In Fiscal Year (FY) 2017/2018, the total budget expenditure for Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV and AIDS)-dedicated programmes and Tanzania Commission for AIDS (TACAIDS) amounts to approximately Tanzanian Shillings (TSh) 212 billion which constitutes 1 per cent of the Government’s total spending (excluding Consolidated Funds Service (CFS)).

The total HIV and AIDS-related spending constitutes 19 per cent of the Ministry of Health, Community Development, Gender, Elderly and Children’s (MoHCDGEC) budget.

The budget of TACAIDS in FY 2017/2018 stands at TSh 6 billion. Recurrent expenditures constitute 42 per cent of the budget. It has recorded a significant reduction from FY 2015/2016 following the winding up of TSh2.6 billion in grants from the TACAIDS to Local Government Authorities (LGAs).

Execution rates at TACAIDS and MoHCDGEC are below average when compared with other Ministries, Departments and Agencies (MDAs). In FY 2016/2017, budget performance stood at 66 per cent and as low as 49 per cent in the past five years. The Government’s largest contribution to the HIV response is through the provision of human resources and infrastructure. It is difficult to estimate the value of this contribution with the National Budget in its current form. In the future, the Government may consider to include estimated HIV and AIDS spending on an annual basis. Comprehensive budget reporting will require improving monitoring, accounting and reporting at all levels of the Government.

Tanzanian HIV and AIDS budget is significantly reliant on external financing, with the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) contributing almost three quarters of the budget in FY 2017/2018. This exposes the sector to funding risks that are beyond the Government’s control.

HIV prevalence among children 0-14 years was 0.4 per cent. However, there were marked geographical variations, with three regions higher than 9 per cent HIV prevalence. New HIV infection rates were more than twice as high in women (0.4) as compared to men (0.17), and HIV prevalence in girls and women was double that of men, pointing to the urgency for a stronger, gendered HIV response.

With 40 per cent of all new HIV infections in 2016 in young people, mostly in girls, and more than 200,000 adolescents and young people already living with HIV, more attention is urgently needed to address their specific realities and scale up comprehensive interventions, including those which address structural drivers of new infections.

Large differences in prevalence between regions need to be addressed with a well-defined strategy. The Government could consider moving towards targeted funding mechanisms based on the number of people living with HIV. However, for maximum results, a more advanced model is needed that takes into consideration different per-capita costs of responding to the HIV epidemic where prevalence is 15 per cent and when it is under 1 per cent.

Viral load suppression was low across all regions and particularly low in children with 18.4 per cent, calling for further improvements in the HIV treatment programme.

Key Messages and Recommendations

1. CFS refers to all revenues received by the Government by way of direct taxes and indirect taxes, money borrowed and receipts from loans given by the Government flow into the Consolidated Fund of United Republic of Tanzania.
2. Government of Tanzania Budget Files
1. INTRODUCTION

HIV and AIDS sector overview

The first cases of HIV in Tanzania were detected in 1983 and the first nation-wide guideline was adopted in 1985, with the introduction of the first ‘Short Term Plan’. The epidemic peaked eight years later when in 1993 the rate of new incidents reached 7.7 cases per 1000 people. The rate of new infections has retreated since. Today the number of people living with HIV in Tanzania is estimated at 1.4 million. Falling transmission rates and improved access to antiretroviral treatments has resulted in a near stabilisation of the number of HIV positive individuals in the country, which is a positive development.

However, Tanzania remains among top 15 countries with a high number of people living with HIV in the world. Half of Tanzanians living with the virus are unaware of their status, and 90 percent of those who are aware of their status receive treatment. The majority of young people remain unaware of HIV prevention methods, with 40 per cent of young men and 49 per cent of young women not using condoms during high-risk sexual encounters.

Heterosexual intercourse is the most common source of transmission of the virus. However, much higher incidence of HIV is recorded among vulnerable and high-risk populations than the general population. The general population has a HIV prevalence rate of 5 per cent, while for Female Sex Workers (FSWs) the HIV prevalence was estimated to be 26 per cent, for men who have sex with men, prevalence is estimated to be 25 per cent and for people who inject drugs 36 per cent.

