposed in comments on our draft report would be to use an allocation formula that combines regional HIV prevalence and district data on poverty and on orphans[3]. This would be a neat solution, as numbers of OVCs in difficult circumstances are both a direct indicator of relative need, and likely to be correlated with HIV/AIDS infection rates. To ensure that the formula off-sets some of the biases from existing programmes, we would suggest that allocations should also take account of funding from other sources, and should for example be reduced pro rata if the LGA is fortunate enough to receive HIV/AIDS funding from GFATM.

Monitoring of the use of the HIV/AIDS grant within individual LGAs can be done through the quarterly performance reports that each LGA is now required to produce. These show both physical progress (e.g. numbers of orphans provided with uniforms) and financial progress (actual expenditure as a share of budget). The problem is that LGAs are not using the PLANREP software for reporting, and obtaining a consolidated

[3] e-mail from Masuma Mamdani of REPOA

performance report can only at present be done manually. The problem should eventually be solved by the on-going roll out of PLANREP training. In the interim, commissioning someone to do analysis on a random sample of the quarterly reports would be a feasible way to obtain reliable information on how the funds are being used.

Other reporting requirements can be met. The audit should be asked to look also at a sample of districts, to check that expenditure is properly coded and properly vouched for, with receipts and expenditure reconciled to bank statements.

# 1. Introduction

This annual multi-sector HIV/AIDS public expenditure review was undertaken in three weeks in November-December 2007. Our terms of reference are annexed. They would have been ambitious even had everything gone smoothly. Unfortunately, problems in obtaining data and in organising the programme, together with computer crashes and illnesses of team members and their families reduced what could be achieved.

# 2. HIV Aids Expenditure and Financing Update

## *2.1 Overall Trends in HIV-AIDS Expenditure and Financing*

Table 2.1 shows recent developments in Government and development partner expenditure on HIV/AIDS. The most remarkable feature is the continued rapid growth in donor HIV/AIDS spending. Aid for HIV/AIDS is expected to reach TSh568mn in 2007/8, and will finance 95% of the total of Government plus donor spending on HIV/AIDS. Total Government plus donor spending on HIV/AIDS is equivalent to over 3% of GDP, and (including off-budget donor spending) is equivalent to over 10% of Government expenditure. According to IMF estimates and projections of official external grants and loans, nearly one third of total aid flows to Tanzania are being spent on HIV/AIDS (Table 2.1).[4]. The same IMF report discusses a 'high scenario', in which external support reaches 12.8% of GDP. Even if this higher aid level were to be reached as early as 2007, HIV/AIDS would still be equal to one quarter of total ODA disbursements. The focus of such a large share of donor resources on this single disease seems increasingly disproportionate. We strongly re-iterate the recommendation made last year, that there should be explicit high-level consideration of the appropriate level of public expenditure on HIV/AIDS. There are consequences for macro-economic management[5], for the distortion of priorities in the health sector, for the squeezing out of other equally important priorities from donor support and from the time of Tanzanian civil servants and health sector professionals. There are also big risks of establishing expectations that will not be sustainable if support is not maintained. The main focus of

[4] IMF Country Report No 07/246, United Republic of Tanzania, 2007 Article IV Consultation and First Review Under the Policy Support Instrument, July 2007

[5] For discussion of the macro-economic issues, see Foster, Mick and Killick,T (2006), What would doubling aid do for macroeconomic management in Africa: a synthesis paper (ODI Working paper 264, April 2006). Downloadable fromhttp://www.odi.org.uk/publications/working_papers/index.html

external support has been on treatment programmes that Government could not afford from its own resources.

Recommendation 1: TACAIDS and MOF should facilitate a debate, involving the political leadership and the external development partners, on the share of Government and donor resources that should be devoted to HIV/AIDS, and the implications of current expenditure levels and trends.

Roughly 23% of the aid is included in the 2007/8 budget: as recently as 2005/6, the figure was nearly half. The reason for the declining share in on-budget aid is that the main growth in aid spending and in commitments has come from development partners who are either entirely outside the Government budget (US PEPFAR), or mainly so (GFATM).

## Table 2.1: Public and Donor Expenditure on HIV/AIDS, and How It Is Funded: - TSh Billions

| | Actual 2005/6 | Budget 2006/7 | Actual 2006/7 | Budget 2007-8 |
|---|---|---|---|---|
| 1.MDA Recurrent | 21.8 | 24.0 | 21.4 | 21.6 |
| 2.MDA Development | 96.9 | 36.8 | 29.3 | 107.0 |
| -Of which, GOT funded | | 0.3 | 0.0 | 5.9 |
| 3.Transfers to regions and Districts | 1.2 | 10.9 | 11.3 | 28.6 |
| 4.Total Budget expenditure on HIV/AIDS (=1+2+3) | 119.9 | 71.7 | 62.0 | 157.2 |
| 5.Of which, ODA financed | 98.1 | 47.4 | 40.6 | 129.7 |
| 6. Off-budget ODA for HIV/AIDS | 106.1 | 283.2 | 337.2 | 438.5 |
| 7.Total ODA for HIV/AIDS(=5+6) | 204.2 | 330.6 | 377.8 | 568.2 |
| 8.Estimated Total Public & Donor Expenditure on HIV/AIDS (=4+6) | 226.0 | 354.9 | 399.2 | 595.7 |
| **Total HIV spending as a % of:-** | | | | |
| Total Govt Spending | 5.8 | 7.4 | 8.3 | 10.9 |
| GDP | 1.6 | 2.2 | 2.5 | 3.3 |
| HIV aid as % of total aid | 15.1 | 21.8 | 24.9 | 32.9 |
| HIV aid as % of high Scenario Aid | 11.2 | 16.1 | 18.4 | 24.5 |
| ODA as % of HIV/AIDS expenditure | 90.4 | 93.2 | 94.6 | 95.4 |
| % of HIV/AIDS aid included in Govt budget | 48.0 | 14.3 | 10.8 | 22.8 |
| Memorandum items | | | | |
| Total Government Spending TShBns | 3873 | 4800 | 4800 | 5477 |
| GDP TShBns | 14209 | 16016 | 16016 | 18096 |
| Total ODA TShBns | 1355 | 1516 | 1516 | 1727 |
| Total 'High Scenario' ODA TShBns | 1819 | 2050 | 2050 | 2316 |

Sources: Ministry of Finance; and IMF, July 2007. See Annex 1.

In real, inflation-adjusted terms, total public plus donor expenditure on HIV/AIDS increased by 66% in 2006/7, led by a 74% increase in ODA to HIV/AIDS, while Government spending from domestic revenues and general budget support fell by 8% (Table 2.2). The 2007/8 budget and declared donor intentions imply a further 42% increase in spending in 2007-08, with aid increasing by over 40%, and Government-financed budget expenditure also increasing by over 20%.

**Table 2.2 Public and Donor Expenditure on HIV/AIDS in Constant 2006/7 Prices TSh Bn**

| | Actual 2005/6 | Actual 2006/7 | Budget 2007-8 |
|---|---|---|---|
| ODA for HIV/AIDS | 216.9 | 377.8 | 541.1 |
| GOT-financed spending on HIV/AIDS | 23.2 | 21.4 | 26.2 |
| Total spending on HIV/AIDS | 240.0 | 399.2 | 567.3 |
| % increase in ODA | | 74.2 | 43.2 |
| % increase in GOT-financed spending | | -7.6 | 22.4 |
| % increase, total | | 66.3 | 42.1 |
| Memorandum item | | | |
| Inflation rate (GDP deflator) | | 6.2 | 5.0 |

Source: GDP deflator from IMF, July 2007

## *2.2 Central Government Expenditure on HIV/AIDS*

Including external support that is captured in the budget, Government expenditure on HIV/AIDS only accounts for 26% of the total of Government and donor expected spending in 2007/8. Recurrent MDA expenditure identified as being on HIV/AIDS has been broadly flat in cash terms, implying some reduction in real terms from inflation over the last couple of years. Development expenditure captured in the budget shows a sharp dip in 2006/7, but this is purely the result of MOHSW not including aid-financed development expenditure in their budget in 2006/7. Development expenditure from GFATM (partial), JICA, SIDA and Norway is included in the MOHSW budget in 2007/8, and accounts for the increase in total Government expenditure to Tsh157 bn in the 2007/8 budget (Table 2.3).

All budget expenditure on HIV/AIDS is supposed to be classified as Objective A. Most MDAs and LGAs are following this practice, although TACAIDS itself has been classifying some expenditure under different objectives, a practice which they have agreed to discontinue. Although Objective A is in principle divided between separate targets for prevention, care and treatment, economic and social support, and cross-cutting expenditure, Table 2.3 shows that most expenditure is in practice recorded as 'cross-cutting' or 'other', rendering the breakdown by target of very little use.

Recommendation 2 MDAs and LGAs be reminded of the definitions of the standard targets within Objective A, and be encouraged to use them, perhaps by inclusion of suitable text in the budget guidelines for 2008/9.

## Table 2.3 MDA Expenditure on HIV/AIDS By target

| | 2006-07 | 2007-08 Budget |
|---|---|---|
| Cross cutting | 14% | 22% |
| Prevention | 4% | 3% |
| Care & Treatment of PLWHA | 0% | 34% |
| Economic & Social Support | 0% | 1% |
| Other | 82% | 41% |
| TOTAL | 100% | 100% |

Source: Ministry of Finance

Table 2.4 shows total Government expenditure on HIV/AIDS by vote. Expenditure continues to be dominated by health and TACAIDS. Community development was the only other MDA spending more than TSh1bn on HIV/AIDS in 2006/7. The 2007/8 budget features significantly increased budget spending by the uniformed services, the MOEC, and labour and youth development.

## Table 2.4 Government Expenditure on HIV/AIDS TSh Bns

| | Actual 2005/06 | Actual 2006/07 | Budget 2007/08 | 2006/07 % Spent | %Shares 2007/08 |
|---|---|---|---|---|---|
| Public Safety & Security | 0.236 | 0.510 | 3.895 | 87% | 3.01% |
| Home Affairs - Prisons Services | 1.500 | 0.442 | 2.133 | 19% | 1.65% |
| Defence | 0.048 | | 0.399 | | 0.31% |
| The National Service | 0.050 | | 0.847 | | 0.65% |
| Education and Vocational Training | 2.120 | 0.050 | 2.042 | 3% | 1.58% |
| Ministry of Health & Social Welfare | 77.440 | 12.536 | 56.120 | 99% | 43.32% |
| Community Development etc | | 2.842 | 0.589 | 96% | 0.45% |
| PMORALG | 2.690 | 6.204 | 1.272 | 95% | 0.98% |
| Labour and Youth Development | 5.486 | 0.078 | 1.012 | 15% | 0.78% |
| TACAIDS | 27.823 | 28.023 | 53.270 | 97% | 41.12% |
| Other | | | | | |
| TOTAL MDAs | 118.65 | 58.17 | 129.542 | 87% | 100% |
| Regions | | 3.863 | 11.777 | | |
| LGAs | 1.178 | ? | 15.938 | | |
| Transfers TACAIDS to LGAs | | | | | |
| Grand Total | 119.83 | 62.03 | 157.26 | | |

Source: Ministry of Finance IFMS data, October 2007

Our TORs call for analysis of the plans and MTEFs of several MDAs (Health, Agriculture, Education, Community development and Water). It was agreed that TACAIDS would obtain copies of the relevant MTEFs before the mission started, and would facilitate meetings with relevant staff in the MDAs. It proved unexpectedly difficult to obtain copies of the final MTEFs for analysis. To permit analysis in the PER, TACAIDS probably needs to secure copies of these in June when they are finalized. By December, most MDAs struggle to locate copies, something which is perhaps indicative that the MTEF is not in practice seen as the key document guiding budget implementation. Of the listed MDAs, MTEFs were only obtained for health, TACAIDS

and education. It also proved difficult to secure appointments with relevant MDA staff and to obtain the requested information. Other pressures on TACAIDS staff meant that the requested appointments were not set up in advance of the consultant arriving, and most of the necessary letters of introduction had either not been sent or had gone astray. Although the MTEFs for health, TACAIDS and education were available in good time, others were never obtained. Some key appointments (for example, with the NACP) were never arranged, other Ministries were reluctant to divulge information without a formal approach from TACAIDS that we ran out of time to arrange. The analysis of MDA spending plans and execution is therefore more limited than we would have wished.

## MOHSW

Even with the majority of funding for health interventions off-budget, the Ministry of Health still accounts for 43% of MDA spending on HIV/AIDS. The great majority of the on-budget spending appears to be for care and treatment, although not all of it is appropriately coded. Of the TSh12.7 bn in the recurrent budget for 2007/8, TSh10.6bn is described as 'procurement and distribution of ARVs', but this is allocated to the cross-cutting Target 1 rather than to target 3 for care and treatment. All of the TSh42.5bn in the development budget is described under 'Target A03S: Number of ART Sites Increased from the current 200 to 900 Sites by 2010.' The included development budget support is the MOHSW part of global fund spending, plus JICA expenditure (mainly HIV test kits) and expenditure by SIDA. The only parts of the health sector spending that are not for treatment appear to be some minor expenditure on work-place interventions, a TSh1bn programme to 'reduce prevalence of the general population' (not further elaborated in the document), and some minor spending on advocacy. As a minimum, at least 95% of the 'objective A' spending by the health ministry is for treatment. Expenditure in the MTEF recurrent budget is expected to double across the board in 2008/9, while the development budget remains broadly unchanged.

## TACAIDS

TACAIDS accounts for a further 41% of Government spending, mostly transfers for implementation by others. The big increase in TACAIDS expenditure budgeted for in 2007/8 is composed mainly of:-

i. TSh10bn transfers to AMREF and CCSC for the GFATM Round 3 project. This assumes approval of the October 2007 disbursement request, and is the first disbursement on round 3 since April 2006.
ii. Assumed acceleration of TMAP, expected to disburse TSh31bn from the TACAIDS vote in 2007/8, mostly as transfers to fund NGO projects (TSh18bn to RFAs for the TMAP CARF programme)
iii. Support to the Rapid Funding Envelope, roughly TSh4bn was assumed from CIDA and DFID.

The 2007/8-2009/10 MTEF envisages the TACAIDS recurrent budget falling from TSh3.6bn to TSh3.1bn by the last year of the MTEF. This might merit

reconsideration. Elsewhere in this report, we identify a number of areas where TACAIDS needs to further develop the role that it is playing. This includes the work required to coordinate development partner and donor efforts in support of the new NMSF, a role that requires more active TACAIDS leadership in identifying where there are resource gaps, and persuading development partners to re-allocate their resources in order to ensure that they are filled. We also argue that TACAIDS could expand the role that it already plays in developing and disseminating knowledge of best practice in behaviour change and in economic and social support, providing guidance, support and contacts for MDAs, LGAs and NGOs who are implementing aspects of the essential services package. There is also an unfinished agenda for ensuring that the TOMSHA system generates useful information and supports stakeholders in using it to improve services. Each of these roles needs to be adequately resourced, but the evidence seems to suggest that TACAIDS is over-stretched in fulfilling existing functions. There is probably scope for making off-setting savings, especially by decentralising decision-making to district and regional level and reducing the time devoted to reviewing small project and LGA budget proposals. Nevertheless, there is a case for reconsidering the future trend in the recurrent budget during the preparation and negotiation of the new budget and MTEF.
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Recommendation 3. Director Finance to review with MOF whether the decline in the TACAIDS recurrent budget that was proposed in the 2007/8-20009/10 MTEF should be re-considered

## MOEC

The IFMS figures from finance differ from those in the copy of the education MTEF we obtained from MOEC, probably because it may not have been the final version. The overall story is nevertheless fairly consistent. There may be significant off-budget support, but the allocated budgets of TSh2bn or less in recent years seem inadequate to the scale of the task, and actual recorded spending of just TSh50mn in 2006/7 seems pitifully low (Table 2.5). This feeling is supported by the finding that many LGAs are including provision for training teachers and supporting school-based HIV/AIDS programmes within their own budgets, frustrated by slow progress by MOEC.

The Ministry of Education MTEF has objectives to put in place effective programmes for prevention and control of HIV/AIDS, build capacity in schools colleges and VTCs, develop and disseminate education materials on HIV/AIDS, and provide care and support to those affected. There may be some ambivalence within the Ministry: - one of the stated ‘challenges’ is that the advocacy approach ‘promotes sex’. Nevertheless, useful progress was made in 2005/6, with new curricula and examinations featuring HIV/AIDS messages produced for Standard IV- VII, and for post-primary vocational education, with supporting teacher training materials produced and disseminated. The MTEF includes enhancing the capacities of 9000 people (presumably teachers) in HIV/AIDS education, as well as some support for an HIV/AIDS database, for management meetings, and for monitoring and evaluation, particularly of the teaching of the new curriculum. There are a number of activities of the education institute that are also coded ‘A’, though it is unclear to us what their HIV/AIDS content is.

There remains a need to accelerate progress in developing the HIV/AIDS and life skills content of the school curriculum at all levels, ensuring that teachers are trained in how to use it and that teaching and learning materials are available to support it.

**Table 2.5 MOEC HIV/AIDS Budget and Expenditure TSh Millions**

| Target/Activity | 2006/7 Budget | 2006/7 Actual | 2007/8 Budget | 2008/9 MTEF |
|---|---|---|---|---|
| Improve basic education and vocational training in HIV/AIDS | 2000.0 | | 2200.0 | 2400.0 |
| Management committee meetings | 46.6 | | 90.0 | |
| TIE, writing and evaluating new courses | 52.4 | | 36.6 | 18.2 |
| TOTAL (MTEF) | 2099.0 | | 2326.6 | 2418.2 |
| TOTAL (IFMS) | 1570.0 | 50.00 | 2042.0 | |

### Water

The water ministry has a very limited role in HIV/AIDS. It undertakes work-place interventions for 1800 staff, and allows TACAIDS a tent at the annual 'Water Week.' Although water groups could be an opportunity for delivering HIV/AIDS messages, any such interventions would need to be organised via the LGAs.

### Agriculture

No significant expenditure identified or recorded. The Ministry of Agriculture has some responsibility to develop policy and tools on how to support vulnerable households involved in agriculture, including those headed by vulnerable orphans or widows, or lacking skilled and healthy members to work the land. They may also have a role in developing approaches to producing nutritional foods for PLWHA. These roles are identified in a 2006 strategy. However, implementation remains with the LGAs. The financing needed for developing the Ministry role is relatively modest, but is not currently provided for in the budget.

### Community Development

Community development was the only other department that disbursed more than TSh1bn of budget funds classified as 'Objective A' in 2006/7. In addition to work place interventions, the main expenditure has been on outreach via the 58 vocational training colleges around the country. It is not clear if all of the expenditure has been correctly coded. A large share of the reported spending on Objective A relates to building rehabilitation, construction of hostels, and related consultancy and equipment costs. Genuine HIV/AIDS spending thus seems to have been significantly over-stated, and is

probably little different from the far lower spending recorded in previous years. There were some complaints that the existing system of releasing TMAP funds (the main source used for actual HIV spending) causes uncertainty in the budget process by subjecting their plans to TACAIDS scrutiny before funds are released. We asked what was being planned or implemented to support the CHACs in their role in coordinating HIV/AIDS activities. Nothing very specific was mentioned. We were unable to secure a copy of the MTEF.