Main policies and strategies

The first crucial HIV epidemic related legal act in Tanzania was the Tanzania Commission for AIDS Act of 2001. It established and described roles of one of the main government institutions managing HIV-related activities and shaping related policies. In 2008 Tanzanian Government ratified the HIV and AIDS (Prevention and Control) Act of 2008. The Act is very comprehensive, covering all aspects of HIV and AIDS prevention, treatment and community response. Specifically, it addresses education and awareness building – putting the responsibility on community and religious leaders, testing and counselling – emphasising accessibility and volition, patients’ rights including that of confidentiality, access to condoms and anti-discriminatory provisions. However, age of consent for HIV testing was then prescribed at 18 years and above.

The key policies guiding procedures related to the HIV and AIDS epidemic in Tanzania are the Standard Operating Procedures for HIV Testing and Counselling Services, National Guidelines for the Prevention of Mother-to-Child Transmission of HIV and Keeping Mothers Alive, National Guidelines for the Management of HIV and AIDS. The National Policy on AIDS of 2001 was the first comprehensive policy which laid the foundation for future policies. The National AIDS Policy provides a background for leadership and coordination of the national response to the epidemic. Further, the National Multisectoral Strategic Framework (NMSF) for HIV and AIDS 2013/14 - 2017/18 is providing specific details for the country. A new Framework for 2018/2019 – 2022/2023 is under development. In addition, the country has also developed a Health Sector HIV and AIDS Strategic Plan.

Main institutions and their objectives

The MoHCDGEC and the TACAIDS (Department under the Prime Minister’s Office) are the Government’s institutions central to addressing of the HIV epidemic in the country. The division of tasks between the two is along the lines of multi-sector coordination for TACAIDS and health oriented planning, guidelines,
policies, and oversight for NACP of HIV interventions delivered in the health sector. By and large MoHCDGEC’s mandate includes HIV testing and treatment services, and preventive tools such as condoms and educational materials for health workers. TACAIDS assumes tasks such as overall resource mobilisation from internal and external agents and multi sector policy formulation.12

There are four thematic areas that are prioritised by the Tanzanian Government in the HIV and AIDS response. Firstly, prevention aims to reduce HIV incidence, especially by targeting communities where HIV prevalence is high. The second area focuses on care and treatment for people living with HIV and AIDS, which includes clinical services and provision of antiretroviral medications. The third aims at reducing stigma and/or discrimination and condom promotion. Finally, the fourth area focuses on health system strengthening through improving human and physical infrastructure used for the treatment of people living with HIV.13 In recent years Tanzania has seen a shift of focus towards treatment and away from other areas.

Sector performance

Tanzania has recorded significant gains in its fight against HIV. In 1993 the growth rate of new infections slowed and has been declining at the rate of 8 per cent a year since.14 From 2014 the number of AIDS-related deaths has also been dropping and the number of people living with HIV has stabilised. The introduction of large-scale antiretroviral programmes, that have been steadily increasing their reach since 2010, has played a large role in stopping the spread of HIV. Tanzania has also made significant improvements in testing, accessibility of condoms as well as the promotion of male circumcision, with some regions approaching 100 per cent coverage among target groups.15

The mother-to-child transmission rate has reduced due to the rapid roll out of HIV testing at Maternal and Child Health (MCH) centres and availability of antiretroviral treatment (ART) to mothers living with HIV. An estimated 93 per cent of reproductive and child health facilities nationwide have integrated prevention of mother-to-child transmission (PMTCT) services, up from 78 per cent in 2009.16 Recent data from UNAIDS show improvements in the rates of mother to child transmission have stalled and even worsened. The number of AIDS related deaths amongst the population under 1 year have also increased slightly. This suggests the need for further investigation.

Despite positive results, the success of further HIV reduction is at risk due to economic and non-economic barriers. Epidemic control is reached when the total number of new HIV infections falls below the total number of deaths from all causes among HIV-infected individuals.17 In Tanzania HIV-related deaths have fallen faster than the number of new infections.

Tanzania faces health system challenges that are likely to hamper further improvement in the fight against HIV. The country has one of the lowest health worker to population ratios in the world, with the situation especially concerning in the public sector.18 There is also the occurrence of essential drugs being out of stock at times.19

HIV is a disease which impacts on men and women differently, as women also often bear the greater responsibility for caring for those with HIV. The disparity in HIV prevalence between males and females is most pronounced among younger adults, with women in age groups 15 to 19, 20 to 24, 25 to 29, 30 to 34 and 35 to 39

### TABLE 1: Compared responsibilities of MoHCDGEC and TACAIDS

<table>
<thead>
<tr>
<th>MoHCDGEC</th>
<th>TACAIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support the implementation of prevention and care interventions: These include patient care (hospital-based, and home-based), sexually-transmittable disease (STD) services, blood safety, HIV testing and counselling.</td>
<td>Coordination of internal and external partners (donors, Non-Governmental Organisation (NGOs), sectors including Districts, etc.)</td>
</tr>
<tr>
<td>Research Coordination</td>
<td>Strategic Planning</td>
</tr>
<tr>
<td>Technical Support for other Sectors</td>
<td>Resource Mobilisation and Utilisation</td>
</tr>
<tr>
<td>Surveillance</td>
<td>Policy formulation</td>
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<tr>
<td>Intervention development</td>
<td>Advocacy</td>
</tr>
<tr>
<td>Distribution of commodities such as condoms. Health Learning Materials and Supplies.</td>
<td>Monitoring and Evaluation including overall Programme Reviews</td>
</tr>
<tr>
<td></td>
<td>Secretariat to National Committees</td>
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<tr>
<td></td>
<td>Sharing and Dissemination of Information</td>
</tr>
<tr>
<td></td>
<td>Promotion of best practice</td>
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</tbody>
</table>

12. National AIDS Control Programme
13. Third Sector HIV and AIDS Strategic Plan (HSHSP III)
14. Avert, HIV and AIDS in Tanzania
15. Ibid.
16. UNICEF, Elimination of mother-to-child transmission of HIV (eMTCT)
17. PEPFAR, Strategy for Accelerating HIV and AIDS Epidemic Control (2017-2020)
18. World Development Indicators (WDI) Databank
19. Ibid. This data does not refer to an antiretroviral (ARV) drug in particular
all having prevalence more than double that of males in the same age groups.20 A study of time use has shown women spend three times as much time on unpaid care of children, the sick, disabled, and elderly, than males.21

Social stigma associated with living with HIV is also an issue to eliminating AIDS in the general population. Community based therapeutic care providers have stated stigma as having an impact on testing and proper treatment and counselling. The fear of having their HIV status disclosed to the community has been an impediment for those accessing testing. Similarly, people living with HIV and AIDS (PLHIV) have often not joined patient support groups and allowed medical workers to visit homes due to fear of having their HIV status disclosed.22

20. Tanzania HIV Impact Survey (THIS) 2016-2017
22. A qualitative study of the determinants of HIV guidelines implementation in two south-eastern districts of Tanzania, Mary N Mwangome et.al. 2017
Takeaways

- Tanzania has made a significant improvement in treating people living with HIV and reducing HIV transmission.

- Some of the most significant improvements were achieved in the prevention of mother-to-child transmission.

- Further improvement is needed as Tanzania remains among countries with a high prevalence of the virus. Arguably low awareness of HIV status remains a significant concern.

- Women face a double disadvantage when it comes to HIV. For a number of age groups women are twice as likely to live with HIV. Women also spend three times the amount of time providing unpaid care of children, the sick, disabled and elderly than males.
2. HIV AND AIDS SPENDING TRENDS

It remains difficult to estimate what is spent in Tanzania on HIV and AIDS. While TACAIDS has the status of a vote and its budget is stipulated in budget books, the National AIDS Control Programme (NACP), which manages most of the earmarked HIV funds from development partners, operates under the MoHCDGEC. Many of the MoHCDGEC budget lines aggregate expenditure for HIV and AIDS prevention with other activities managed by the Ministry. Analysing data at sub-national levels also remains difficult. Like many reports on HIV financing in Tanzania, this report also suffered from a lack of disaggregated HIV spending. Moving to a programme-based budgeting system and away from less transparent line-item budgeting, and incorporating aspects of functional accounting would greatly assist analysis and understanding of Government spending.

In FY 2017/2018, the total budget expenditure for HIV and AIDS-dedicated programmes and TACAIDS, amounts to approximately TSh212 billion. This constitutes 1 per cent of the Government’s total spending (excluding Consolidated Funds Service). This number does not include health worker wages and health facilities which receive the largest contributions from the Government. Almost all the HIV and AIDS funds captured in this analysis - 97 per cent - are managed by the MoHCDGEC. The remaining 3 per cent is managed by the Tanzanian Commission for AIDS. The total HIV and AIDS-related spending constitutes 19 per cent of the MoHCDGEC budget.