### Other MDAs

Defence has significant expenditure financed largely off-budget with PEPFAR support, particularly on care and treatment within their health facilities. Turning to the budget for 2007/8, the uniformed and prison services envisage disbursing between them about TSh7bn. Together with education and health, these are the branches of Government with large numbers of direct staff who are in high-risk groups. Defence also runs health facilities that offer HIV treatment to members of the armed forces and their families.

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No other MDA has significant budget provision. This reflects a limited and low-cost role of providing workplace interventions for relatively low numbers of staff.

## *2.3 Development Assistance for HIV/AIDS*

Total donor disbursement on HIV/AIDS in 2006/7 was about 14% above the projection made last year (Table 2.6).

### Table 2.6 Aid to HIV/AIDs TSh Bns

| Development Partner | 2006/7 Expected | 2006/7 Actual | 2007/8 Projection | 2008/9 Projection | 2009/10 Projection | 2010/11 Projection |
|---|---|---|---|---|---|---|
| USG | 190.4 | 260.8 | 385.7 | 381.4 | 381.4 | 381.4 |
| GFATM | 77.1 | 71.2 | 101.0 | 103.4 | 103.4 | 74.3 |
| IDA | 25.8 | 16.6 | 50.9 | 7.5 | | |
| CIDA | 11.8 | 11.0 | 0 | 11.5 | 0.7 | 0 |
| SWEDEN | 7.4 | 13.6 | 7.3 | 8 | 8.8 | 0 |
| NORWAY | 4.9 | 0.1 | 6.3 | 1.8 | 2 | 0 |
| NETHERLANDS | 4.7 | 0.1 | 6.2 | 0 | 0 | 0 |
| JAPAN | 3.9 | 2.3 | 4.2 | 7.3 | 2.8 | 0.1 |
| IRELAND | 2.4 | 1.7 | 3.5 | 2.8 | 0.3 | 0 |
| ITALY | 0.6 | | | | | |
| BELGIUM | 0.6 | 0.5 | 0.7 | 0 | 0 | 0 |
| UNDP | 0.4 | | | 0.4 | 0.4 | 0.4 |
| UNFPA | | | | 0.8 | 0.8 | 0.8 |
| UNICEF | 0.3 | | | | | |
| SDC | 0.3 | | | 0.5 | 0 | 0 |
| GERMANY | | | | | | |
| **WFP** | | | 2.4 | 6.8 | 6.8 | 6.8 |
| **Total** | **330.6** | **377.8** | **568.2** | **532.2** | **507.4** | **463.8** |

Sources: See Annex 1

With a further sharp increase in US funding compensating for lower than expected disbursement by IDA, a further massive increase to around TSh568bn is forecast for the

current year, and the higher spending is expected to be maintained at over TSh500bn per annum for the next few years. Although the projection shows some tailing off after 2007/8, there are a number of probable future commitments that are at this stage too uncertain for inclusion, but at least some of which are likely to materialise: - no allowance is made for probable maintenance of sector budget support, including funds from CIDA and possibly other donors, nor for any successor to World Bank TMAP, nor for future bids to the Global Fund.

The projected support is significantly higher than the best case scenario for the total resource envelope as identified in the February 2007 assessment made for the NHSP[6].

## Table 2.7 Aid Forecasts and NMSF 'Best case' Scenario Compared US$Mns

| | 2006/7 Expected | 2006/7 Actual | 2007/8 Estimate | 2008/9 Forecast | 2009/10 Forecast | 2010/11 Forecast |
|---|---|---|---|---|---|---|
| NMSF 'Best case' | 292.9 | | 318.1 | 351.2 | 382.3 | 413.5 |
| Our Forecast | 330.6 | 366.1 | 575.6 | 538.1 | 513.3 | 436.1 |

Source: Kireria and Ngowi, TACAIDS 2007; MOF Aid Database; and team estimates.

The US and the Global Fund account for 86% of donor support expected in 2007/8, and may reach more than 90% of the total in 2008/9. We therefore tried to analyse the distribution of support from these two donors in terms of the four targets identified in the budget (Table 2.8). For US support via PEPFAR, the analysis is based on the Country Operational Plan for 2006/07; for GFATM, it is based on applying the percentage shares in the approved budget for Round 4 to actual spending in 2006/07. The analysis shows that care and treatment represented 64% of combined US and Global Fund spending in 2006/7. Prevention was just 15% of total expenditure; economic and social support about 8%. We have not attempted a similar breakdown of total expenditure, because of the problems in interpreting the MDA expenditure data, but spending on care and treatment by these two donors alone represents 55% of all expenditure on HIV/AIDS in 2006/07. Other sources also spend heavily on treatment. For example, in the 2007/8 budget, the MOHSW is intending to spend TSh25bn on care and treatment funded from domestic sources and by donors other than the 'big two.' Care and treatment accounts for 60-70% of all spending on HIV//AIDS in Tanzania.

[6] Source: TACAIDS, Alexander M. Kireria and Daniel Ngowi, assessment of the human and financial resources for the revised HIV/AIDS national multi-sectoral strategic framework (NMSF), Final report, March, 2007

**Table 2.8 USG and GFATM Expenditure 2006/7 By HIV/AIDS Target, TSh Bns**

| | Prevention | Economic and Social Support | Care and treatment | Cross-cutting | Total |
|---|---|---|---|---|---|
| USG 2006-07 Financial year | 47.8 | 18.8 | 164.0 | 30.7 | 261.4 |
| GF Round 4 | 4.4 | 7.9 | 52.5 | 10.2 | 74.9 |
| Estimated total expenditure 2006-07: | 52.2 | 26.7 | 216.5 | 40.9 | 336.3 |
| % Shares US | 18.3 | 7.2 | 62.8 | 11.8 | 100.0 |
| % Shares GF | 5.8 | 10.6 | 70.0 | 13.6 | 100.0 |
| % Shares, Combined | 15.5 | 7.9 | 64.4 | 12.2 | 100.0 |
| % of all HIV/AIDS spending | 13.2 | 6.8 | 55.0 | 10.4 | 85.4 |

## *2.4 PEPFAR*

We examined PEPFAR expenditure in a little more detail, based again on the Country Operational Plan.

Treatment is allocated US$93mn in FY07, just over half of all PEPFAR support that is allocable by target. ARV drugs represent 10.9% of total spending, ARV services 38.5%. The GOT will continue to procure first-line regimens utilizing Global Fund resources, and USG ARV procurements will be limited to alternate first line, second line, and pediatric formulations. USG funds also will assist in the procurement of medications necessary for the treatment of opportunistic infections, test kits, and laboratory reagents. US procurement is undertaken directly by the Partnership for Supply Chain Management (PFSCMS). PFSCMS also supports capacity building and monitoring of supply chains, emergency and buffer stock procurements, and quantification.

Care receives US$52mn (28.9%). In the previous table, we adjusted these figures to show the orphan programmes under economic and social support (US$14.7mn) and paediatric AIDS (US$4.7mn) under treatment. Of the remaining budget for care, the largest components are palliative care and the treatment of opportunistic infections and TB. Support to counselling and testing (US$13.1mn) is also included under care. The intention was to particularly promote testing to adult men, as testing uptake among men remains low.

Prevention receives 20.7% of the budget. Nearly half of this relates to medical interventions to prevent transmission of the disease, including prevention of mother to child transmission ($11.5mn, 6.4%), and support to blood safety (2.4%) and injection safety (0.6%). US support is helping to expand PMTCT services to new sites, including support to HIV-positive women and their children, as well as trying to improve service quality and strengthening PMTCT-antiretroviral treatment (ART) linkages. At the national level, a standard training curriculum is being implemented, monitoring systems are being strengthened, PMTCT guidelines revised to introduce a more effective prophylaxis regimen, and job aids developed to promote infant feeding counseling.

Blood safety programmes aim to scale up to provide national level coverage through the National Blood Transfusion Services (NBTS) as an executive agency and a blood transfusion advisory board. Coverage will be extended to hard-to-reach areas by renovating regional and municipal hospital-based facilities.

The behaviour change component of prevention maintains US support of abstinence-be faithful (AB) programs including life skills training for youth, community outreach, and support for standardized messaging in accordance with the recently finalized National HIV/AIDS Communications and Advocacy Strategy. US support is helping strengthen programming for B messaging with the adult male population, to address high-risk social norms and discourage multiple partnering and cross-generational sexual practices. Although some US support is delivered via religious NGOs who focus only on the 'abstinence-be faithful' part of the message, PEPFAR also supports a comprehensive ABC (abstain, be faithful, and correct and consistent use of condoms) approach to reduce transmission in most at risk populations (MARPs), including specific workplace interventions and prevention messages to persons living with HIV/AIDS (PLWHA). Focused behavior change communication includes peer education programs, interpersonal communications, and other activities that directly interface with MARP target groups in high HIV transmission areas. USG aims to increase the variety of "edutainment" methods used, and increase the social marketing of condoms and associated behavior change. Interventions target the military and uniformed services, agricultural workers, people in prostitution, communities along the transport corridors, and a growing urban population of intravenous drug users, in order to reduce HIV transmission and link prevention services to the continuum of care.

Coordination poses a major challenge for PEPFAR. USAID is one of six US agencies or departments of Government that are running PEPFAR programmes in Tanzania, and accounts for less than half of the total spend. Some $25mn of the $205mn allocated in 2006/7 was centrally managed from Washington. Implementation is via a very large number of NGO partners. The annual planning meeting is a huge affair, rivalling in scale the Government-run bi-annual review of the NMSF. The regionalization that occurred among USG treatment partners in fiscal year 2006 has helped to reduce the degree of institutional complexity and overlap, and is to be introduced in palliative care and, 'to the extent possible', with OVC programs. Internally, the USG meets on a weekly basis with agency heads of the Interagency HIV/AIDS Coordinating Committee (IHCC). This body, chaired by the Deputy Chief of Mission, oversees all USG activities and is the arbitrating body for internal matters. Nevertheless, the number of individual activities and actors involved remains huge, and the administration and coordination costs are undoubtedly higher than would be the case with a more concentrated programme. Although the identified cross-cutting and management costs are shown as just $24mn in the COP, this does not include the management and overhead costs of the contracted partners who actually deliver the programmes.

## *2.5 GFATM*

The two GFATM programmes concerned with HIV/AIDS are:-

i. The Round 3 HIV/AIDS and TB programme has an approved phase 1 budget of $83mn for scaling up VCT. It started in September 2004, and phase 1 should have ended in September 2006, but there has been no disbursement from GFATM since April 2006, and total expenditure has only reached $20mn. Round 3 HIV has three Sub-Recipients, namely AMREF, CSSC (Christian Social Services Commission) and Ministry of Health and Social Welfare. TACAIDS is still waiting to hear whether a further disbursement request for US$17mn will be approved.

ii. The Round 4 GFATM HIV/AIDS grant has a total commitment of $293mn for a five year programme approved in September 2005. Only disbursement of the phase 1 $88mn has been approved, and actual disbursement is just $59mn. Government is waiting to hear the fate of the latest disbursement request for a further $59mn.

The long delays experienced are very largely attributable to a GFATM approach that ignores domestic planning, budgeting, approval and implementation timetables, and requires multiple approval stages before funds are finally released for spending. The fate of disbursement requests is very uncertain, as is the timing of approvals, making it difficult to rely on GFATM financing actually being available. MOHSW has been understandably reluctant to include GFATM funds in the budget before disbursement approval has been secured, but this has caused problems when the funds are finally approved, necessitating the concerned Ministry re-allocating the budget or obtaining a supplementary budget to enable the funding to be spent. We were told this had occasioned a 4-5 month delay in MOHSW. Quarterly meetings between key stakeholders and the Ministry of Finance are now being held to try to avoid this problem re-occurring, the probable solution being to include a provisional sum for GFATM in the budget subject to the funding being subsequently received.

The NGO partners (AMREF and CSSC) have also suffered from the uncertainty of GFATM support. They had been asked to prepare detailed work-plans, but then had to find alternative funding sources to maintain momentum when promised funding did not arrive when expected.

## *2.6 Conclusions on Financing Trends*

There are few precedents for how Government can retain (or acquire) the lead role that it ought to have in policy and planning when 95% of the funding is coming from external aid, with over 80% of it off-budget, and subject to parallel planning and approval processes that are dominated by the donors. The expansion of treatment involves Government committing itself to long-term obligations to provide free treatment, obligations that it can not possibly afford from domestic sources. These obligations are being financed with external aid that is far from secure. Aid from the two largest donors who account for over 80% of total spending on HIV/AIDS is committed annually, and is uncertain as to what funds will be approved, what they will be used for, what conditions or restrictions will be imposed, and how long the funding will be sustained. Although both of the 'big two' donors accept the moral case for sustaining financial support to patients started on ART, both are also subject to political and institutional processes where the outcomes and timing are uncertain and difficult for anyone to control. PEPFAR

has so far proved the more reliable and predictable source of funding of the two. With Government now at best a marginal source of funding for HIV/AIDS programmes in Tanzania, and with most of the action happening off-budget, there is an urgent need for a 'donor expenditure review', which need not wait until next year. The objectives would be partly backward looking (what is being financed, what impact is it having), and partly aimed at advising on the future( facilitating discussion with stakeholders on what more can and should be done to bring the external partners more fully within a coherent policy and expenditure framework under Government leadership). It is important to stress that any such review would need to be done in a supportive way that recognises the contribution of external donors, and the constraints within which they have to work. The objective is to find constructive approaches for improving planning, coordination and sustainability. For the review to achieve its objectives, the reviewers will need to have credibility and be trusted by the donors as well as the Government.

Recommendation 4. Undertake a 'donor expenditure review' in HIV/AIDS, to improve understanding of how off-budget funds are used, what impact they are having, and to advise on how Government can exercise leadership and have a positive influence over the allocation and management of external support for HIV/AIDS.

In the case of the GFATM, many of the difficulties are systemic, and have been documented in other countries as well as Tanzania. Although change requires action beyond Tanzania, every case study example adds to the pressure for change. If donor members of the DPG accept the criticisms of the GFATM approach, they should raise them with their head offices at as high a level as possible. GFATM procedures are incompatible with Paris principles of donor coordination and with the 'three ones' approach that the donors (including GFATM) have signed up to[7].

Recommendation 5. DPG members should ensure that senior HQ staff responsible for GFATM are aware of the problems that make Global Fund support to Tanzania unpredictable and difficult to integrate within national plans and budgets.

# 3. Local Government and HIV/AIDS

This chapter is based on:-

i. Review of budget and expenditure data and of documents in Dar es Salaam, including review of the performance budgets of 18 districts;

ii. Discussions with informants in Dar es Salaam;

[7] 'UNAIDS, together with the Global Fund, bilateral donors and other international institutions, has committed to three new principles of harmonization called the *Three Ones*. These are: one agreed HIV/AIDS action framework, which provides the basis for coordinating the work of all partners; one national HIV/AIDS coordinating authority with a broad-based multi-sectoral mandate; and one agreed country-level system for monitoring and evaluation.' Aid effectiveness in health: executive summary. Contributed by: the World Bank and the World Health Organisation. Global forum on development: pre-meeting on aid effectiveness in health, 4 December 2006.

iii. Visits to 5 LGAs (Kongwa DC in Dodoma, Kilombero and Mvomera in Morogoro region, Kinondoni MC in Dar es Salaam, and Mkuranga DC in Coast region).

## *3.1 Financing LGA Expenditures on HIV/AIDS*

The main sources of funding for planned and budgeted LGA spending on HIV/AIDS have been World Bank TMAP money disbursed via TACAIDS, and the HIV/AIDS earmarked grant that is presently funded by CIDA.

Substantial amounts of Global Fund money also goes to LGAs, but the GFATM approve funds for a twelve month period starting from the date of the signing of the agreement. Final versions of the LGA budgets have to be prepared and approved before the Tanzanian budget starts in July, at which time there is no certainty as to what GFATM funds will be available. The funds and the work programme approved by GFATM therefore do not form part of the approved budget of the LGA. What happens in practice is that there is a dual budget and dual reporting on it. The GFATM operates to a separate, parallel budget cycle and finances what is in effect a parallel plan with different approval timings, and requiring quarterly reports to a different format that have to be prepared at irregular intervals not corresponding to those of the budget. LGAs do their best to integrate the programme within their overall plans, but it represents very bad donor practice completely at odds with the international agenda of increased alignment and harmonisation, and inconsistent with the 'three ones' principles (one coordinating structure, one implementing plan and one monitoring and evaluation system at central, regional and LGA levels).

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GFATM money in 2006/7 included TSh6bn for some 40 districts under Round 4, and roughly TSh 550mn from year two of Round 3 for some 19 local authorities. The Round 3 money went to the council health management team. We heard complaints from one LGA that the GFATM money bypassed council decision-making and went directly to the DMO.

The health-related aspects of HIV/AIDS spending at LGA level are mainly financed from funds that are either centrally managed, or are off-budget at LGA level. ARV drugs and some other supplies are largely financed from central funds and delivered in kind, significant parallel support is delivered to facilities via PEPFAR partners, and GFATM provides support for VCT under Round 3 and for a broad range of local activities under Round 4 that are as we have seen outside the approved budget. The other major cost, the time of health sector staff spent on HIV/AIDS, is financed from the PE budget, and we have not costed it. Some health basket expenditure is also spent on HIV/AIDS.

The 2006/7 budget guidelines indicated that TSh 12bn would be available via the new HIV/AIDS earmarked block grant, and every LGA prepared a budget for HIV/AIDS at least equal to the funding that it had been advised that it would receive from that source. The expected TSh12bn HIV/AIDS grant funding for LGAs was intended to be spent on financing the HIV/AIDS plan prepared by the council, and to be consistent with the guidelines issued by TACAIDS on the 'minimum essential package' of interventions.

The 2007/8 budget guidelines required LGAs to observe the following proportions when allocating the grant:-
25% for allowances for supervision, distribution, outreach, short-term training,
25% for transport for supervision
10% for training, mainly for local level
25% for support to orphans and PLWHAs
15% for minor repairs and maintenance at facility level

Although these percentages are said to be 'maximums', they add to exactly 100%, which means they are also 'minimums' if the LGA wishes to spend the entire budget. Although these shares do not identify the objective or target to be supported, the nature of the expenditure categories implies that the main intention is to support the prevention and impact mitigation objectives. It is these targets that are mainly supported through spending on transport, supervision, training, and direct support to households, rather than the health-related interventions that would imply more of a focus on material supplies.

In 2006/7, the proposed HIV/AIDS grant was almost the only source of direct support that LGAs expected to receive for spending on prevention and economic and social support. In the event, the CIDA grant was not signed until half way through the year, and the proposed TSh12bn was removed from the 2006/7 budget at a late stage after LGA budgets had been finalised. The only central funding actually received by LGAs for non-health aspects of HIV/AIDS was a total of TSh1.5bn from TMAP, distributed between 55 of the 133 LGAs (those not in arrears in accounting for past advances). The result of the TSh10.5bn shortfall was that 2006/7 was the second year in a row in which LGAs were encouraged to prepare ambitious plans that could not then be implemented due to lack of funding. This undermines the credibility of the whole planning and budget process, as well as causing real hardship when needed support is not provided.

TMAP funding of LGAs has ceased with effect from 2007/8, partly because of the continuing problems of obtaining financial reports to account for advances using TMAP funds, but mainly because of the availability of Canadian financing for the new HIV/AIDS block grant. It is therefore of great importance to institutionalise the HIV/AIDS grant as a source of budget funding on which LGAs can rely.

Some TSh1.8bn was finally released from the HIV/AIDS earmarked grant in August 2007, for financing activities originally planned under the 2006/7 budget. In the districts we visited, these funds were quickly used, although Treasurers complained of the problems of releasing funds to finance expenditures within a budget year that was long closed by the time the funds arrived. In those cases where activities from the previous year had not been brought forward and included in the current year budget, financial control is potentially undermined by funding activities for which there is no current budget provision.

For 2007/8, the LGA budget for HIV/AIDS as reflected in the central Government MTEF consists entirely of the new HIV/AIDS block grant, although once again individual LGAs are planning to finance additional activities, mainly health related, from other sources

including the health basket, and these are captured in LGA MTEFs. Once again, GFATM is not included because the third year Round 4 action plan and budget had not been approved as the budget was finalised. Most LGAs also include some spending from other sources such as the balance of GFATM spending approved the previous year and some contribution from health basket funding, but the MTEFs have not been centrally consolidated by objective, and the budget figures shown in Table 2.9 are limited to the expected LGA grant. Adding the proposed and requested GFATM support to districts to the HIV/AIDS grant indicates that Global Fund are nearly half of central funding for LGA expenditures. However, their funding has not been approved as yet, half way through the financial year, and only around half of districts are expected to benefit.

## Table 2.9 Expected HIV/AIDS Transfers To LGAs, 2007/8 TSh

| 2007/8 LGA Budget for Objective A | Additional Funds Not In 2007/8 LGA Budget | | | Forecast |
|---|---|---|---|---|
| HIV/AIDS Grant | 2006/7 HIV grant actually paid in 2007/8 | Requested GF 2007/8 round 3 transfers | Requested GF 2007/8 round 4 transfers | Total funds to LGAs 2007/8 |
| **15,520,000,000** | **1,852,000,000** | **2,031,265,650** | **14,191,883,784** | **33,595,149,434** |
| 46.2 | 5.5 | 6.0 | 42.2 | 100.0 |

The approved LGA MTEFs envisage a 2007/8 HIV/AIDS budget of TSh15.52bn, based on the external finance expected to be available from CIDA. The introduction of the President's initiative on voluntary counselling and testing required additional funds for regions to finance the campaign, and TSh1.9bn has been allocated to the regions for this purpose, and removed from the funds available for the LGAs. However, this is balanced by the TSh1.85bn 'for 2006/7' that was actually only disbursed in 2007/8, and the total releases to LGAs in 2007/8 should on present plans be close to the original budget:-

| | |
|---|---|
| Disbursed in August 2007 | TSh 1.852bn |
| Disbursed in November 2007 | TSh 6.099bn |
| Balance carried forward | TSh 1.445bn |
| Expected from CIDA in Jan-March 2007 | TSh 6.086bn |
| Total for Year | TSh 15.482bn |

This assumes that the balance of the funds will be released to LGAs without further pro rata reductions to finance the costs of the regional administrations.

Late release of the funds for 2007/8 reflects late approval of the national budget. Although the budgets of the LGAs had been approved in June, it is the practice of the MOF not to release funds (other than for personal emoluments) until the national budget has been approved by parliament. Parliament received the budget in mid-June but did not approve it until end August. Actual disbursement decisions by the MOF are based on availability of funds, since Tanzania runs a 'cash budget.' This should not have occasioned any further delay, since CIDA funds had been disbursed, and the plan was to

disburse funds in September. Further delays were occasioned by the perceived need to adjust the allocations, firstly for exchange rate changes reducing the TSh value of the CIDA grant, and secondly because the president's initiative on voluntary counselling and testing required funds for regions, some of which were taken from the HIV/AIDS grant. By the time the adjustments had been agreed and disbursements made, it was 10th November. The funds released by MOF in November had yet to reach three of the five LGAs we visited in early December, probably reflecting delays within the banking system.

Although funds are now available, it is very undesirable that they have been released late. MOF has still not released all of the funding made available from CIDA. The funds have been split into two halves, and TSh1.445bn of the funds that are already available from CIDA have been held back for later disbursement. The LGA can not rely on funds until they are actually received, and indeed they are normally given no advance warning (LGAs did not know that funds had been released, and hence were unable to make enquiries of their bankers). Funds received half way through the year leave too little time for implementing the activities in a way that meets the original objectives, especially with regard to time-specific programmes such as the purchase of school books or uniforms, but all activities will require time to organise and to procure necessary materials. The theoretical alternative of giving advance notice of the expected disbursement schedule would have no credibility with LGAs, given past failures to disburse on time, and would not enable them to start activities.

Recommendation 6. In order to permit LGAs to plan and implement prevention and economic and social support activities, MOF should make provision for the HIV/AIDS earmarked block grant in their budget plans each year without it being dependent on the timing of a specific external grant to finance it.
Recommendation 7. Donors providing financial support for the HIV/AIDS block grant should negotiate with MOF for earlier and full release of the grant

## *3.2 LGA Planning and Budgeting for HIV/AIDS*

**Review of 18 LGA Performance Budgets**

In addition to the five LGAs that we visited, we reviewed the content of the 2007/8 'performance budget' in one randomly selected LGA in 18 of the 21 regions. Overall, the plans appear to mention a range of generally appropriate interventions, but are limited in scope, partly due to the limited budget that LGAs expected to have available in 2007/8. Summarising this information:-

i. All but one of the 18 LGAs prepared a performance budget, and had HIV/AIDS activities listed under Objective A, though one LGA reported on overall health sector improvements under the HIV/AIDS and service delivery target. The definition may need clarifying to avoid future misunderstandings. The highest number of identified HIV/AIDS activities was 23, most have 10-15 discrete proposals, but a significant number have only 5-10 often limited to sensitization, training, and activities to support the CHAC;

ii. Nearly all LGAs have included at least some training and sensitization activities for LGA staff and for MACs at various levels. A couple of LGAs have included relatively expensive transport and communications equipment within their MTEFs (e.g. Dodoma MC intended to buy a car), and one or two plan to spend on upgrading council facilities for the CHAC, but the overall focus does not justify the criticism occasionally voiced by TACAIDS staff that LGAs can not be trusted to make good use of HIV/AIDS funding.

iii. At least some prevention activity was planned in most LGAs (14 of the 18). This includes work with schools (5) and youth groups (3) and adult education(3); with a range of methods mentioned including distributing condoms (4), work using peer educators (4) and drama groups (3 examples). There are examples of targeted outreach to high risk groups (3 examples), and cases where other departments have been involved not only in WPI, but also in outreach, for example via the transport department working with road gangs. Health related prevention interventions include interventions on STIs (5 examples), and with traditional healers (2).

iv. About two thirds of LGAs include support for orphans normally in the form of school uniforms and fees for secondary school, and 11 of the 18 provide economic and social support to PLWHAs, typically income generating activities but with some providing nutrition advice and support. The numbers being supported under each category are typically small, reflecting the limited budget available.

v. Care and treatment interventions are mainly concerned with home based care, VCT, PMTCT, and supportive investments in CTCs. Most of the major expenditure planned on treatment is presumably mainly either off-budget or not mentioned under Objective A.

**Field Visits to 5 LGAs**

Within the five LGAs that we visited, there is a participatory process for preparing the overall LGA plan and budget, with the involvement of village and ward level. However, we were told in Kilombero that HIV/AIDS does not rank high among community level priorities, and would be unlikely to feature in village plans unless funds are earmarked for the purpose. The HIV/AIDS plans therefore involve at best a constrained form of participation. Multilateral HIV/AIDS committees exist in the districts we visited at village, ward, and district level, but in three of the districts the village and ward committees are inactive due to lack of funds for sensitisation and facilitation, while in one district the CMAC did not meet at all in 2006/7 due to lack of funds for members expenses. In principle, HIV/AIDS priorities are established via proposals put forward from the village level, and then discussed at ward and district level, with decisions on priorities involving council members representing each ward. Within the districts we visited both this year and last, the highest priorities coming from the villages are economic and social support for orphans and vulnerable children; and economic and social support and home-based care support to households affected by HIV/AIDS. Village level planning seems to need fairly active facilitation by the district. The COMATA approach to village level HIV/AIDS planning that was first used in Hai

district is also being adopted in Kilombero, and a major activity in their budget is to provide financial support for the implementation of village plans developed using the approach.

The extent to which stakeholder views are in practice taken into account in decision-making was questioned in Kilombero. The constitution of the CMACs does not give voting rights to community representatives, and we were told that decision-making is in practice dominated by the elected councillors. A case can be made for this system, based on the argument that they are democratically accountable via the ballot whereas community representatives are not and may in practice represent the interests of the particular group they represent rather than taking a broader view. We make no recommendation, but it might at some stage be worth researching the way in which CMACs are operating in practice in order to identify whether there is a case for change.

**Guidance to LGAs on the 'Minimum Package.'**

The draft guidance on a 'minimum package' of HIV/AIDS interventions is incorporated in the working draft of the 'Medium term Strategic Planning and Budgeting Manual for RS and LGAs.' Each of the activities within the minimum package is given a unique target number, with activities listed under each target. In principle, reporting against these Segment 2 codes would provide comparable data as to exactly what LGAs were planning to implement, what they were budgeting and actually spending and, via their performance reports, what they actually achieved in terms of output. Before discussing the problem of consolidating this reporting, there are some important points to be made about the content of the 'minimum package.'

The draft guidance[8] lists over 60 activities that are described as things that each LGA 'must have' in their plans, plus a further 17 described as 'nice to have.' All of them involve costs, some of them substantial costs. Simple division of the available LGA budget by the number of 'must have' activities suggests that this is unrealistic: - the average spending per intervention would need to be less than TSh2mn based on this year's MTEF. Even if affordable, the management burden is clearly beyond anything that LGAs could be expected to manage, given that the CHAC and the DAC both have other responsibilities beyond HIV/AIDS. It compares with LGA plans currently including typically 10-20 activities, with no district we examined having more than 23.

Moreover, it is at least arguable that the existing approach to HIV/AIDS at LGA level is already too scattered, doing too many different things at too small a scale to have real impact. The LGA plans we reviewed involve a number of activities, but most of them on a very small scale relative to the population of the district. Of course, the LGA is not the only stakeholder, and Kilombero for example tries to focus support on the more distant wards, in order to offset the urban bias of the NGOs and CSOs. Nevertheless, current plans in most areas are barely touching the surface of the problem. Given the limited financial resources, and even more limited implementation capacity, there is an urgent need to prioritise based on evidence of where resources can be most effective.

[8] Plan of Operation: HIV and AIDS responses by LGAs

The existing draft of the minimum package does not include any specific material on how to go about implementing any of the proposed interventions, nor does it refer readers to where guidance might be found. The scarcity of detailed guidance may partly reflect the fact that significant LGA spending on HIV/AIDS is still relatively new, and it would be wrong to limit the scope for local initiative and adaptation, especially as international evidence on the most effective approaches is also relatively limited[9]. It may also be that this is intended to be included in the final version. TACAIDS has been working on producing guidance and manuals in a number of areas. A manual on behaviour change has been developed by TACAIDS, and will be disseminated to all stakeholders. The TACAIDS department dealing with the district and community response is working on modification of 11 training modules to reflect on OVCs, gender, parenting skills, counselling, nutrition, and basic facts on ART. A training guide has been developed by TACAIDS, ILO, GTZ and AMREF for use by the private sector[10]. Detailed curricula and supporting teaching materials have been developed by MOEC for use in schools.

It is clearly the case that Tanzania can learn from experience of what has worked elsewhere, and each district can learn from the experience of others. TACAIDS and other national partners such as AMREF have developed specific guidance in a number of areas, and there may be far more available than we are aware of, but we did not find it much in evidence at LGA level, and LGAs were in some cases developing their own training materials. Some of the CHACs are relatively inexperienced, and may need more detailed guidance to help them to implement the minimum package.

We recommend that the minimum package be supplemented by TACAIDS developing a series of user friendly supporting material for each intervention, including 'how to' notes with appropriate examples of sensitisation, training, and learning materials, 'what works' evidence, and contacts and links for those with computer access. All of this material should be accessible via the TACAIDS website, with paper copies of operational guidance made available to CHACS and kept regularly updated. It should become the basis of a regular programme of training for new CHACs and refresher and professional development training for existing ones.

Recommendation 8. The minimum essential package of interventions should be subject to detailed review with development partners and experienced CSOs, together with representatives of those at LGA level expected to use it (the CHACs), and be re-cast as a menu of options, with clear guidance on how to prioritise.
Recommendation 9. The minimum package should be supported with best-practice guidance and supporting materials related to each of the interventions, and information on where to get further advice. It should become the basis for pre and in-service training

[9] References found in an internet search include:- Epstein, Helen, The Invisible Cure: Africa, the West, and the Fight Against AIDS (2007); Bertozzi S, Padian NS, Wegbreit J, et al. HIV/AIDS Prevention and Treatment. In: Disease Control Priorities in Developing Countries. April 2006; Wegbreit J, Bertozzi S, Demaria LM, et al. Effectiveness of HIV prevention strategies in resource-poor countries: tailoring the intervention to the context. AIDS. 2006; 20:1217-1235.
[10] TACAIDS Annual Report 2006-07 (draft).

for CHACs. The material needs to be kept under review, supported by action research to update and extend knowledge of 'what works', based on Tanzanian and international experience. Some of this is already happening, but TACAIDS may need additional staff resources to expand capacity to fulfil this challenging role.

## *3.3 LGA Support of CSOs*

In principle, one way to supplement limited LGA capacity is to contract out the implementation to others, particularly NGOs. However, the LGAs we visited are providing support to primary recipients including community based groups such as local groups of PLWHAs and are supporting village level initiatives, but they are keeping control of the disbursement of the funds, and are not themselves providing support via other implementing agencies such as NGOs. They are involved in the appraisal and approval of NGO projects supported under the TMAP CARF, but the disbursements are administered by the RFAs, and it is doubtful if LGAs would choose to spend money via NGOs if given a free choice. There is strong mutual suspicion, with LGAs we visited complaining of the lack of NGO transparency and unwillingness to provide reports on their activities. There is also some fear of the risks of sub-contracting to NGOs, exacerbated by the lack of clear procedural guidance on how to go about this.

There is wide recognition that the RFAs have been an expensive mechanism for disbursing funds to CSO projects, as the 2006 PER argued, and there is an on-going discussion of what should replace them. Existing contracts end in 2008. Options under discussion include:-

- Extending the contracts of RFAs that are performing well until the new end date of TMAP in 2009;
- Performing the same functions, possibly with some of the same staff, but bringing the RFAs within TACAIDS as a 'regional' arm of the organisation.
- Bringing the responsibility for supporting CSOs at local level within the LGAs, who already do much of the work in collaboration with the under-staffed and under-resourced RFAs.

An appropriate institutional mechanism needs to be developed to provide guidance and supportive supervision to the LGAs in carrying out this role. The sustainable longer term solution for supporting LGA work on multi-sectoral aspects of HIV/AIDS is to reinforce capacity within the RAs. There could therefore be a case for financing dedicated staff in each region, with an appropriate travel and subsistence budget. The role would be to provide supportive supervision of the CHACS and to provide support, guidance, and training to help them in implementing their HIV/AIDS programmes, both those that are directly implemented, and those that are earmarked for support to CSOs. It would make sense to also try to continue to make available expertise from NGOs and CSOs operating in the region, continuing the supportive role that the stronger RFAs had begun to develop. The regional CHAC could perhaps be provided with a budget for sub-contracting some institutional support services to CSOs, who would be tasked with helping to build capacity in smaller CSOs and CBOs working on HIV/AIDS in the region. To minimise the risk of abuses or of wasteful expenditure, there could be a national process for

accreditation of NGOs with the skills to fulfill the support role, and national agreement on rates of remuneration.

Making LGAs responsible for programmes of support to CSOs is relatively novel, and will take time to set up. There may be a case for piloting initially in just one or two regions. As with any pilot, the evaluation will need to be designed before the pilot starts in order that necessary baseline and comparative data can be collected to ensure that lessons can be learned. Meanwhile, continuity of support to CSO programmes needs to be maintained, which may require an extension to the contracts of those RFAs that have performed satisfactorily.

Recommendation 10. LGAs should be responsible for channelling financial support to CSO projects, via an earmarked block grant, with RAs provided with staff and travel and subsistence budgets to provide supportive supervision.
Recommendation 11. TACAIDS will facilitate detailed operational guidance, cleared with relevant authorities, and covering practical matters such as fund flow, procurement, financial and physical monitoring.
Recommendation 12. Regional capacity to support CHACS and CSOs in receipt of block grant funds should be supplemented by sub-contracting institutional support functions to NGOs accredited to provide these services.
Recommendation 13 New institutional arrangements should be piloted and evaluated before national adoption.
Recommendation 14. While future arrangements are being put in place, consider extending the contracts of RFAs to maintain some continuity.
Recommendation 15. Support to CSOs should include longer-term financing of programmes to support PLWHAs and OVCs.
Recommendation 16. In the spirit of increased decentralisation, individual CSO projects should no longer go to TACAIDS centrally for approval, but should remain within the authority and accountability of the LGA, as an intrinsic part of the LGA budget.

## *3.4 LGA Financial and Physical Reporting*

Ministry of Finance in Dar es Salaam hold copies of the final approved MTEF for every LGA in the country, and we were able to take the volumes for the LGAs that we visited to the field with us. These set out clearly the activities that are planned to be undertaken under all objectives, including Objective A (HIV/AIDS), and how those activities are intended to be financed. They also set out the physical performance targets, for example numbers of teachers to be trained or VCT tests to be completed. Each LGA is obliged, in consultation with PMORALG, to submit a quarterly performance report to MPEE and to MOF, and to prepare and submit an annual performance report with additional written explanation of performance. The first quarterly performance report for 2007/8 has just been submitted, and we were able to review an example, and satisfy ourselves that it included the required detail on physical performance and financial expenditure by HIV/AIDS target. Unfortunately, we were not able to obtain the quarterly performance reports submitted in respect to the 5 LGAs we visited, although we did obtain

performance reporting that was prepared for the district council, and that would form the basis on which the overall quarterly report is prepared.

There is at present no simple way to aggregate the quarterly performance reports from 133 LGAs. For preparing the budget and the MTEF, LGAs are using the PLANREP software. This enables consolidated reporting of the budget to be prepared relatively easily by importing the data directly into the database, without any manual re-entry or cutting and pasting of data. However, LGAs are experiencing difficulty in using the PLANREP facility for reporting actual expenditure, and the quarterly reports have been prepared manually and submitted in spreadsheets or hard copy. These can not be directly imported into PLANREP. Preparing a consolidated report on HIV/AIDS spending would require PMORALG to scan through every quarterly report looking for expenditures against Objective A, and manually enter or cut and paste into the database in order to generate a report. This is what is done at present in order to generate the reports on sectoral expenditure that are reported on the 'logintanzania' web-site, but they do not at present include any reporting specifically on HIV/AIDS. Capacity to prepare existing reports is already inadequate, and adding a responsibility to report on HIV/AIDS would be unwelcome, and would be unlikely to result in reliable and timely data.