Almost all the HIV and AIDS funding considered in the following analysis is categorised as development and is entirely donor funded. While the Ministry incurs recurrent expenditures, mostly on salaries, it is not currently possible to disaggregate this spending. MoHCDGEC estimates that over 90 per cent of NACP expenditure is financed by external funds from donors. The Government does fund NACP salaries (by providing most of the staff) and some infrastructure expenses (by providing buildings).

The budget of TACAIDS in FY 2017/2018 stands at TSh6 billion. Recurrent expenditures constitute 42 per cent of the budget. It has recorded a significant reduction from FY 2015/2016 following the winding up of TSh2.6 billion in grants from the Commission to Local Government Authorities. Out of TSh3.5 billion dedicated by TACAIDS towards development, TSh3 billion is allocated to finance AIDS Trust Fund managed by TACAIDS.

3. COMPOSITION OF HIV AND AIDS SPENDING

Fluctuations in TACAIDS spending are significant, but less so when seen in the context of actual expenditures

MoHCDGEC manages the largest part of HIV and AIDS expenditure through its sub-department NACP. Unfortunately, the institution does not have a separate budget line and therefore it remains difficult to determine its spending. It is, however, informative to look at the budget dynamic of the Ministry as well as of the main HIV and AIDS-related programmes managed by NACP. In the FY 2017/2018 budget, expenditure on the HIV and AIDS Prevention Programme constituted 26 per cent of total development expenditures of the Ministry. This was an increase from a mere 6 per cent a year before and 2 per cent a year earlier. This increase accompanied a large donor-funded HIV and AIDS programme. It is likely this domestically funded increase is a ‘one-off’ and HIV and AIDS spending will decline in the next fiscal year. The planned increase in the budget is partially driven by new World Health Organisation (WHO) guidelines recommending that all people living with HIV be prescribed ARV treatment, instead of only those with a high CD4

FIGURE 9: TACAIDS Budget (billion TSh)

Source: Budget Books 2017/2018

24. It remains difficult to extract the number from the budget in its current form
25. CFS refers to all revenues received by the government by way of direct taxes and indirect taxes, money borrowed and receipts from loans given by the government flow into the Consolidated Fund of United Republic of Tanzania.
26. Government of Tanzania Budget Files
27. Health Policy Plus; Budget Execution for HIV-Related Allocations in Tanzania Review of Performance for Fiscal Year 2016/17
28. MoFP Integrated Financial Management Information System (IFMIS)
count. The new policy will result in a funding gap which will be addressed by the Global Fund under its Scale up (tuberculosis) TB and HIV interventions in Tanzania Grant.29

The budget speech of the Minister of Health emphasised the importance of HIV and AIDS prevention and treatment. ARV treatment, prevention of Mother-child transmission and male circumcision emerged as priorities in the speech.30 However, while HIV, as well as other communicable diseases, remain priorities for the Government, their high share in the total budget is driven by foreign rather than domestic contributions.

Outcomes against commitments

Tanzania has committed to meeting the goals of the United Nations Joint Programme on HIV and AIDS global 90-90-90 targets31 by 2020. The nature of this cascading indicator means that only achieving the goal of the ‘percentage of people living with HIV’ makes further indicators meaningful. Therefore, while both treatment rates among populations aware of their status and suppression rates among those on treatment are high, the very low level of HIV status awareness poses a significant challenge to countering the HIV epidemic. The prospect of this positive development is worsened by the overall shift towards treatment and away from education and prevention.

As of 2017 only 52.2 per cent of people living with HIV aged 15-64 know their status. This rate is significantly higher for women than for men (55.9 per cent vs 45.3 per cent) due to mandatory testing of pregnant women. This is worse for young people where 64.9 per cent are not aware of their HIV status. Among those who know about their positive-HIV status, the uptake of ART treatment is significant at 90.9 per cent, and again higher among women than men. Finally, suppression rates for the virus are also high but naturally limited by the number of people who access treatment. Among the population aged 15-64 who receive treatment, 89.2 per cent of women and 84.0 per cent of men are virally suppressed.32 Viral suppression rates improve with age for both men and women, with young men seeing the lower rates. Viral load suppression in children is very low at 18 per cent.