It is not straightforward for LGAs to keep track of expenditure by objective. Although the full 28 digit code is used for preparing the budget, 'segment 2' (the objectives and targets) are not used for financial control purposes. The approved estimates identify the vote, the sub-vote (e.g. health services), and the detailed item code (e.g. postal charges), but not the specific activity. The Treasurer reports to finance committee against these control ceilings, not against targets and objectives. Requests for funding sent to the treasurer do not necessarily quote even these parts of the budget code, still less the objectives and targets, but the treasurer can readily check if e.g. the community welfare department has sufficient budget provision for per diems to enable him to release funds for a specific request. However, he is not in a position to report spending by objective. It is the individual departments that are able to report how what they have spent relates to objectives and targets, and what has been achieved against the targets. In order to overcome this problem, Kilombero is introducing a system whereby the department requesting funds is required to state in detail the balance available in the budget against the objective, the amount required, and the closing amount, making them responsible for monitoring spending against the estimated cost of the activity.

Although the department heads are the source of information on performance against targets, they are not the ones who have been trained on PLANREP. In order to prepare a quarterly report, the planning officer needs to obtain returns from each department on spreadsheet or in manual form, and check that the expenditure numbers add up to the right amount as recorded by the treasurer. Translating the quarterly report into PLANREP would require someone who knows and can use the system to manually key in all of the data provided by department heads. The planning officer may know how to use the PLANREP software for reporting purposes (in Kilombero, both the Treasurer and the Planning Officer were clearly conversant with the system, and the Planning officer demonstrated how he will use it for generating the second quarter financial and physical

performance report). However, there may be transactions costs in actually using it for reporting.

A big push is underway to train staff on how to use the system for expenditure reporting. This is the best solution, but it does not solve the immediate problem of how to generate the reporting that CIDA require on the use of the HIV/AIDS grant. We return to this issue in our discussion of financing instruments in section 5.

# 4. Implementing the National Multi-Sectoral framework

## *4.1 Costs and Resources for the NMSF and the HSHSP*

Two new strategic planning documents are in the process of finalisation:-

i. The new National Multisectoral Strategic Framework, the final draft of which was prepared in July 2007;
ii. The new Health Sector HIV and Aids Strategic Plan (HSHSP) 2008-2012 is in a fairly advanced draft.

Including complementary investment in health facilities and strengthening of health staffing, the health sector HIV and AIDS strategic plan envisages expenditure averaging US $444-486mn per annum over the next five years, depending on whether scenario 1 or scenario 2 prevails. The NMSF, which focuses more on the multisectoral aspects, is a more broad-brush strategy document and has not been explicitly costed. Indeed, costing it would be impossible in the absence of operational plans, but expenditure on non-health aspects of prevention and economic and social support would need to be added.

We have estimated that total resources available for HIV/AIDS over the coming MTEF period are likely to be in the range of TSh540-TSh590bn per annum, averaging $445mn per annum. As explained in the previous paragraph, the health HIV/AIDS plan is estimated to require $444-$486mn per annum. In other words, the health sector HIV/AIDS plan alone would require more than the entire sum currently forecast to be available, before considering the non health-sector costs of the multi-sectoral response to HIV/AIDS. We have pointed out that the external aid commitments to HIV/AIDS implied by this level of support are equal to between one quarter and one third of total aid to Tanzania, and have suggested that this is already disproportionately large, and that there is no case for further increasing the level of support. For example, the scenario 1 estimate of the costs of HIV health sector spending in 2009/10 would be equal to 8.8% of total public expenditure in that year, before even considering the multi-sectoral response. This admittedly includes human resources and health facility improvements that go beyond simply HIV/AIDS, but it represents a share of public expenditure that will be very difficult to afford, given the many other calls on scarce resources.

The cost estimates quoted in the draft HSHSP are derived from an MKUKUTA costing exercise done in 2006, and appear a little strange, and inconsistent with other aspects of the plan. The HIV/AIDS direct costs are shown as being broadly constant over the next five years. This is somewhat surprising, given that the number of patients on ART is

planned to quadruple to 400,000 over this period[11]. The bulk of the increase in costs consists of additional expenditure on human resources and, to a lesser extent, additional spending on health facilities. Both could presumably be stretched out over a longer time frame. Indeed, the wisdom of embarking on a substantial increase in payroll costs funded externally with short term aid commitments could be questioned.

The focus on human resources seems slightly inconsistent with other tables in the plan which propose that half will be spent on care and treatment, 20% on health-related aspects of prevention, and 30% on health systems and facilities improvements.

**Table 4.1: Mkukuta based MDGs costing for the Health Sector sub-sector –HIV and AIDS, HRH and Health facilities- Scenario 1 US$**

| | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Total |
|---|---|---|---|---|---|---|
| *HIV* | 51,045,150 | 51,198,084 | 51,354,930 | 51,515,789 | 51,691,093 | 256,805,046 |
| *HRH* | 144,101,046 | 190,443,228 | 243,016,031 | 302,702,506 | 370,492,897 | 1,250,755,708 |
| *Health facilities* | 186,619,692 | 188,192,254 | 189,395,495 | 147,483,378 | 214,735,233 | 778,942,674 |
| ***Total*** | 381,765,888 | 429,833,566 | 483,766,456 | 354,218,295[12] | 636,919,223 | 2,286,503,428 |

**Table4.2: Mkukuta based MDGs costing for the Health Sector sub-sector –HIV and AIDS, HRH and Health facilities- Scenario 2 US$**

| | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Total |
|---|---|---|---|---|---|---|
| *HIV* | 51,045,150 | 51,198,084 | 51,354,930 | 51,515,789 | 51,691,093 | 256,805,046 |
| *HRH* | 126,546,636 | 162,482,114 | 203,109,708 | 249,105,024 | 301,190,126 | 1,042,433,608 |
| *Health facilities* | 186,619,692 | 188,192,254 | 189,395,495 | 147,483,378 | 214,735,233 | 778,942,674 |
| ***Total*** | 364,211,478 | 401,872,452 | 443,860,133 | 300,620,813[13] | 567,616,452 | 2,078,181,328 |

Source: HSHSP

A more credible and detailed costing and prioritisation exercise clearly needs to be undertaken with respect to both plans. The existing pattern of expenditure and of aid commitments is clearly inconsistent with the priorities of the HSHSP, with spending on care and treatment taking a considerably larger share than half of total spending.

The health sector plan contains explicit analysis and quantification of the gaps between existing coverage and the numbers in need of specific services. This is helpful for prioritisation. Striking comments include:-

- Only a few women (17%) and men (19%) know that there are special drugs that can be given to pregnant women infected with HIV to reduce the risk of transmitting the virus to the baby[i].
- Limited access of pregnant women and children to a comprehensive package of Reproductive Health and HIV prevention, care and treatment services
- Adolescent sexual and reproductive health is not mainstreamed into HIV/AIDS at all levels, IEC and BCC interventions targeting young people are inadequate,

[11] NMSF says more than 70,000 were on ART as at the end of 2006. PEPFAR 2007 COP quotes a national target of 85,000 on ART at the end of FY 2006-07, targeted to increase to 125,000 by end of FY 2007-08.
[12] There appears to be an error in the original source, this should sum to over $500mn.
[13] There appears to be an error in the original, this figure should be US$448mn.

coordination between partners is weak at all levels, the majority of IEC interventions use ineffective channels of communication for effective behavior change

- Public awareness of core interventions is still low, with many myths and misconceptions, but BCC programming remains weak, with inadequate human resources at all levels, messages not contextualized to local settings, poor linkages and coordination at all levels, no monitoring tools for establishing effectiveness
- Problems in reaching vulnerable populations due to illegality and socially unacceptable behaviours
- Inadequate documentation and dissemination of best practices at all levels
- Frequent mention of coordination difficulties throughout the document, e.g. poor linkage of vertical programs leading to inefficiency and at times artificial shortages of drugs and other commodities E.g. Isoniazid from the TB program is not accessible to the Care and Treatment program, while cotrimoxazole is not accessed by TB patients in districts which have no TB/HIV integration activities.

This paints a picture of many interventions that are poorly coordinated with each other, and not achieving the required scale, with the prevention effort in particular needing to be scaled up and made more professional and evidence-based in approach.

## *4.2 Challenges in Coordination*

Although TACAIDS has overall responsibility for co-ordination, in practice coordination of health sector aspects is parallel to and separate from the coordination of the multi-sector response. In principle, the over-arching coordination framework for health should be the health sector wide approach and the annual reviews carried out within the health sector. In practice, it is the specific forums established by the main HIV/AIDS donors that are the most important institutions for coordination of health sector HIV/AIDS interventions. This limits the extent to which HIV/AIDS expenditures are in practice able to be reviewed in the context of overall health sector priorities.

The health sector is the dominant part of the HIV/AIDS plans, with NACP, US PEPFAR, and GFATM the dominant stakeholders. The HSHSP is intended to provide the strategic framework within which support from Government and from the external partners is planned and coordinated.

PEPFAR, the biggest source of funding for the sector, holds an annual joint planning session with NACP and the PEPFAR implementing partners leading to preparation of the annual operational plan. However, the final decision on the approved budget is made by the US Government, and Congress can change and attach conditions to what has been agreed in country. The planning meeting is timed to fit the September start date of the US financial year, though the timing is not ideal from a GOT perspective.

Although the system has serious disadvantages for coordination, in practice every effort is made to maintain continuity of funding. This theoretically off-budget and unpredictable funding source has grown rapidly in recent years, has in practice proved more predictable

than World Bank or bilateral support or funding via the budget, and has been the source of emergency funding when other approvals have been late (e.g. 7 emergency procurements in 2007). The biggest problem with it is the large number of funding channels and implementing partners. This probably adds to transactions costs and may contribute to the drain of relevant technical staff out of Government to work in PEPFAR partners; it also makes it difficult for anyone to have a clear overview of what exactly is being funded and where, and with what impact. Although PEPFAR dominates in financing terms, the wide spread of partners reduces visibility and contributes to a widely held perception, whether fair or not, that the results are not commensurate with the level of spending. The very rapid ramping up of expenditure over the last two years must also strain the capacity of implementing agents. When budgets increase at such speed, quality often suffers as more effort needs to be devoted to getting the money out of the door. In fairness, we have no evidence on the effectiveness of PEPFAR expenditure, but the importance of PEPFAR funding argues for giving more in-depth attention to reviewing how PEPFAR fits in to the overall NMSF.

As previously discussed, the GFATM approach makes it impossible to integrate their funding within a 'three ones' approach coordinated around the budget. The TCCM was established to coordinate GFATM funding, but membership includes USG PEPFAR partners and the World Bank, and meetings do attempt with some success to ensure that GFATM proposals are coordinated with other stakeholders. There has been improvement in coordination of all partners involved in the Care and Treatment Plan, with regional concentration of implementing partners to avoid duplication, and harmonization of management of the major commodities (i.e. ARVs, diagnostics) at all levels, with clear allocation of responsibility.

Despite these efforts at coordination around a national strategy, the weaknesses identified in the HSHSP persist. To these, we can add uneven access to key services, with a strong urban bias, and some districts receiving heavy support from GFATM while others are relatively neglected. There are major issues of sustainability, particularly with regard to GFATM support. In addition to issues regarding the uncertainty of future funding for GFATM, there is the ever present risk that applications may not be approved, as occurred with the Round 7 HIV/AIDS application, while the demanding annual work-planning cycle has been associated with interruptions and delays in the funding of those programmes that have been nominally approved, exacerbated by the need to adjust approved budgets to accommodate funding approved within the budget year. Given these uncertainties, there is a strong case for focusing GFATM support more on capital expenditure than on financing consumables and recurrent costs.

The aid coordination task is daunting, and not well served by the proliferation of forums in which some coordination is attempted. The development partners group organized by TACAIDS meets every two months. TACAIDS also organizes a formal review every second year, though it is unclear what impact this has had. It has not provided an authoritative view of progress, nor has it focused on identifying under-financed areas and directing GOT and EDP resources towards funding them. TACAIDS has historically had problems in engaging the major players, particularly PEPFAR, but USAID has very recently taken over the donor joint chair, which should help strengthen their engagement,

though GFATM remain outside the country and outside this forum. Coordination with MOHSW should also improve with the appointment of the new executive chair and the new director of policy and planning, both of whom come from the MOHSW.

### *4.3 Moving From Strategy to Implementation*

External development partners, including USAID, would welcome stronger guidance from Government on where they should focus their efforts. The new US chair of the DPG would like to see a process whereby Government identifies expenditure priorities and directs resources towards filling the gaps. This would involve dialogue with off-budget donors on how their resources can best support the strategy, given the restrictions on how they can be used, with more flexible funding sources being used to fill any gaps. There is recognition that this approach sounds neat in principle but will be messy in practice, given the large number of stakeholders involved. It requires the identification of needs and the allocation of resources for filling them at a variety of levels:-

i. Financing for the expenditure plans of the health sector. In order to turn the HSHSP into an implementation strategy, the executive chair of TACAIDS identifies a need for the key Tanzanian and external stakeholders to sit together and agree on who will finance what, when, and where. This needs to focus on strategic allocation (regional areas of concentration, responsibility for major procurements and programmes within each thematic area), and should not attempt detailed planning of activities.

ii. For the multi-sectoral aspects that fall more directly under TACAIDS leadership, the coordination task is even more complex, and the need to maintain a focus on strategy rather than implementation is even greater. The prevention and economic and social support agenda is one that needs to be implemented largely through Local Government structures and through geographically scattered CSOs. It is arguable that TACAIDS and the TMAP project have in the past given excessive attention to central MDAs, who have spent funds on work place interventions for relatively small numbers of employees, while the responsibility for planning and delivering programmes to the mass of the population is with local initiatives under the responsibility of Local Government.

iii. There is a complex challenge of geographical allocation, between and within regions and districts, given the large number of individual CSOs receiving support from multiple funding channels. Past attempts to ‘map’ this activity have not achieved comprehensive coverage, and have become rapidly out of date with the growth in donor support. The new TOMSHA monitoring system has yet to achieve sufficient coverage to generate useful information, though may do so in future if TACAIDS succeeds in re-enforcing the incentives to report. LGAs do have a general sense of which NGOs and CSOs are active in their area and what support they are providing, but do not have access to financial data nor necessarily to detailed information on coverage. TACAIDS

would like to see Government and development partners working jointly to maintain geographical mapping of donor support to be updated at six monthly intervals.

iv. The RFAs have proved an expensive way to administer small grants and provide fairly limited capacity building support to CSOs and LGAs, but the regional administrations (the obvious and sustainable alternative) lack capacity to take on the role. On the health side, regional HIV/AIDS coordinators exist. There is also existing capacity in community development at regional level, with nominal responsibility for supporting the CHACs at district level, but in practice HIV/AIDS gets limited attention.

The executive chair identifies a need for TACAIDS to develop a 'process roadmap' for turning the NMSF into something that can be implemented. In order to do this, we recommend that the following steps need to be taken:-

i. **Provide practical, evidence-based guidance**. The draft minimum essential package needs to be reviewed with stakeholders, prioritized to something that is more manageable and gives more operational guidance on the choice and design of interventions and their likely impact. This requires the central MDAs, and particularly TACAIDS and the MOHSW, to put even more effort into identifying 'what works', and generating models, 'how to' notes, and best practice guidance, based on increased commitment to gathering the lessons of international and Tanzanian experience, and investing in operational research.

ii. **Allocate Resources Based On Criteria Of Need** When the results of the new THIS become available, re-visit the allocation formula for the HIV/AIDS grant in order to reflect new evidence on the nature of the epidemic. The most likely amendments to the existing formula will be to introduce weighting based on prevalence of the disease. Prevalence data from THIS will only be available to regional level, but the formula could use district level census data on the numbers of orphans in difficult circumstances as a proxy.

iii. **Ensure promised funds are made available in full and on time.** The Ministry of Finance should tell LGAs in the budget guidelines of the amounts available for financing their HIV/AIDS plans, and should ensure that the funds proposed in the guidelines are actually provided in full, and early enough in the year to permit timely implementation.

iv. **Allow LGAs more flexibility** LGAs should be advised that their plans should be consistent with the NMSF and with the revised minimum essential interventions and accompanying guidance, but they should be left with flexibility to chose which interventions should be prioritized within their budget, and to adapt them to local circumstances. The present practice of detailed earmarking of the HIV/AIDS grant should cease, and central departments (TACAIDS, PMORALG and MOF) should not be involved in

detailed review of LGA plans, provided that the ceiling is respected and the proposals are consistent with the guidance.

v. **Pilot alternatives to the RFAs for supporting CSOs** as argued in the previous section.

vi. **Promote the development of mutual learning networks at national and regional level** As is evident from the quotations from the health sector HIV strategy, we do not yet have confidence in the most effective approaches to prevention, particularly with respect to BCC. Similar comments could also be made regarding economic and social support, where options for less prescriptive approaches would be worth exploring (cash transfers linked to evidence of school attendance as in Kenya rather than direct supply of uniforms and books, more choice to the recipient on how IGA support should be used). More support for forums where CHACS and CSOs can learn from each others experiences could be accompanied by modest 'innovation funding', which could be allocated on a competitive basis, possibly through competitions and awards to encourage and identify good practice, accompanied by support to enable promising approaches to be evaluated and written up.

vii. **Identify financing gaps, and channel resources towards them** The process for channelling Government and EDP resources towards the identified funding gaps will require an open and transparent process of discussion of how best to utilise both Government and donor resources, on budget and off-budget. At the highest levels, TACAIDS and NACP may be engaged in discussing regional concentration and thematic responsibilities with the major stakeholders, as well as identifying interventions that need to be expanded or contracted, and the responsibility for doing so. A particular difficulty is to identify under-funded districts, given the proliferation of NGOs and CSOs with significant funds but limited transparency. Detailed mapping may not be feasible at reasonable transactions cost, but is worth exploring with the major funding sources. If detailed data can not be collected, it may nevertheless be possible to informally identify regions and districts that are relatively under or over-resourced using less formal assessments based on the collective knowledge of stakeholders regarding who is working in which districts on which problems. At lower levels, more limited and technical forums may be needed to thrash out the details of individual interventions, for example what programmes will be implemented in schools and who will support which aspects from developing curricula and teaching materials for specific age groups through to working with teachers and pupils in specific regions. At district level, LGAs will coordinate district level plans with local CSOs, as several of the LGAs we reviewed already attempt to do.

Recommendation 17. In moving from NHSP to an implementation roadmap, the following critical components should be considered, as elaborated in more detail in section 4.3:

i. Provide practical, evidence-based guidance to those implementing HIV/AIDS interventions;
ii. Allocate resources based on criteria of need; establishing a small working group to develop a formula for allocating the HIV/AIDS block grant
iii. Ensure promised funds are made available in full and on time;
iv. Allow LGAs more flexibility on how to use resources, within the scope of national strategy and the guidance provided;
v. Pilot alternatives to the RFAs for supporting CSOs;
vi. Promote the development of mutual learning networks at national and regional level;
vii. Identify financing gaps, and develop regular institutional mechanisms for directing Government and donor resources towards filling them.

# 5. Financing Instruments

## *5.1 The HIV/AIDS Grant*

### Allocation Formula

The HIV/AIDS earmarked block grant is the key source of funding for LGA prevention and impact mitigation work on HIV/AIDS. It is at present allocated via the same formula as the health sector block grant. This is a pragmatic solution, but the formula is not particularly relevant to HIV/AIDS, and a more appropriate formula should be applied once the results of the new THIS are known. Problems in finding a suitable alternative are:-

i. Population and HIV/AIDS incidence are the obvious criteria to use, but incidence is only known at regional level, and there are big differences between and within districts;
ii. Urban incidence is about double rural incidence, which might suggest giving extra weighting to urban areas within a region to reflect this. However, municipalities also generally have far better access to services, and more partners working there, and this needs to be taken into account in allocating the grant;
iii. The HIV/AIDS grant is only one source of funding to LGAs, and in 2007/8 is actually smaller than the Global Fund support. An optimal distribution of the HIV/AIDS grant in isolation will result in a distorted allocation of total resources because the larger GFATM resources are concentrated in just some districts (from 2008/9, about 90 of the 133 LGAs will benefit).

The formula should be developed by a small working group of TACAIDS staff plus co-opted experts. It has been suggested that the formula should supplement regional HIV/AIDS incidence data by making use of district-level data on the number of most vulnerable children as one important indicator that is quite closely correlated to

HIV/AIDS incidence, and is a direct indicator of the need for funding[14]. The formula should also be adjusted to give a larger share to those LGAs not receiving funding from other external partners. Ideally, the formula should take account of all direct support received by the LGA for HIV/AIDS. That is likely to prove practically impossible, but it should as a minimum be possible to focus additional resources on those LGAs not benefiting from GFATM support for HIV/AIDS.

## Conditions of Use

The criteria for use of the fund that were set out in the budget guidelines are strict in principle, but scrutiny of the MTEFs suggests that they are ignored in practice, fortunately so as they are unworkable. The budget guidance mandates detailed percentages that add up exactly to 100% giving the LGA no flexibility at all. The 2006 PER recommended dropping these restrictions, as there is no rational basis for them, and they are not in practice monitored or adhered to, which undermines the credibility of those conditions that are important . If some guidance is required on allocation (and we are not convinced that it is needed), then the guidance should ensure that there are real ranges, not a prescriptive percentage allocation that everyone must use.

## Reporting

CIDA requires various reports to be produced on the use of the funds, and we explored the feasibility of providing these:-

i. Approved annual estimates for HIV/AIDS (objective A) by vote. This is available for the MDAs, and for LGAs the intended allocation of the HIV/AIDS block grant is specified in the annual estimates. LGA spending on Objective A from other sources (such as the health basket) is not identified ex ante in the overall national budget estimates and MTEF, though it is shown in the MTEFs of individual LGAs, which are available from the Ministry of Finance. The problem is simply one of extracting the data from individual LGA budgets, not all of which are submitted in PLANREP for easy entry on the database.

ii. Quarterly disbursement report. It is straightforward for the Ministry of Finance (Assistant Budget Director, Local Government) to provide data on quarterly disbursements to LGAs from the HIV/AIDS grant. It is delivered as an earmarked block grant to LGAs, paid at present into the LGA TMAP bank account. There is some evidence of delay between the date when funds are sent by MOF and the date when they are received by LGAs. It is important to explore the reasons for this, and to ensure that LGAs are informed when funds are sent, in order that they can chase up the banks.

iii. Annual PER for HIV/AIDS. Can be done, but needs to be far better prepared, and should ideally become a routine TACAIDS responsibility rather than continuing to rely on external consultants. There is a strong case for TACAIDS appointing someone with responsibility for providing advice and analysis on public expenditure issues throughout the budget cycle, rather than

[14] Masuma Mamdani, comments on the first draft. Estimated numbers of MVCs by district and by urban/rural within districts are given in MOHSW, 'The costed MVC Action Plan 2007 to 2010.'

relying on an annual one-off exercise. It would require TACAIDS to appoint an economist dedicated to this role, with some initial external support.

iv. Annual financial report on HIV/AIDS (Objective A) expenditure by vote. It is easy to get annual (and indeed quarterly) expenditure reporting on Objective A for MDAs, who report using the full budget code, including segment 2. This PER report includes relevant information for 2006/7 provided by the accountant general. The reports use the sub targets (cross-cutting, prevention, care and treatment, and economic and social support), and reporting can be generated by vote, sub-vote, objective, target, and detailed item. This is available in database form, and it is easy to generate whatever specific tables are required. From 2007/8, it is our understanding that it should also be possible to obtain performance reports, showing physical implementation progress against each objective and target.

v. However, there is a problem with respect to LGA reporting of actual expenditure. Quarterly reports are being submitted by LGAs, with both expenditure and performance data on objective A, but they do not use the required software (PLANREP), making it difficult to combine the data in a consolidated expenditure report. This problem will take some time to solve, requiring training and support to LGAs. Meanwhile, TACAIDS will be unable to carry out their responsibility to provide a consolidated annual report on expenditure on Objective A. They can report what funds have been sent to LGAs, but not whether they have been spent. For simple overall reporting of expenditure, TACAIDS can continue to ask LGAs to provide reports on inflows, expenditure, and balances in their TMAP bank accounts, as is done at present for TMAP. Ideally, these should be reconciled to copies of the bank statements. TACAIDS will likely continue to experience problems in getting LGAs to report (though the threat of withdrawal of funds that will in future be more regular should help). However, this will only reveal total spending by LGA, and will not capture the rich data now available on expenditure and performance by objective and target. In the interim, one option would be to undertake a special exercise to consolidate data on Objective A from the reports submitted by LGAs. This would probably need additional support to PMORALG to do this, and it might be sufficient to do it on a random sample basis of 30 or so LGAs rather than working on all 133 LGA reports.

vi. Annual audit of HIV/AIDS Account. Straightforward to audit the inflows in Can $, outflows to LGAs, and balances in the central account. It would be wise to also ask NAO to follow the audit trail down to a sample of LGAs, to check that expenditure on LGA TMAP accounts relates to Objective A activities within the approved budget, and is supported by appropriate vouchers and receipts and complies with GOT financial regulations.

vii. Biannual NMSF review. There is a strong case for arguing that donors providing budget support for HIV/AIDS should have an annual opportunity for dialogue on what has been achieved in the previous financial year, and to receive clear advice from Government regarding the strategic priorities of the programme that they will be helping finance in the coming year.

# 6. Recommendations

## *6.1 Review of 2006 Recommendations*

Before discussing the recommendations of the current report, we first consider the status and continuing relevance of recommendations made in the 2006 PER. Table 6.1 is adapted from a draft produced by the director of finance and administration in TACAIDS.

### Table 6.1 STATUS OF RECOMMENDATIONS OF 2006 PER

| Recommendation | Suggested Lead Responsibility | Timing | Status as at October 2007 | Continuing relevance? |
|---|---|---|---|---|
| 1: Develop and implement institutional arrangements to annually prioritise and roll-forward the NMSF, directing Government and all types of donor resources towards filling financing gaps. | TACAIDS director policy and planning to ensure the issue is discussed with development partners, and is addressed in the design of NMSF implementation arrangements. | 2007 annual review to discuss financing requirements and funding gaps for new NMSF[15]. | Implementation in progress. NMSF has been recently finalized. We are planning to prepare an action plan and finally cost it. | Yes, especially with HIV/AIDS grant now available |
| 2: Ensure closer involvement of the major donor partners in TACAIDS coordination, including ensuring that the process for preparing the new NMSF meets their needs. | TACAIDS director policy and planning to review NMSF process, TORs, timetable with Govt and development partner stakeholders, and amend as required. | Immediate. | Implemented. It was considered when developing a new NMSF. The new NMSF was developed in collaboration with Development Partners. | Still other areas where consultation has been lacking, e.g. essential package of interventions |
| 3: TACAIDS finance director and Ministry of Finance need to meet with World Bank TMAP task manager and disbursement officer to find a way to solve the problem of low disbursement | Finance and Administration Director, TACAIDS | Immediate | Implemented. Disbursement problem has been solved by paying bigger sums directly from the World Bank Washington to the various recipients like RFAs or Suppliers. | |
| 4: From 2007/8, reserve a portion of the HIV/AIDS grant for district support to CSOs and CBOs, develop LGA procedures as needed to facilitate this, and phase out RFA management of CARF in order to focus on capacity building for LGAs and CSOs. | TACAIDS Director Finance and Administration to propose in draft budget guidelines, advise PMO-RALG on suggested changes to LGA procedures, consult WB on RFAs | Budget guidelines drafted January for agreement and issuing by March | Implemented. Guidelines sent to LGAs for the budget preparation for 2007/08 stated that all LGAs to give grants to CSOs for the portion of the funds given. Essential package for LGAs HIV/AIDS | Future of support to CSOs and of RFAs remains an issue |

[15]JAST proposes that the timing of reviews should in future be August, to feed in to the GBS review.

| Recommendation | Suggested Lead Responsibility | Timing | Status as at October 2007 | Continuing relevance? |
|---|---|---|---|---|
| | | | interventions was developed and training conducted. | |
| 5: There should be explicit debate on the level of expenditure on HIV/AIDS, including how much donor support to accept, in Parliament, and between Ministry of Finance and key MDAs including Health and PMO-RALG. The ceilings of MOHSW and of PMO-RALG need to be adjusted to accommodate within the budget the level of aid to HIV/AIDS that is accepted, without squeezing other spending. | Ministry of Finance (budget director and/or director policy and planning?), in context of annual public expenditure review discussions. | Issue resolved before March 2007 issue of MDA budget guidelines | Partially implemented. The 2007/08 budget guidelines included all sources of funds that pass through Government machinery. Ceiling issue was also considered. | Still relevant. No national discussion on 'how much for HIV/AIDS', financing study for new NMSF is still envisaging a larger envelope rather than discussion of priorities within the sustainable funding available. WB CEM discusses the issue. |
| 6: Other development partners should consider joining the sector budget support arrangement, subject to the putting in place of an effective process for joint review of plans and budgets for implementing NMSF. | Development partners group, with TACAIDS (who?) also networking to seek additional commitments. | Desirable to firm up commitments in time to reflect them in March 2007 budget guidelines | We have considered the recommendation by making special session with DPs on the modality and how it operate, two DPs are considering joining after this PER. | At least one other donor is actively considering supporting the HIV/AIDS grant, but needs evidence to show that the modality works and can generate informative data for monitoring purposes. |
| 7: TACAIDS should propose to PMO-RALG and MOF that CIDA SBS be used to fund block grant disbursements to LGAs as envisaged in the March 2006 budget guidelines, modified as in Box 6.1. | Director Finance and Administration | Immediate, to permit disbursement in 2006-2007 | Implemented. But not the proposed Box 6.1 simplifications. | Recommendation reiterated for 2008/9 budget guidelines. |
| 8: From 2007/8, allocate all HIV/AIDS support to district councils (HIV/AIDS grant, TMAP, GFATM support to CHMTs) through a single formula-based allocation, adjusting grant allocations to offset GFATM support to CHMTs. As far as possible, the district planning and budgeting process for the grant and for GFATM and TMAP should also be unified within a single budget and MTEF. | Director policy and planning to consult GFATM. Director Finance and Administration to reflect adjusted formula in proposed budget guideline totals for districts. | Budget guidelines proposals for 2007/2008 are to be issued by March 2007. | We are still discussing with the GFATM, it cannot be done very fast, as it involves amendment of the agreements. Global Fund projects are renewed based on performance of specific periods. We have currently agreed with the Global fund to harmonize audit issues and align them to Government audit cycles. | Still relevant, see discussion of formula |

| Recommendation | Suggested Lead Responsibility | Timing | Status as at October 2007 | Continuing relevance? |
|---|---|---|---|---|
| | | | TMAP was supposed to end in 2008, but received a no cost extension to 2009. We have discussed with the World Bank to consider that modality of financing in the next phase of TMAP. | |
| 9. Review these recommendations with HIV/AIDS development partners group, agree action, assign responsibility, and review progress until action is complete. | Director policy and planning | Next meeting of development partner group. | Implemented. PER report was discussed with the DPs. | |
| 10: The management of the CARF should be made less restrictive, with more decision-making delegated to the RFAs. The TSh5000 CARF limit for projects should be at least doubled, the practice of splitting project grants into two or more tranches should be ended, and reporting requirements with respect to small short-term grants should be eased, possibly to require simply a physical and financial report on completion | World Bank task manager and Finance and Administration Director | | Implemented. CARF was adjusted for bigger CSOs, they receive more funds. In this financial year we financed through that system to the tune Tshs. 6 billion | Progress welcome, still rather bureaucratic and expensive, decisions are needed on future of RFAs and of CSO funding |

## *6.2 Recommendations*

The recommendations are highlighted and numbered in the body of the report. They are reproduced here for convenience. We further recommend that, as happened last year, they should be formally reviewed by the whole DPG group (not just the PER working group).

1: TACAIDS and MOF should facilitate a debate, involving the political leadership and the external development partners, on the share of Government and donor resources that should be devoted to HIV/AIDS, and the implications of current expenditure levels and trends.

2 MDAs and LGAs be reminded of the definitions of the standard targets within Objective A, and be encouraged to use them, perhaps by inclusion of suitable text in the budget guidelines for 2008/9.

3. Director Finance to review with MOF whether the decline in the TACAIDS recurrent budget that was proposed in the 2007/8-20009/10 MTEF should be re-considered

4. Undertake a 'donor expenditure review' in HIV/AIDS, to improve understanding of how off-budget funds are used, what impact they are having, and to advise on how Government can exercise leadership and have a positive influence over the allocation and management of external support for HIV/AIDS.

5. DPG members should ensure that senior HQ staff responsible for GFATM are aware of the problems that make Global Fund support to Tanzania unpredictable and difficult to integrate within national plans and budgets.

6. In order to permit LGAs to plan and implement prevention and economic and social support activities, MOF should make provision for the HIV/AIDS earmarked block grant without it being dependent on the timing of a specific external grant to finance it.

7. Donors providing financial support for the HIV/AIDS block grant should negotiate with MOF for earlier and full release of the grant

8. The minimum essential package of interventions should be subject to detailed review with development partners and experienced CSOs, together with representatives of those at LGA level expected to use it (the CHACs), and be re-cast as a menu of options, with clear guidance on how to prioritise.

9. The minimum package should be supported with best-practice guidance and supporting materials related to each of the interventions, and information on where to get further advice. It should become the basis for pre and in-service training for CHACs. The material needs to be kept under review, supported by action research to update and extend knowledge of 'what works', based on Tanzanian and international experience. Some of this is already happening, but TACAIDS may need additional staff resources to expand capacity to fulfil this challenging role.

10. LGAs should be responsible for channelling financial support to CSO projects, via an earmarked block grant, with RAs provided with staff and travel and subsistence budgets to provide supportive supervision.

11. To help LGAs implement direct support to CSOs, TACAIDS and PMORALG should facilitate detailed operational guidance, cleared with relevant authorities, and covering practical matters such as fund flow, procurement, financial and physical monitoring.

12. Regional capacity to support CHACS and CSOs in receipt of block grant funds should be supplemented by sub-contracting institutional support functions to NGOs accredited to provide these services.

13 New institutional arrangements for supporting CSOs should be piloted and evaluated before national adoption.

14. While future arrangements are being put in place, consider extending the contracts of RFAs to maintain some continuity.

15. Support to CSOs should include longer-term financing of programmes to support PLWHAs and OVCs.

16. In the spirit of increased decentralisation, individual CSO projects should no longer go to TACAIDS centrally for approval, but should remain within the authority and accountability of the LGA, as an intrinsic part of the LGA budget.

17. In moving from NHSP to an implementation roadmap, the following critical components should be considered, as elaborated in more detail in section 4.3:-

i. Adopt a decentralised approach, with the centre setting out policies and priorities, and providing practical, evidence-based guidance, but allowing decentralised implementers discretion

ii. Allocate resources based on criteria of need, establishing a small working group to develop a formula for allocating the HIV/AIDS block grant

iii. Ensure promised funds are made available in full and on time

iv. But allow LGAs more flexibility on how to use them, within the scope of national strategy and the guidance provided.

v. Pilot alternatives to the RFAs for supporting CSOs

vi. Promote the development of mutual learning networks at national and regional level

vii. Identify financing gaps, and develop regular institutional mechanisms for directing Government and donor resources towards filling them

18. For future PERs, any required MTEFs and budget documents should be acquired by TACAIDS in June as they are finalised, leaving this until November usually means that copies are no longer readily available.

19. These recommendations should be formally reviewed by the whole DPG group (not just the PER working group).

# Annex 1 Forecast Aid to HIV/AIDs: Statistics and Sources

## Table A1-1 Aid for HIV/AIDS by Donor 2006/7-2010/11 TSh Bns

| Development Partner | 2006/7 Expected | 2006/7 Actual | 2007/8 Projection | 2008/9 Projection | 2009/10 Projection | 2010/11 Projection |
|---|---|---|---|---|---|---|
| USG | 190.4 | 260.8 | 385.7 | 381.4 | 381.4 | 381.4 |
| GFATM | 77.1 | 71.2 | 101.0 | 103.4 | 103.4 | 74.3 |
| IDA | 25.8 | 16.6 | 50.9 | 7.5 | | |
| CIDA | 11.8 | 11 | 0 | 11.5 | 0.7 | 0 |
| Sweden | 7.4 | 13.6 | 7.3 | 8 | 8.8 | 0 |
| Norway | 4.9 | 0.1 | 6.3 | 1.8 | 2 | 0 |
| Netherlands | 4.7 | 0.1 | 6.2 | 0 | 0 | 0 |
| Japan | 3.9 | 2.3 | 4.2 | 7.3 | 2.8 | 0.1 |
| Ireland | 2.4 | 1.7 | 3.5 | 2.8 | 0.3 | 0 |
| Italy | 0.6 | | | | | |
| Belgium | 0.6 | 0.5 | 0.7 | 0 | 0 | 0 |
| UNDP | 0.4 | | | 0.4 | 0.4 | 0.4 |
| UNFPA | | | | 0.8 | 0.8 | 0.8 |
| UNICEF | 0.3 | | | | | |
| SDC | 0.3 | | | 0.5 | 0 | 0 |
| Germany | | | | | | |
| **WFP** | | | 2.4 | 6.8 | 6.8 | 6.8 |
| **Total** | **330.6** | **377.8** | **568.2** | **532.2** | **507.4** | **463.8** |
| Missing donors | | 0.46 | 3.0 | 2.4 | | |

Sources
The external aid database was the starting point for compiling the data, but there are considerable gaps in coverage and we supplemented the information from other sources. For the future MTEF years, we used the data submitted by donors to UNDP for forwarding to MOF for the MTEF. For USG, we used data provided by the US staff, drawing on their budget summary and FY 2007 country operational plan. Although the FY 2008 budget is yet to be approved, we used the $300mn proposal as our guide assumption and assumed it is maintained at this level, based on advice from the USG team in Tanzania.

For GFATM, the figures are based on quarterly disbursements to date and the forecast cash-flows for the disbursement requests currently under consideration for Round 3 and Round 4. The remaining balance of funding from approved programmes is then assumed to disburse evenly over the remaining life of the grants. We have not included any assumptions regarding support from future rounds.

IDA figures are based on discussion with the WB and documents provided by them.

CIDA figures assume the balance of the Can $20mn commitment disburses in 2008/9. No disbursement is assumed in 2007/8 because the current disbursement was only released to LGAs in November.