Spending against other countries

Tanzania spends less per person living with HIV than its ‘peer countries’. Kenya, which is the closest of analysed countries in terms of profile (similar prevalence, similar total number of PLHIV), allocated over 50 per cent more resources for each person living with the virus (Figure 11). While some of this can be explained by more successful sourcing of foreign funds, 20 per cent of the HIV and AIDS budget in Kenya is funded from domestic resources, while in Tanzania dedicated domestic contributions are low.

| FIGURE 10: MoHCDGEC Budget and HIV and AIDS focused programmes (billion TSh) |

Source: Budget Books 2017/2018 and 2016/2017

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29. Global Fund, Tanzania
30. Minister of MoHCDGEC, Budget speech 2016/2017
31. 90-90-90 means 90 per cent of all people living with HIV are diagnosed and know their HIV status, 90 per cent of those diagnosed are initiated and maintained on ART, and 90 per cent of those on ART are virally suppressed.
Takeaways

- The largest financial contribution of the GoT to the HIV and AIDS sector is through the provision of personnel and infrastructure. An estimation of total Government contributions to the HIV and AIDS sector would demonstrate the Government’s prioritisation of the sector and could attract different foreign funding.

- It is difficult to estimate the value of this contribution with the National Budget in its current form. In the future, the Government may consider to include estimated HIV and AIDS spending on an annual basis. Comprehensive budget reporting will require improving monitoring, accounting and reporting at all levels of the Government.

- There is a need to improve the rates of HIV testing. Only 52 per cent of adult Tanzanians living with HIV know their status. This is worse in young people where 65 per cent are unaware of their HIV status. HIV testing is the most important building block in achieving UNAIDS 90-90-90 target.

4. BUDGET CREDIBILITY AND EXECUTION

The visibility of HIV spending in the budget is low. Until recently only the budget of TACAIDS was visible and assessment of its performance was therefore possible. For example, purchasing of antiretroviral drugs, arguably one of the most significant and indicative HIV related expenditures, was not included in the budget under a separate line. This has changed in FY 2016/2017.33 However, despite the presence of the line item, no recorded disbursement for the purchase of medication has been made in the budget year. Related expenditure for the Medical Store department was only 20 per cent of the FY 2016/2017 budget planned for procurement and supply chain management. A recent audit by the Global Fund identified poor accounting and inefficient ARV supply chain management, including up to 50 per cent of medical kits unaccounted for, as pressing issues.34 Execution rates at TACAIDS, the main body responsible for strategic planning of HIV and AIDS, and the MoHCDGEC are well below average, when compared with other Ministries, Departments and Agencies (MDAs). Table 2 shows the execution rates for TACAIDS and MoHCDGEC compared to the total budget for the GoT. In FY 2016/2017, budget performance stood at 66 per cent and in the past five years, it has been as low as 49 per cent. FY 2013/2014 was the best performing year with 75 per cent execution.35 Reasons include lack of credibility, lack of predictable revenue collection and optimistic budget estimates. Further, high dependence on donors and challenges with tax collection create unavoidable fluctuations. Disbursement of funding has faced greater in-year budget cuts. Both MDAs have consistently underperformed the government average. Low predictability of funding was identified as key issues complicating the task of planning by both TACAIDS and NACP within MoHCDGEC.
**Takeaways**

- Lack of functional HIV and AIDS budget classification means that it remains challenging to fully capture all related expenditure. While foreign funding, which is by far the main source of funding, is well accounted, the domestic share that include cost for staff and building is difficult to capture.

- The largest spender of the HIV budget is MoHCDGEC as it manages all the donor-funded treatment expenditures. MoHCDGEC and TACAIDS have both suffered from low execution rates. Both MDAs have had lower execution rates than the Tanzanian Government on average for the past three fiscal years.

- Tanzania’s budget per each person living with HIV is lower than in its peer countries.

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**5. DECENTRALISATION AND EQUITY**

The prevalence of HIV in Tanzania is not uniform, with south-western regions suffering from the highest prevalence and regions such as Lindi with a low prevalence (Figure 12). This is an historical trend that has seen little change. For many years, however, the general perception was that these inequalities were not being addressed by proportionate budgetary allocations. As of 2011/2012, Tanzania’s National Multi-sectoral Strategic Framework for HIV and Aids (NMSF) grant, set aside a budget for TACAIDS and President’s Office, Regional Administration and Local Government (PORALG), aimed at strengthening HIV and AIDS coordination and capacity-building at the national and subnational levels. This support improved the capacity of HIV and AIDS focal persons and the committees to coordinate HIV and AIDS activities at all levels.36 This effort was supported by PEPFAR which has also committed to distributing resources based on the number of PLHIV.