Other donor figures are based on the aid database and on the returns submitted via Development partners group (DPG). There appear to be some gaps in this data, and there are some uncertainties to resolve (for example, we wondered if the SIDA disbursement of TSh13.6bn in 2007/8 reflected two years of support and should be offset by reduced aid in the following year). The gaps are too minor to affect the overall picture, amounting to less than 3% of total disbursements.

Overall disbursements in 2006/7 seem to have been close to the anticipated level, with a further increase in the US budget making up for slower than forecast spending by IDA and GFATM. A further sharp increase TSh568bn is expected in the current year, dependent on USG actually approving the increased budget, IDA disbursements continuing their accelerated performance, and GFATM spending increasing with the approval of phase 2 of round 4. Existing commitments and indications imply flows continuing above TSh500bn per year, before considering likely new commitments including a possible GFATM Round 8 bid, a possible successor to IDA TMAP, and likely continuation of Canadian support possibly with participation from others.

USG
Data includes all USG PEPFAR sources, in country and local. US financial year data for year starting 1st October is applied to GOT financial year starting in previous July, without adjustment. For both 2006/7 and subsequent years, we used an exchange rate of 1US$=TSh1272.

# Annex 2 Government Expenditure on HIV/AIDS: Tables and Notes on Statistics

## Table A1 Government recurrent Expenditure by Vote TSh Bns

| | Actual | Actual | Budget | Actual | Budget |
|---|---|---|---|---|---|
| | 2004/05 | 2005/06 | 2006/07 | 2006/07 | 2007/08 |
| State House | | 0.0 | | | 0.3 |
| *Police Force* | 0.1 | | | | |
| Public Safety & Security | | 0.1 | 0.4 | 0.5 | 0.4 |
| Home Affairs - Prisons Services | 0.1 | 0.0 | 2.3 | 0.4 | 0.1 |
| PO & Cabinet Secretariat | | 0.0 | | | 0.2 |
| Vice President's Office | 0.0 | | 0.1 | 0.1 | 0.0 |
| PO-Public Service Management | 0.1 | 0.1 | | | 0.0 |
| Foreign Affairs & International Coop | | 0.0 | 0.4 | 0.2 | 0.6 |
| Defence | | | | | 0.2 |
| The National Service | | 0.1 | | | 0.6 |
| Judiciary | 0.0 | | 0.1 | 0.1 | 0.1 |
| Agriculture, Food Security & Cooperatives | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 |
| Industry, Trade & Marketing | | 0.0 | 0.0 | 0.0 | 0.1 |
| National Audit Office | 0.3 | | 1.9 | 1.9 | 0.9 |
| Education and Vocational Training | 0.0 | 1.3 | 0.1 | 0.1 | 0.0 |
| Land, Housing & Human Settlements | 0.1 | 0.0 | 0.1 | 0.0 | 0.1 |
| *Ministry of Water and Livestock* | | | | | |
| Ministry of Water | 0.1 | 0.0 | 0.2 | 0.1 | 0.0 |
| Ministry of Home Affairs | 7.1 | | 0.1 | 0.1 | 0.0 |
| Ministry of Health & Social Welfare | 0.1 | 16.1 | 12.7 | 12.5 | 12.7 |
| Community Development etc | 0.0 | | 1.0 | 0.9 | 0.2 |
| PMORALG | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 |
| Ministry of Energy and Minerals | 0.0 | | 0.1 | 0.1 | 0.1 |
| Labour and Youth Development | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 |
| Planning, Economy & Empowerment | 0.1 | 0.0 | 0.2 | 0.1 | |
| Higher Education, Science & Technology | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 |
| Natural Resources &Tourism | | 0.0 | 0.0 | 0.1 | 0.0 |
| Land Court | 4.2 | | 0.0 | 0.0 | 0.0 |
| TACAIDS | | 3.8 | 3.2 | 3.1 | 3.6 |
| Immigration Department | | 0.0 | 0.2 | 0.2 | 0.2 |
| Public Service Commission | | | 0.1 | 0.1 | 0.0 |
| Information, Culture & Sports | | 0.0 | 0.1 | 0.1 | 0.1 |
| East African Cooperation | | | 0.0 | 0.0 | 0.1 |
| Infrastructure Development | | | 0.1 | 0.1 | 0.1 |
| Ministry of Livestock Development | | | 0.1 | 0.1 | 0.0 |
| TOTAL MDAs | **12.6** | 21.8 | 24.0 | 21.4 | 21.6 |
| Regions and LGAs | | 0.6 | 1.4 | 0.8 | 1.5 |
| Grand Total | **12.6** | 22.4 | 25.4 | 22.3 | 23.1 |

## Table A2 Government Development Expenditure on HIV/AIDS by Vote TSh Bns

| | Actual | Actual | Budget | Actual | Budget |
|---|---|---|---|---|---|
| | 2004/05 | 2005/06 | 2006/07 | 2006/07 | 2007/08 |
| Public Safety & Security | | 0.100 | 0.200 | 0.000 | 3.518 |
| Home Affairs - Prisons Services | 0.000 | 1.500 | | | 2.033 |
| PO & Cabinet Secretariat | | 0.200 | | | |
| Vice President's Office | 0.010 | | 0.240 | 0.046 | 0.012 |
| PO-Public Service Management | 0.084 | | 0.715 | 0.191 | 0.504 |
| Prime Minister's Office | 0.000 | | | | 0.150 |
| Defence | | | | | 0.203 |
| The National Service | | | | | 0.203 |
| Judiciary | 0.000 | | 0.300 | 0.000 | 0.400 |
| Justice & Constitutional | 0.000 | | | | 0.250 |
| The National Assembly Fund | | | | | 0.150 |
| Agriculture, Food Security & Cooperatives | 0.000 | 0.100 | 0.150 | 0.000 | 0.100 |
| Industry, Trade & Marketing | 0.000 | | 0.133 | 0.105 | 0.070 |
| Education and Vocational Training | 0.457 | 0.800 | 1.520 | 0.000 | 2.000 |
| Land, Housing & Human Settlements | 0.000 | 0.100 | 0.169 | 0.000 | 0.172 |
| Ministry of Water | | 0.100 | 0.150 | 0.000 | 0.100 |
| Ministry of Finance | 0.007696 | | 0.194 | 0.086 | 0.198 |
| Ministry of Home Affairs | 0.000 | | 1.173 | 0.532 | |
| Ministry of Health & Social Welfare | 11.161 | 61.330 | 0.000 | 0.000 | 43.424 |
| Community Development etc | 0.000 | | 1.961 | 1.961 | 0.408 |
| Comm. For Human Rights etc | 0.000 | | 0.260 | 0.000 | 0.119 |
| PMORALG | 0.990 | 2.690 | 0.356 | 0.167 | 0.325 |
| Ministry of Energy and Minerals | 0.273 | | 0.441 | 0.000 | 0.250 |
| Industrial Court of TZ | | | 0.551 | 0.000 | 0.200 |
| Commercial Court of Tanzania | 0.000 | | | | 0.200 |
| Labour and Youth Development | 0.000 | 5.419 | 0.437 | 0.000 | 0.923 |
| Planning, Economy & Empowerment | | | 0.598 | 0.043 | 0.230 |
| Higher Education, Science & Technology | 0.226 | 0.256 | 0.017 | 0.000 | 0.250 |
| Natural Resources &Tourism | 0.000 | 0.200 | 0.000 | 2.209 | 0.200 |
| Anti-Drug Commission | | | | | 0.400 |
| TACAIDS | 7.911 | 24.004 | 25.788 | 23.489 | 49.632 |
| Immigration Department | 0.029 | 0.100 | 0.500 | 0.500 | |
| Information, Culture & Sports | | | 0.490 | 0.000 | 0.270 |
| Infrastructure Development | | | 0.300 | 0.000 | 0.065 |
| Ministry of Livestock Development | | | 0.150 | 0.000 | 0.115 |
| TOTAL MDAs | 21.149 | 96.899 | 36.8 | 29.328 | 107.074 |
| Regions and LGAs | 0.015 | 0.575 | 3.397 | 3.014 | 15.520 |
| Transfers PMORALG to municipal councils GF3 | | | 6.067 | 6 | 0.889 |
| Transfers TACAIDS to LGAs | 0.271 | | | 1.474 | |
| Grand Total | 21.435 | 97.47 | 46.26 | 39.77 | 123.48 |

## Table A3 Total Government Budget Expenditure on HIV/AIDS

| | Actual | Actual | Budget | Actual | Budget |
|---|---|---|---|---|---|
| | 2004/05 | 2005/06 | 2006/07 | 2006/07 | 2007/08 |
| State House | 0.0 | 0.0 | 0.0 | 0.0 | 0.3 |
| *Police Force* | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 |
| Public Safety & Security | 0.0 | 0.2 | 0.6 | 0.5 | 3.9 |
| Home Affairs - Prisons Services | 0.1 | 1.5 | 2.3 | 0.4 | 2.1 |
| PO & Cabinet Secretariat | 0.0 | 0.2 | 0.0 | 0.0 | 0.2 |
| Vice President's Office | 0.0 | 0.0 | 0.3 | 0.1 | 0.1 |
| PO-Public Service Management | 0.1 | 0.1 | 0.7 | 0.2 | 0.5 |
| Foreign Affairs & International Coop | 0.0 | 0.0 | 0.4 | 0.2 | 0.6 |
| Prime Minister's Office | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 |
| Defence | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 |
| The National Service | 0.0 | 0.1 | 0.0 | 0.0 | 0.8 |
| Judiciary | 0.0 | 0.0 | 0.4 | 0.1 | 0.5 |
| Justice & Constitutional | 0.0 | 0.0 | 0.1 | 0.0 | 0.3 |
| The National Assembly Fund | 0.1 | 0.0 | 0.0 | 0.0 | 0.3 |
| Agriculture, Food Security & Cooperatives | 0.0 | 0.1 | 0.3 | 0.1 | 0.1 |
| Industry, Trade & Marketing | 0.0 | 0.0 | 0.2 | 0.1 | 0.1 |
| National Audit Office | 0.3 | 0.0 | 1.9 | 1.9 | 0.9 |
| Education and Vocational Training | 0.5 | 2.1 | 1.6 | 0.1 | 2.0 |
| Land, Housing & Human Settlements | 0.1 | 0.1 | 0.2 | 0.0 | 0.2 |
| Ministry of Water | 0.1 | 0.1 | 0.3 | 0.1 | 0.1 |
| Ministry of Finance | 0.0 | 0.0 | 0.2 | 0.1 | 0.3 |
| Ministry of Home Affairs | 7.1 | 0.0 | 1.2 | 0.6 | 0.0 |
| Ministry of Health & Social Welfare | 11.2 | 77.4 | 12.7 | 12.5 | 56.1 |
| Community Development etc | 0.0 | 0.0 | 3.0 | 2.8 | 0.6 |
| Comm. For Human Rights etc | 0.0 | 0.0 | 0.3 | 0.0 | 0.1 |
| PMORALG | 1.0 | 2.7 | 0.4 | 0.2 | 0.4 |
| Ministry of Energy and Minerals | 0.3 | 0.0 | 0.6 | 0.1 | 0.4 |
| Industrial Court of TZ | 0.0 | 0.0 | 0.6 | 0.0 | 0.2 |
| Commercial Court of Tanzania | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 |
| Labour and Youth Development | 0.0 | 5.5 | 0.5 | 0.1 | 1.0 |
| Planning, Economy & Empowerment | 0.1 | 0.0 | 0.7 | 0.2 | 0.2 |
| Higher Education, Science & Technology | 0.2 | 0.3 | 0.1 | 0.1 | 0.3 |
| Natural Resources &Tourism | 0.0 | 0.2 | 0.0 | 2.3 | 0.2 |
| Land Court | 4.2 | 0.0 | 0.0 | 0.0 | 0.0 |
| Anti-Drug Commission | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 |
| TACAIDS | 7.9 | 27.8 | 29.0 | 26.5 | 53.3 |
| Immigration Department | 0.0 | 0.1 | 0.7 | 0.7 | 0.2 |
| Public Service Commission | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 |
| Information, Culture & Sports | 0.0 | 0.0 | 0.6 | 0.1 | 0.4 |
| East African Cooperation | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 |
| Infrastructure Development | 0.0 | 0.0 | 0.4 | 0.1 | 0.2 |
| Ministry of Livestock Development | 0.0 | 0.0 | 0.2 | 0.1 | 0.2 |
| TOTAL MDAs | 33.8 | 118.7 | 60.8 | 50.7 | 128.7 |
| Regions and LGAs | 0.0 | 1.2 | 4.8 | 3.9 | 17.0 |
| LGAs | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Transfers PMORALG to municipal councils GF3 | 0.0 | 0.0 | 6.1 | 6.0 | 0.9 |
| Transfers TACAIDS to LGAs | 0.3 | 0.0 | 0.0 | 1.5 | 0.0 |
| Grand Total | 34.1 | 119.8 | 71.6 | 62.0 | 146.5 |

## Table A4 Budget Execution and Percentage Shares in HIV/AIDS Expenditure

| Vote | % Spent | % Shares 2006/7 | | % Shares 2007/8 |
|---|---|---|---|---|
| | **2006/7** | Budget | Actual | Budget |
| State House | | 0 | 0 | 0.2 |
| Vice President | | 0.1 | 0.1 | 0.0 |
| Registrar of Political Parties | | 0.0 | 0.0 | 0.1 |
| Public Safety & Security | 87.5 | 0.8 | 0.8 | 2.7 |
| Home Affairs - Prisons Services | 19.2 | 3.2 | 0.7 | 1.5 |
| PO & Cabinet Secretariat | | 0.0 | 0.0 | 0.2 |
| Vice President's Office | 37.9 | 0.4 | 0.2 | 0.0 |
| PO-Public Service Management | | 1.0 | 0.3 | 0.3 |
| Foreign Affairs & International Coop | 38.4 | 0.5 | 0.2 | 0.4 |
| Prime Minister's Office | | 0.1 | 0.1 | 0.2 |
| Defence | | 0.0 | 0.0 | 0.3 |
| The National Service | | 0.0 | 0.0 | 0.6 |
| Judiciary | 23.0 | 0.6 | 0.2 | 0.3 |
| Justice & Constitutional | 49.7 | 0.1 | 0.1 | 0.2 |
| The National Assembly Fund | | 0.0 | 0.0 | 0.2 |
| Agriculture, Food Security & Cooperatives | 37.0 | 0.4 | 0.2 | 0.1 |
| Industry, Trade & Marketing | 82.8 | 0.2 | 0.2 | 0.1 |
| National Audit Office | 100.0 | 2.6 | 3.0 | 0.6 |
| Education and Vocational Training | 3.2 | 2.2 | 0.1 | 1.4 |
| Land, Housing & Human Settlements | 22.6 | 0.3 | 0.1 | 0.2 |
| Ministry of Water | 40.4 | 0.4 | 0.2 | 0.1 |
| Ministry of Finance | 43.5 | 0.3 | 0.1 | 0.2 |
| Ministry of Home Affairs | 48.0 | 1.7 | 1.0 | 0.0 |
| Ministry of Health & Social Welfare | 98.8 | 17.7 | 20.2 | 38.3 |
| Community Development etc | 95.8 | 4.1 | 4.6 | 0.4 |
| Comm. For Human Rights etc | 8.2 | 0.4 | 0.0 | 0.1 |
| PMORALG | 57.0 | 0.6 | 0.4 | 0.3 |
| Ministry of Energy and Minerals | 18.0 | 0.8 | 0.2 | 0.2 |
| Law Reform Commission | | 0.1 | 0.1 | 0.0 |
| Industrial Court of TZ | 0.0 | 0.8 | 0.0 | 0.1 |
| Commercial Court of Tanzania | | 0.0 | 0.0 | 0.2 |
| Labour and Youth Development | 15.0 | 0.7 | 0.1 | 0.7 |
| Planning, Economy & Empowerment | 24.4 | 1.0 | 0.3 | 0.2 |
| Higher Education, Science & Technology | 71.9 | 0.1 | 0.1 | 0.2 |
| Natural Resources &Tourism | | 0.0 | 3.7 | 0.1 |
| Anti-Drug Commission | | 0.0 | 0.0 | 0.3 |
| TACAIDS | 91.5 | 40.5 | 42.8 | 36.4 |
| Immigration Department | 100.0 | 1.0 | 1.1 | 0.1 |
| Public Service Commission | 99.5 | 0.2 | 0.2 | 0.0 |
| Information, Culture & Sports | 12.9 | 0.8 | 0.1 | 0.2 |
| Infrastructure Development | 21.3 | 0.6 | 0.1 | 0.1 |
| Ministry of Livestock Development | 34.2 | 0.3 | 0.1 | 0.1 |
| TOTAL MDAs | 83.5 | 84.8 | 81.8 | 87.8 |
| Regions and LGAs | 80.1 | 6.7 | 6.2 | 11.6 |
| Transfers PMORALG to municipal councils GF3 | | 8.5 | 9.6 | 0.6 |
| Transfers TACAIDS to LGAs | | 0.0 | 2.4 | 0.0 |
| Grand Total | 86.6 | 100.0 | 100.0 | 100.0 |

## Central Government HIV/AIDS Spending

Sources of data:-
2005/6 budget and actuals: - A/G data as recorded in spreadsheet 2005_06 budget outturns and 2006_07 approved expenditure; and 2005/6 data from 2006 PER. The spreadsheet does not include the objective codes explicitly and data has been compiled from project descriptions and item names.
2006/7 Budget and Outturns: - Budget and expenditure on Objective A, as recorded in accountant general data, reflected in spreadsheet 2006_07budget outturns_vr4
2007/8 budget: - A coded expenditure plus all expenditure of TACAIDS, from spreadsheet 2007_08 budget estimates Vr 4, based on A/G data.

## Regions and LGAs

Sources we have for LGAs:-

i. 2005/6 data based on the annual accounts produced by PMORALG and included in 2006 PER, but the data is very suspect.
ii. Data from TACAIDS on transfers made from TMAP to councils in 2005/6 and 2006/7 and data on amounts for which financial reporting has been produced.
iii. From TACAIDS (Milton Lupa), GFATM payments under round 3 to the LGAs being supported.
iv. We also have round 4 payments by partner including individual LGAs for year 1 and year 2
v. From MOF (Mr Maswi), we have 2007/8 transfers from the HIV/AIDS fund by district.
vi. From TACAIDS, 2006/7 transfers from the HIV/AIDS fund by district, actually made in 2007/8.

What we do not have is reporting of actual expenditure by LGAs in a form that we can analyse.

# Annex 3: Analysis of the HIV/AIDS Content of Performance Budgets for 18 LGAs

The attached table extracts and summarises the HIV activities listed by 18 LGAs in their 2007/8 performance budgets, in order to verify the findings from our district visits by reference to a larger sample of LGAs. The performance budget data in the pink books (Annex to Volume 3 of the Estimates) does not reveal the expenditure envisaged under each target, but does provide useful information on the quantified outputs envisaged under each target and activity. One LGA was randomly selected from each of 18 of the 21 regions.

Summarising this information:-

1. All but one of the 18 districts prepared a performance budget, and had HIV/AIDS activities listed under Objective A, though one LGA reported on overall health sector improvements under the HIV/AIDS and service delivery target. The definition may need clarifying to avoid future misunderstandings. The highest number of identified HIV/AIDS activities was 23, most have 10-15 discrete proposals, but a significant number have only 5-10 often limited to sensitization, training, and activities to support the CHAC;

2. Nearly all LGAs have included at least some training and sensitization activities for LGA staff and for MACs at various levels. A couple of LGAs have included relatively expensive transport and communications equipment within their MTEFs (e.g. Dodoma MC intended to buy a car), and one or two plan to spend on upgrading council facilities for the CHAC, but the overall focus does not justify the occasional criticism that LGAs can not be trusted to make good use of HIV/AIDS funding.

3. At least some prevention activity was planned in most LGAs (14 of the 18). This includes work with schools (5) and youth groups (3) and adult education(3); with a range of methods mentioned including distributing condoms (4), work using peer educators (4) and drama groups (3 examples). There are examples of targeted outreach to high risk groups (3 examples), and cases where other departments have been involved not only in WPI, but also in outreach, for example via the transport department working with road gangs. Health related interventions include interventions on VCT 95 LGAs), STIs (5 examples), and with traditional healers (2).
4. About two thirds of LGAs include support for orphans normally in the form of school uniforms and fees for secondary school, and 11 of the 18 provide economic and social support to PLWHAs, typically IGA but with some providing nutrition advice and support.
5. Care and treatment interventions are mainly concerned with home based care, VCT, PMTCT, and supportive investments in CTCs. Most of the major expenditure planned on treatment is presumably mainly either off-budget or not mentioned under Objective A.

Overall, the plans appear to mention a range of generally appropriate interventions, but are limited in scope, partly due to the limited budget that LGAs expected to have available in 2007/8.

## Table A3.1 2007/8 HIV/AIDS Activities in A Sample of LGA Budgets

| Code | LGA | Cross Cutting | Economic and Social Support | Prevention | Care and Treatment |
|---|---|---|---|---|---|
| 70-3006 | Arusha Monduli DC | 15 activities:- Purchase IEC and prevention materials for 7 high transmission areas; train 11 WMACs; involve PLWHA in planning interventions in 6 centres; M&E including 4 coordination meetings for CSOs; | Identify OVCs, support to 80 vulnerable in high transmission areas | Works Dept is procuring and distributing condoms and IEC material | Train community based HBC, support 22 PLWHA, 2 from each ward |
| 71-3085 | Mkuranga DC, Coast | Training of WACs, VEOs, HQ staff; M & E and quarterly meetings with 40 leaders from 20 CSOs;, | School uniforms for 300 OVCs; seminars on small projects for 50 young PLWHA; Works involved in prevention activities; residential training and inputs on goat rearing. | Identify traditions and customs that are unhelpful and 'eliminate them by June 2008'; train 60 artists from different cultural groups; sensitise youths to volunteer for VCT via football tournament. School debates. Seminars to adult literacy learners. Procure STI medicine. | Lab machines, reagents, video machines (!), VCT, PMTCT, raise numbers involved in CTC |
| 72-2003 | Dodoma MC | No details, envisages buying a car and computer, training workers, M&E, training CMAC | Unspecified support to orphans | | |
| 73-2026 | Njombe TC | Training and supervision of MACs, furnish office | IGA for 50 PLWHA, unspecified numbers OVC ; fees and uniforms; support 4 orphanage centres; support 10 PLWHA groups on management of IGS | Prepare IEC and drama groups; train 150 youth groups; train primary school teachers in HIV/AIDS and life skills curriculum; adult educators; train peer educators on STD/HIV | 7 day Training HB carers |
| 74-3022 | Kasulu DC | Objective A clearly misunderstood, 'to improve services and reduce HIV/AIIDS infections' used as objective for a wide range of health service | | | |

| Code | LGA | Cross Cutting | Economic and Social Support | Prevention | Care and Treatment |
|---|---|---|---|---|---|
| | | improvement objectives (10 pages); very little outside health interventions. | | | |
| 75-3103 | Siha DC | Limited community sensitization only | | | |
| 76-3029 | Nachingwea DC | No performance budget provided, HIV not identifiable | | | |
| 77-3034 | Musoma, Mara | Training, supervision and running costs WEG, TVs and generators in 5 youth centres, sensitise teachers on VCT, conduct mobile VCT | Support 1500 OVC in primary, secondary, and out of school | Awareness in 153 primary schools, training MACS at all 3 levels; WPI and BCC of LGA workers; | Food supplements to 1300 PLWHA |
| 78-3038 | Ilege DC | 21 activities, training a wide range of groups | Orphan support | Peer educators | A lot on HBC , stigma, acceptance of AIRV, |
| 79-3043 | Morogoro DC | Training MACs | IGA for PLWHA, OVC support | Condoms; prevention skills to all primary teachers, iec on STIs in 20 high risk areas, seminars for 250 road workers | Nutrition training, CD4 count, establish new vct sites, train counsellors |
| 80-3049 | Masasi DC | 8 activities total, training staff, commemorate WAD, ICMAC, supportive supervision of VEOs | OVC school support, food for PLWHA | VCT in prisons | |
| 81-3054 | Magu DC | 23 activities total. Quarterly stakeholder meeting; COMATAA process in 30 villages leading to village AIDS plans | Food to PLWHA | BCC in fishing villages, other activities mentioned but few details | Dispensary construction coded as A |
| 82-2015 | Songea MC | 5 activities only, supportive supervision, transport, | Material support (unspecified) to PLWHA | Train peer educators | Rehab VCT centres |
| 83-3058 | Shinyanga DC | 14 activities. Training, advocacy, monitoring. | OVC school support; food, clothing for PLWHA and OVC through clubs; | Train youth and traditional healers on reproductive health and life skills; procure IEC material for primary schools; health staff orientation on post exposure prophylaxis; procure materials and reagents of HIV/STI; health staff training materials. | |
| 84- | Singida DC | 14 activities. Meetings, | Supporting | Training health staff on | Training health |

| Code | LGA | Cross Cutting | Economic and Social Support | Prevention | Care and Treatment |
|---|---|---|---|---|---|
| 3062 | | transport, sensitization, monitoring. | PLWHA, small (30) number of orphans | STI | staff on ARV, PMTCT; strong care and treatment focus, referral from VCT; |
| 85-3091 | Sikongwe DC | 6 activities in total. Training CMAC, monitoring and supervision. | Some support to PLWHA | Procure condoms, train villages in proper use; distribute leaflets and posters at village level; | |
| 89-2027 | Mpanda | 21 activities | Orphan and PLWHA support | Trad healers, peer educators, condoms, | |
| 95-3005 | Mbulu DC | 10 activities. Sensitisation | 160 OVC food, fees, materials, training; unspecified PLWHA support | Train trad healers and THAS, produce IEC materials | Sensitise primary teachers on support available for PLWHA; establish CTC services; train health centre staff on care and management of STI/HIV |

# Annex 4 District Visits

## *Kilombero District*

### 1. Background

Population is 90% in agriculture, mostly subsistence, rice maize beans and bananas. Aims to be the granary of Tanzania. Large scale sugar and paddy, other cash crops are cotton and sim sim and cocoa. Livestock is significant. Selou game reserve generates significant local revenue, revenue from hunting is 25% of collections from Central Government. Health facilities well equipped, but lack of staff, 'poor families unable to pay for cost sharing.' Council is well equipped. Road system impassable in places in wet season, lack of technical staff. Problems of land conflict. Pastoralists move in and out of the district. Has 5 divisions, 19 wards, 81 villages, 360 hamlets. Population was 322,000 in 2002, the district is attracting migrants for business, agriculture and livestock. Total spending 11.6bn.

Overall (not just HIV/AIDS), the district budget in 2005/06 experienced a slight shortfall in recurrent spending, but the development budget was received in full and 88% implemented (price variation on construction). Some problems of untimely fund release also caused delays, some problems complying with 2001 procurement act. But the overall performance is impressive, though the council need more for running costs. Mid year fy07 report also impressive, all funds for development released.

### 2. Plans and Budgets related to HIV/AIDS

Targets under Objective A in the MTEF include care and treatment of 45 PLWHA; and reducing the infection rate from a high 11% to 10.5% by 07/8 (unclear how they will know if achieved). Objective A is being used to record HIV/AIDS spending, but attribution of expenditures to individual targets seems arbitrary, e.g. some prevention activities shown under support to PLWHA, some economic and social support to orphans shown under care and treatment, so activities have been re-allocated in table below, drawn from the MTEF.

There are just 9 activities listed in the district MTEF, and the total cost is less than the resources planned to be made available from the HIV/AIDS grant. Indeed, the allocation expected by Kilombero is less than the TSh151mn shown in the allocation schedule for the grant, and thus the surplus funding could be greater than shown here – if the grant is fully disbursed. The main activities are support to OVCs, and some attention to home based care. The council is also working with villages to develop HIV/AIDS plans using the participatory COMATA approach. Not included in the budget is support from the GFATM, mainly focused on care and treatment although it also includes support for income generating activities by PLWHA. The problem appears to be more one of needing to scale up rather than lack of capacity in the district. There is a clear, costed work plan for the activities that are proposed, with attention to support and supervision for those responsible for implementation.

**Table Kilombero 1: HIV/AIDS Activities in the MTEF**

| Objective, target, activity name | 2007/8 Budget TShs | 2008/9 MTEF | 2009/10 MTEF | Funding Source |
|---|---|---|---|---|
| | | | | |
| 1. Cross-cutting projects and programmes | | | | |
| 1.1 performance review with ward staff | 5,072,000 | 5,244,360 | 5,378,640 | |
| 1.2 Vehicle maintenance | 4,680,000 | 4,914,000 | 5,159,700 | |
| 1.3 COMATAA training in villages | 13,150,115 | 13,775,826 | 14,414,527 | |
| 2. Preventive projects and programmes | | | | |
| 2.1 Promote voluntary testing | 5,234,000 | 5,441,660 | 5,628,630 | |
| 2.2Support 10 village AIDS prevention plans | 20,000,000 | 21,000,000 | 22,100,000 | |
| 2.3.Support WAD | 2,440,000 | 2,562,000 | 2,694,000 | |
| 3. care and treatment | | | | |
| 3.1 HBC 30 villages (food) | 33,292,885 | 34,957,529 | 36,705,480 | |
| 4. Economic and social support | | | | |
| 4.1 Uniforms 300, school fees 100 OVCs | 28,000,000 | 29,188,000 | 30,313,500 | 5492 TMAP |
| 4.2 Support 2 orphan centres | 5,960,000 | 6,166,400 | 6,330,450 | |
| TOTAL | 117,829,000 | 123,249,775 | 128,724,927 | 0 |
| Funding | 120,893,000 | 126,937,650 | 133,284,533 | HIV/AIDS development grant |

Stakeholders involved in HIV identified as UNICEF, Plan International (children in difficult circumstances, STIs), AMREF (community awareness), AXIOS (PMTCT). There are 7 active CARF projects managed by the RFA.

The district has 10 community development officers, no vacancies. On health staff, there are some gaps for nurses and clinical officers.

## *Kongwa: Visit By HIV/AIDS Public Expenditure Review Team*

The CHAC was attending training and not available, but we were able to have useful discussions with the DAC, the planning officer, accountant, treasurer, and acting CHAC.

## 1. Background

The district has a population of 250,000 (2002), growing at 2.4% per annum, 120,000 men to 130,000 women. It is a poor district (per capita income $120). The population is 90% rural, mostly occupied in subsistence farming and livestock activities. Productivity is low as a result of low rainfall and a serious problem of environmental degradation of soil. There were food shortages in FY2006-07. Major crops are maize, millet, groundnuts, sunflower seeds, there is some horticulture along streams. The district has 14 wards, 67 villages, 286 vitongoji. Total receipts and expenditure were surprisingly close to budget levels in 2005/6 and H1 2006/7.

## 2. HIV/AIDS Activities In 2006/7

Kongwa has so far received very limited external support for HIV/AIDS, partly reflecting the relatively low infection rate (4%). In 2006/7, ARV treatment was started at the district hospital using supplies provided free of charge by MOHSW, and relying on Dodoma to undertake analysis of CD4 counts for patients. About 200 patients are now on ARV treatment at one site, the intention is to expand this to 7.. There is no NGO support for ART, though NGOs are working in the district on prevention and economic and social support. CD4 counts are currently done at the regional hospital, though a CD4 machine is included in the proposed budget under GFATM round 4. Health basket funds were used to undertake training of 23 clinical officers in HIV/AIDS and sexually transmitted infections. The small sum of TSh1.284mn (about $1000) received from TACAIDS in 2005/6 was used to undertake 23 village meetings for sensitisation.

## 3. Plans and Budgets related to HIV/AIDS

Table 1 extracts the HIV/AIDS activities planned for the district as set out in the final version of the medium term plan and budget framework.

### Table Kongwa 1 HIV/AIDS Activities in the MTEF

| Objective, target, activity name | 2007/8 Budget TShs | 2008/9 MTEF | 2009/10 MTEF |
|---|---|---|---|
| 1. Cross-cutting | | | |
| 1.1 training HIV/AIDS taskforces to village level | 5,000,000 | 10,000,000 | 15,000,000 |
| 1.2Workshops training meetings | 10,000,000 | 15,000,000 | 20,000,000 |
| 1.3 Encourage and introduce VCT | 10,000,000 | 20,000,000 | 25,000,000 |
| 1.4 Furnish and equip CHAC office | 5,431,000 | 10,000,000 | 15,000,000 |
| 2. Preventive | | | |
| 2.1 Sensitise communities, procure condoms | 15,000,000 | 45,000,000 | 60,000,000 |
| 3. Care and treatment | | | |
| 3.1 Facilitate access to ARVs | 10,000,000 | | |
| 4. Economic and social support | | | |
| 4.1 Food and clothes for 120 PLWHA | 20,000,000 | 10,000,000 | 15,000,000 |
| 4.2 Food clothes fees for 250 OVC | 10,000,000 | 15,000,000 | 20,000,000 |
| 4.3 IGA for PLWHA (equipment) | 10,000,000 | 10,000,000 | 15,000,000 |
| Total HIV/AIDS | 95,431,000 | 135,000,000 | 185,000,000 |
| Total All Sectors | 8,413,697,543 | | |
| HIV/AIDS % | 1.13 | | |

The plan was prepared through a participatory process starting from village level discussions, and local representatives were involved in final decisions on the approved plan. The planned activities add up exactly to the amount allocated from the HIV/AIDS grant, implying that no other source of funding will be drawn on.[1]. However, this is before taking account of GFATM Round 4 expenditure. Kongwa is being added to the GFATM project for the first time in the current year, but the operational plan for spending the proposed allocation was prepared too late to be included in the district budget, and indeed has yet to be finally approved. The MTEF envisages doubling expenditure on the activities included over the next two years, and does not capture the GFATM activities. Kongwa is thus planning to significantly scale up spending.

Although MOF disbursed the first payment under the 2007/8 HIV/AIDS grant on 10th November, it had not reached Kongwa when we visited in early December. The TSh13.8bn allocated under the HIV/AIDS grant for 2006/7 was not actually received until early in 2007/8, and has been used mainly to support VCT testing. The budget for the president's initiative on VCT has had to be supplemented from other sources including the health basket; there has also been some support for VCT from the region and from NGOs.

The budget has had to be adjusted in the light of the launch of the president's campaign for voluntary counselling and testing, expected to cost TSh24bn but with only TSh10bn in the budget.. Over 32,000 people have been tested since September 2006, with recent acceleration through an outreach programme operating in 106 sites including all 41 health facilities. This effort was beyond the originally envisaged budget of TSh10mn for the activity in 2007/8. Moreover, the HIV/AIDS grant funding for 2007/8 was only released in November, and the payment approved by Ministry of Finance has not yet reached the district. To date in the current year, expenditure of about TSh22mn has been incurred. This has partly been financed using the TSh13.3mn received from TACAIDS under the HIV/AIDS grant and originally intended to finance expenditures in 2006/7. Some additional support was also received from the region, some in-kind supplies such as test kits were received from TACAIDS, and some NGOs provided support. In addition, some funds had to be re-allocated from other budget heads, including planning and the community development department. We were reassured that the expansion of the VCT programme would not be at the expense of the other planned HIV/AIDS activities, provided the promised TSh 95mn is received on time. It was pointed out that the expansion of testing does itself have implications for other expenditure obligations, with a resulting increase in demand for ARV treatment from those found to be positive.

The only budgeted prevention activity involves sensitisation meetings and the procurement of condoms. We questioned the need to procure condoms when there are plenty of supplies available in the country, and were told that there had been a shortage in the district but that additional supplies had been made available from the centre in connection with the VCT campaign, and there was now no intention to procure. We questioned the absence of budget for prevention activities in schools, and were told that this is being undertaken as a 'zero cost' exercise, done in the margins of visits by staff to

the district for other purposes. If budget allows, something a little more planned and systematic would seem to be merited.

## 4. Projects operating outside the LGA budget

Quarterly coordination meetings are held with NGOs operating in the district.

# *Mvomero*

## 1. Background

Mvomero is in Morogoro region. It is a new district, with a population of 260,000 (2002 census), growing at 2.6% per annum. The district offices are located in Morogoro, not in the district itself, although there are plans to move them. It is mainly an agricultural district (95% of households main occupation), with maize, paddy, sorghum, sugarcane, coffee, cotton and sunflower. Per capita income in 2005/6 was $120. Identified weaknesses include poor road network, lack of staff in health and education. Formulation of HIV/AIDS control plans and 'massive behaviour change' towards the disease are identified in key issues in the MTEF and plan..

## 2. Information on HIV/AIDS Budget and Expenditure:

Mvomero produced an HIV/AIDS plan and budget in 2006/7 with a planned disbursement of TSh90mn, exactly equal to the HIV/AIDS grant they expected to receive from TACAIDS. The plan was not implemented because funds were not received. The only activity in 2006/7 was funded by NGOs and by the RFA via the CARF.

HIV/AIDS grant funding of TSh13.8mn for 2006/7 was finally received in August 2007, and has been fully disbursed on activities carried forward, including computer equipment, identification of orphans, and holding of quarterly CMAC meeting, the first for over a year (none were held in 2006/7).Other activities have been deferred including training of councillors and MAC members at various levels, economic and social support to PLWHAs and OVCs, and various activities aimed at behaviour change.. The funding of activities from the 2006/7 budget after the year has closed is causing some problems for the Treasurer, who has no budget provision for them, and will need to have re-allocations or supplementary budget provision approved.

## 3. Plans and Budgets related to HIV/AIDS

The 2007/8 plan was prepared centrally, without much consultation. The Performance budget in Vote 79  3096 is consistent with final version of the medium term plan and budget. Although ward and village level MACs exist, they have been given minimal orientation, while the CMAC did not meet at all in 2006/7, lack of funding being given as the explanation.

Stakeholder analysis identifies TACAIDS as sole partner for HIV/AIDS, the plan shows no development budget. The HIV/AIDS block grant is planned to finance 85% of the budget, but there are also important contributions from the health basket and the district block grant (Table 1). Mvomero was the one district where the 10th November disbursement of 2007/8 HIV/AIDS block grant of TSh38.977bn had been received.