Health resources and services have been largely guided by district population and socioeconomic disadvantage. Different health needs and costs of operation have not been a major consideration. This has led to the inequitable availability of health services between districts, and poor targeting of HIV interventions. Figure 12 shows that the HIV prevalence varies significantly between regions, while Figure 13 shows HIV service coverage is not targeted toward districts with the greatest needs. This seemingly equitable distribution may be ineffective as significantly more affected areas may need much more resources per PLHIV than those where prevalence is minimal. Lindi, the region with the lowest HIV prevalence has a prevalence rate of 0.3 per cent while Njombe, a former district of the Iringa region, the region with the highest HIV prevalence, has a prevalence rate of 11.4 per cent (Figure 12). Many analysts have suggested efficiencies can be realised through better targeting of the worst affected districts.37

Sub-national funding guidelines

Since 2011/2012, the NMSF grant set aside a budget for TACAIDS and PORALG aimed at strengthening HIV and AIDS coordination and capacity-building at the national and subnational levels. This support improved the capacity of HIV and AIDS focal persons and the committees to coordinate HIV and AIDS activities at all levels.38

Until recently each region’s share of Tanzania’s local health funding was aligned with its share of the total population, addressing a long-standing perception of regional inequity in the availability of key health resources. The Big Results Now initiative finally emphasised fair health worker distribution.39 A

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much more equitable approach has also been adopted by donors, including by PEPFAR. Its budget is currently distributed based on the number of people living with HIV and not by the total number of people living in the district. In future, the Government could consider more targeted HIV and AIDS interventions based on HIV incidence in districts rather than total population.

**Takeaways**

- Prevalence of HIV in Tanzania varies widely per region. Focusing on total population, rather than a population’s health needs has resulted in inequitable access to health services including HIV and AIDS. There is also a further concern that by focusing on national-level indicators, which have generally been improving, it is easy to overlook badly affected districts.
- Age-disaggregated data analysis is also required to better understand who and where is at greater risk and in need of support. Adolescent-disaggregated HIV data has for long not been available, risking that this population group is being left behind.
- In recent years both donors and the Government took some steps to address the issue of differing HIV and AIDS region profiles by tailoring planning of HIV prevention activities to better align with characteristics of each region.
- Minorities, including vulnerable groups, have poor access to HIV preventive and treatment services.

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39. PEPFAR, 2015, Prospects for Sustainable Health Financing in Tanzania
6. FINANCING HIV AND AIDS

The largest share of Government finance for HIV and AIDS interventions comes through the provision of health facilities and human resources for health. The most recent National Health Accounts on the subject found the largest portion of government spending cannot be disaggregated. Based on information submitted to PEPFAR by the Government and by the Global Fund, it is possible to analyse areas of focus for each funding body. In general, donors focus on treatment, with only PEPFAR actively funding large prevention schemes. According to this data, the Government’s contribution is underestimating as, due to inadequate budget disaggregation, it does not include human resources and infrastructure.

The largest single donor is PEPFAR which provided about 67 per cent of the total budget for the HIV and AIDS response excluding human resources and infrastructure. This equates to US$527 million budgeted for the period October 2017-September 2018.40 The second largest donor providing specific funding for HIV and AIDS response is the Global Fund to Fight AIDS, Tuberculosis and Malaria. Excluding human resource and infrastructure spending, the Global Fund provided US$126 million in 2016. The largest HIV-related grant to Tanzania is Scale up TB and HIV interventions in Tanzania, under which US$171 million have been disbursed in 2017.41

Increasing the Government’s contribution, and improving accounting and reporting of public spending on HIV programmes is likely to attract additional donor funding. The Global Fund sets aside 15 per cent of its total country programme to incentivise Governments to increase their contribution to the health sector and to progressively absorb funding of key programme costs.42 The Global Fund determined that the GoT had increased the resources available to HIV and tuberculosis programmes. Global Fund co-financing agreement with the GoT required the Government to invest an additional US$29.3 on specific HIV and tuberculosis programmes in 2018 to 2020 compared to 2015 to 2017.43

Takeaways

- Increased government spending on HIV programmes has been rewarded by additional HIV spending from the Global Fund. Demonstrating domestic commitment to HIV programmes is likely to attract additional donor funding.

- By improving reporting and accounting of Government contribution to HIV programmes, including an estimate of infrastructure and human resources, Tanzania will align itself to common reporting practices in the region.

40. tz.usembassy.gov
41. Global Fund