## Table Mvomero 1: Planned HIV/AIDS Activities

| Objective, target, activity name | 2007/8 Budget TShs | 2008/9 MTEF | 2009/10 MTEF | Funding Source |
|---|---|---|---|---|
| World AIDS day | 1,865,000 | 2,060,500 | 2,256,000 | LG block grant |
| Print 1500 IEC materials on STI infection | 1,000,000 | 11,000,000 | 12,000,000 | LG block grant |
| Train 30 FLHW on syndronic mngmnt of STIs | 5,253,400 | 5,657,078 | 6,060,768 | LG block grant |
| Block Grant Total | 8,118,400 | 18,717,578 | 20,316,768 | |
| Theatre groups and performances, 17 wards, 40 villages | 732,500 | 823,000 | 990,000 | Own sources |
| Own Sources Total | 732,500 | 823,000 | 990,000 | |
| Sensitisation in blood transfusion safety | 929,049 | 1,003,905 | 1,078,761 | Health basket fund |
| Sensitisation in 3 sec and 7 primary schools on prevention and transmission HIV | 100,000 | 150,000 | 200,000 | Health basket fund |
| Kits for testing blood donors | 695,000 | 928,000 | 1,160,000 | Health basket fund |
| Hosp commemoration of WAD | 305,000 | 318,000 | 331,000 | Health basket fund |
| Purchase ARV drugs | 761,810 | 952,263 | 1,142,715 | Health basket fund |
| Train 22 FLHW on PMTCM | 5,625,000 | 6,750,000 | 7,500,000 | Health basket fund |
| Community sensitisation on early treatment of STIs | 426,000 | 530,000 | 634,000 | Health basket fund |
| Health Basket Total | 8,841,859 | 10,632,168 | 12,046,476 | |
| Condoms and protective gear procure and dist | 1,970,000 | 3,114,000 | 4,258,000 | HIV/AIDS Grant |
| VCT mobile services at MLALI | 4,160,000 | 4,514,000 | 4,868,000 | HIV/AIDS Grant |
| WPI for MVDC staff | 4,480,000 | 4,960,000 | 6,400,000 | HIV/AIDS Grant |
| Training primary | 6,637,000 | 6,821,000 | 8,285,000 | HIV/AIDS |

| Objective, target, activity name | 2007/8 Budget TShs | 2008/9 MTEF | 2009/10 MTEF | Funding Source |
|---|---|---|---|---|
| teachers, 1 day | | | | Grant |
| CMAC quarterly meetings | 2,766,000 | 2,899,000 | 3,032,000 | HIV/AIDS Grant |
| WAD | 1,315,000 | 1,414,000 | 1,513,000 | HIV/AIDS Grant |
| Sugg boxes | 515,000 | 704,000 | 893,000 | HIV/AIDS Grant |
| M&E | 2,895,000 | 1,807,000 | 1,914,000 | HIV/AIDS Grant |
| Economic and social support:- sensitisation and support to plwha including income earning loans and to orphans | 33,769,800 | 38,745,800 | 48,021,800 | HIV/AIDS Grant |
| Aid coordination office | 19,101,200 | 30,602,400 | 42,103,600 | HIV/AIDS Grant |
| Care and treatment | 21,700,000 | 29,714,000 | 37,728,000 | HIV/AIDS Grant |
| HIV/AIDS grant Total | 99,309,000 | 125,295,200 | 159,016,400 | |
| Total HIV/AIDS Budget | 117,001,759 | 155,467,946 | 192,369,644 | |

## 4. Information on individual projects and programmes:-

After a long period without funds, implementation in the first quarter of 2007/8 has focused on:-

1. WPI for council staff. The District prepared their own materials, choosing to focus on TB.
2. Training of committees at village and ward level. This has not yet started, the cash recently received from TACAIDS will be partly used to fund this.
3. Mobilisation of PLWHAs into groups, with the aim of then providing support via those groups. The council has already provided cash support to two groups to start a revolving fund for income earning activities within the group, though on a very small scale (two groups of 7 beneficiaries, groups receiving TSh1mn each). Orphan support is also in the budget but has not yet started, though some NGOs are active in this area.
4. There is a need for the LGA to be involved in care and support for PLWHAs because the NGOs are said to be very urban biased, and do not cover the remote wards.
5. On the prevention side, the council distributed 27,000 condoms in the first quarter. The staff identify truck drivers and petty traders along the road as key high-risk groups.

6. About two thirds of women give birth in a facility, and are offered a test. There are three sites able to offer PMTCT. Of 756 women delivering at a facility, 695 accepted to be tested, 41 were HIV positive, but the district records only 9 as accepting treatment. This low number may be due to women going to the regional hospital instead.

For future priorities, the council would like to increase the number of permanent VCT sites from the present three, because use of mobile sites (there are 35) is in their view unsustainable.

## 5. Projects operating outside the LGA budget

Family Health International are providing support on care and treatment, the council do not know how much is being spent. Treatment started in 2007, and there are currently 169 people on ARV drugs.

## 6. Organisation and Institutions

The council uses PLANREP for budget preparation but not for reporting. The first quarter performance report has been submitted, but does not specifically report spending on HIV/AIDS (objective A), partly because there was little to report due to lack of funds. The LGA is aware of the need to report expenditure and progress on Objective A in the second quarter.

# *Kinondoni District*

## 1. Background

Kinondoni is a municipality within the city of Dar es Salaam and became autonomous in 2000. Kinondoni, as part of Dar es Salaam Region, enjoys many benefits including being well linked by roads and other communication networks to the rest of the city and other parts of the country. According to the 2002 Census, Kinondoni has a population of 1,088,867 people, comprised of 549,929 men (50.5%) and 538,938 women (49.5%), which makes it the most populous local authority in the country. With a growth rate of 4.1% per annum, the municipality is estimated to have a population of 1,331,140 in 2007. The rapid population increase is influenced by both natural causes and immigration. The municipality is divided into 3 zones, 4 divisions, 27 wards and 127 mitas (or villages).

It is estimated that 360,000 residents (about one third of the population) are employed in both private and public sectors. Out of these, 95% are employed in the private sector while the rest are employed in the public sector. About 18% of the population is self-employed and the majority of the residents are involved in micro business, fisheries, livestock and agriculture. There are no big farms but small plots ranging from 2.5 to 6 acres. Some residents also use their own personal plots for growing cassava and sweet potato for their own consumption and the surplus for income generation.

Kinondoni also provides an abundant number of services to their residents, including primary healthcare, primary and secondary education, solid waste management and infrastructure.

Own source revenue collection is improving from Tsh4.3bn in 2004/5 toTsh5.6bn in 2005/6. The source of the taxes mainly come from property tax, city service levy and bill boards. The total budget for Kinondoni in 2007/8 is Tsh36bn but 65% is going towards recurrent expenditure, of which 74% goes towards salaries.

## 2. HIV/AIDS Activities in 2006/7

In 2006/7, HIV/AIDS estimated budget expenditure totaled Tsh528mn but the municipality only received a fraction of the total (Tsh145mn), of which 84% was spent. The main source of the funds came from the Global Fund 3, years 1 and 2 (i.e. 81%). Other sources for that year were the health basket, cost sharing and some residual funds from TACAIDS from the previous fiscal year. As such most activities were based on Global Fund related activities, such as scaling up VCT.

## 3. Plans and Budgets related to HIV/AIDS

The MTEF for 2007/8 have been prepared in a participatory approach where all stakeholders are engaged from the village level up to the municipal level. Under Objective A the only two targets that are mentioned are targets 1 and 2, i.e. cross cutting support to fight care and treatment and prevention of HIV/AIDS, though only target 1 actually has figures assigned to it.

For 2007/8, the sources of funds are the same as for 2006/7 with a projection of a little less than the year before (Tsh487mn –this figure, provided during the site visit, differs from MTEF figures of Tsh372mn), though the projected Global Fund money has not been included in this year's MTEF. The entire HIV/AIDS grant (Tsh368mn) has been allocated to the Community Development, Gender and Children Department which falls under the domain of the CHAC.

There are only 10 activities listed in the municipal MTEF and the total cost is just a bit over the HIV/AIDS grant. All HIV/AIDS activities are funded by external financing. The main activities have been designated under target 1, specifically to reduce HIV/AIDS prevalence from 11% to 7% by June 2010. However the activities identified seemed to be arbitrarily attributed to target 1, so activities have been re-allocated in table below, drawn from the MTEF.

### Table Kinondoni 1

| Objective, target, activity name | 2007/8 Budget TShs | 2008/9 MTEF | 2009/10 MTEF |
|---|---|---|---|
| 1. Cross-cutting projects and programs | | | |
| Equip VCT sites | 4,386,000 | 4,561,440 | 4,743,898 |
| Equip coordination of office with furniture and computers | 5,820,000 | 6,052,800 | 6,294,912 |
| Conduct quarterly meetings for 27 WMAC, 200 CSO & site visits | 16,335,000 | 16,988,400 | 17,667,936 |
| 2. Prevention projects and programs | | | |
| Conduct awareness workshop to 400 KMC staffs | 19,755,000 | 20,545,200 | 21,367,008 |

| Objective, target, activity name | 2007/8 Budget TShs | 2008/9 MTEF | 2009/10 MTEF |
|---|---|---|---|
| Improve efficiency of 127 MMAC through training | 106,119,000 | 110,359,080 | 114,773,443 |
| Develop and distribute IEC materials with HIV/AIDS messages | 6,750,000 | 7,020,000 | 7,300,800 |
| 3. Economic and social support | | | |
| Conduct needs assessment to identify OVCs and PLWHA | 1,610,000 | 1,674,400 | 1,741,376 |
| Support orphans and PLWHA | 135,000,000 | 140,400,000 | 146,016,000 |
| Establish community participatory tool against STI/HIV/AIDS in 10 villages | 76,720,000 | 79,793,480 | 82,985,219 |
| TOTAL | 372,495,495 | 387,394,800 | 402,890,592 |
| Source of funds all come from HIV/AIDS grant except for equipping VCT sites | | | |

## *Mkuranga*

### 1. Background

Mkuranga is among the seven districts councils of Coast Region in Tanzania. The District has total of 2432 sq km, whereas only less than half of the land (1034 sq km) is suitable for cultivation. It has a population of 222,259 people of which 106,649 (48%) are males and 11,610 (52%) females. It is mainly an agricultural district (95% are small farmers, cultivating cash and food crops) with cashew nuts, coconuts, cassava, rice, maize, and sweet potatoes. To a lesser extent there is also fishing and animal husbandry. Identified weaknesses include lack of transport, lack of properly skilled staff and insufficient supply of OI drugs.

The HIV/AIDS prevalence rate in Mkuranga is below the national rate at 4%. Poor knowledge, poor belief of HIV/AIDS prevention intervention, illiteracy/ignorance and stigmatization are identified as constraints to reducing prevalence. Like other districts visited, the current MTEF places great emphasis on effective sensitization about HIV/AIDS in the community.

### 2. HIV/AIDS Activities in 2006/7

As no monies had been received in the past few years from TACAIDS very little community development related HIV/AIDS activity has occurred in the past few years. The district has mainly been responsible for supporting CSOs in their district that receive money from the Regional Authorities.

Money received from the health basket did go to ARV treatment which started in 2006 with 45 patients and in 2007 more than tripled the numbers to 150 patients. The District

Council Hospital and PASADA are currently supporting the ARV treatments. From the almost 200 patients on ARV, 14 died while on treatment.

## 3. Plans and Budgets related to HIV/AIDS

The District has produced a very detailed and comprehensive MTEF plan (over 400 pages but a total budget of Tsh10bn for 2007/8) outlining all the activities planned for the upcoming three years. Table 1 extracts the HIV/AIDS activities planned for the district as set out in the final version of the medium term plan and budget framework. However, this is before taking account of GFATM Round 4 expenditure.

## Table Mkuranga 1

| Objective, target, activity name | 2007/8 Budget TShs | 2008/9 MTEF | 2009/10 MTEF |
|---|---|---|---|
| 1. Cross-cutting projects and programmes | | | |
| Conduct orientation meetings to CHMT | 6,681,500 | 7,115,825 | 7,550,150 |
| Provide funds for STI/HIV/AIDS/RPR reagents for 14 dispensaries | 9,190,000 | 9,649,500 | 10,109,000 |
| Install 2 TV/Video sets and accessories at Council Hospital | 1,000,000 | 1,050,000 | 1,100,000 |
| Conduct meetings with community home based care providers, care and treatment service providers and PLHA leaders | 1,271,000 | 1,394,000 | 1,516,500 |
| Support Annual World Aids Day | 1,325,000 | 1,595,000 | 1,865,000 |
| Conduct training to 19 HWs from 13 HFs on RPR and HIV test | 1,397,800 | 1,562,350 | 1,762,900 |
| Support orphans (secondary school fees) | 500,000 | 600,000 | 700,000 |
| Conduct seminars/workshops/ training/ debate sessions on HIV/AIDs to various members of the staff & community (business, PLWHA, teachers, etc) | 51,630,000 | 61,668,310 | 71,920,920 |
| Administration | 3,000,000 | 3,600,000 | 4,200,000 |
| Sensitization of community/staff/VWC on their duties | 8,995,000 | 6,582,300 | 11,998,890 |
| Monitoring and evaluation sessions | 2,397,600 | 2,525,460 | 2,663,720 |
| Improve nutritional status of HIV/ affected families | 7,000,000 | 7,503,000 | 8,006,000 |
| 2. Prevention projects and programs | | | |
| Incorporate VCT/PMTCT to RCHC mobiles and outreach clinics | 13,000,500 | 14,240,000 | 15,479,500 |
| Strengthen linkages btn district councils and CSOs | 2,977,400 | 3,317,000 | 3,708,500 |
| 3. Care and treatment of PLWHA | | | |
| Improve database management system | | | |

| Objective, target, activity name | 2007/8 Budget TShs | 2008/9 MTEF | 2009/10 MTEF |
|---|---|---|---|
| | 4,000,000 | 8,000,000 | 12,000,000 |
| 4. Economic and social support to those affected by HIV/AIDS | | | |
| Supprt orphans in primary school - school uniforms | 16,000,000 | 21,728,960 | 27,520,220 |
| **Total** | **130,365,800** | **152,131,705** | **182,101,300** |
| **Source of financing: TSh84,130,000 from HIV/AIDs grant, rest from Health basket and others** | | | |

Preparation of the HIV/AIDS budget plan is centrally based with the main stakeholders based on the existing management structures/committees, such as the Council Health Management team, Council Management team, District Council Social Services committee, Mkuranga District Full Council and also includes regional representation.

Since 2005, Mkuranga has been promised funding for HIV/AIDS activities from TACAIDS but did not receive any funding until this fiscal year. For the current fiscal year, 2007/8, the funding that was to be received in September (from 2006/07) did not arrive until early November due to a banking error not noted by either the district or the central government. When the team met the officials in early December the district had yet to receive the first disbursement for 2007/8 of Tsh33mn. Thus, the total transfer to date from the HIV/AIDS grant will be Tsh44mn.

The main sources of funding for HIV/AIDS come from the health basket block grant, TACAIDS, Columbia University, AMREF and MEDICOS DEL MUNDO (an international NGO). Most of the funding goes to training, sensitization, prevention and care and treatment. For 2007/8, funding that has already been received at the district has also been spent. Mkuranga is also one of the districts that will receive Global Fund Round 4 monies, projected at Tsh290mn, which is three and a half times larger than the subvention received through TACAIDS. TACAIDS subvention is solely dedicated to sub vote 5494 (i.e. Mainstreaming HIV/AIDS in National Development) totaling Tsh84mn which is dispersed amongst the various departments within the District (i.e. trade & economy, education, land development & urban planning, health services, preventive services, agriculture, etc.) The CHAC is responsible for Community Development, Gender and Children and receives about 19% of the total subvention.

# Annex 5 Terms of Reference for the 2007/08 Public Expenditure Review for HIV/AIDS

## 1. Introduction

Tanzania is currently considered amongst the worst affected countries from HIV/AIDS in the world with an estimated prevalence of 7%. However, Tanzania has mobilised resources to approximately 1 billion US$ since adopting a multi-sectoral approach to HIV/AIDS. Having established a multi-sectoral approach, there is a need to coordinate and harmonise the mobilised resources in order to ensure efficient and effective response from all stakeholders.

## 2. Mainstreaming HIV/AIDS into the government planning and budgeting cycle and coordinating with non-state actors

Tanzania has been successful in mainstreaming HIV/AIDS in the government planning and budgeting cycle. At MDA level, there is the need to make HIV/AIDS a priority issue. This is crucial for MDAs such as Education which have a large role to play in the overall response.

Tanzania has introduced HIV/AIDS block grants for LGAs as recommended in the 2005 PER. This is aligned to the on-going reform of local government with the emphasis on decentralisation and is a means of ensuring funds are committed for HIV/AIDS. This will be the first fiscal year of operation and it is planned to produce an operational manual for the block grant in addition to the budget guidelines and the PER will feed into these documents.

## 3. HIV/AIDS and the forthcoming PER

In the forthcoming PER 2007/08 exercise, the focus will be on Ministries, Departments, Agencies and Local Government Authorities their level of

activity and to assess the funding and modalities in use. In addition, the study will assess measures for ensuring a more effective contribution to the National Multi-sectoral strategy of HIV/AIDS into the forthcoming budget round and enhanced civil society action.

It should include (at least the following elements)

a. Review the status of recommendations of the 2006 HIV/AIDS PER
b. Extract from all current MTEFs the HIV/AIDS related activities/ budget and out-turns for the financial year 2006/07
c. Review the implementation of objective "A" in MDA MTEFs for HIV/AIDS activities
d. Provide clarity on the adequacy of funding for all aspects of the NMSF with the focus on under-spending in priority areas (**the PER working group will assist with the identification of priorities**)
e. Visit at least 5 districts to assess use of the HIV/AIDS block grant in terms of their HIV/AIDS content.
    i. Does the formula seem to have been applied? Are there any potential inequities with the current formula[1]?
    ii. To anticipate/ pre-empt problems, did the districts know about the HIV/AIDS block grants? How did they prepare for them? Were the CMACs (or any other groups) involved in the preparation of the plans?
    iii. Were activities prioritised?
    iv. Is it consistent with what should be the priorities?
    v. To what extent are the funds allocated to VMACS and CSOs?

f. Provide a summary status report on development and implementation of LGA activities (i.e an assessment of plans vs. budgets vs. actual expenditures)

g. Assess adequacy of funding modalities for non-state actors at LGA level with regard to accessibility of funds and tracking of expenditure.

i. In this respect a tracking study will be undertaken examining how CSOs access funds and the ability to track funding and expenditure of such modalities.

h. Assess on-going development partner support in support of the NMSF (assess largest projects i.e both project/programme expenditure supporting government and funds flowing directly to non-government entities)

i. Identified current programs and the extent of implementation in the following sectors: Health, Agriculture, Education, Health, Community development and Water.

j. Assess trend of 5 years of budget and expenditure.

k. Review HIV/AIDS Fund, the new funding modality.

l. Assess allocation of funds for 2007/08 based on the thematic areas in the NMSF.

**4. <u>Deliverables including proposed dates</u>**

a. Meeting with PER Working Group

b. Consultants and team commence study

c. A summary report and meeting with PER working group should take place during the study.

d. A full draft report, including annexes, tables, and figures should be submitted by [December 2007] in electronic form (MS word and MS Excel)

e. Comments from CSO, sectoral and overall PER working group [End of January 2008]

f. The report will have a maximum of 40 pages, excluding appendices. It must include an accessible summary on the principal conclusions, policy implications and recommendations for wider distribution to the public (maximum 5 pages)

g. The finalized report taking account of comments/ recommended amendments should be submitted in electronic form (as above ) by [1st week of February 2008]

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