Final Report

Sustaining Effective Coverage for HIV, Tuberculosis, and Malaria in the Context of Transition in Tanzania

Prepared by Results for Development

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Abbreviations

ARVs	Antiretroviral drugs
CCHP	Comprehensive Council Health Plans
DFF	Direct-to-facility financing
GDP	Gross domestic product
Global Fund	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
GoT	Government of Tanzania
HIV & AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
HFS	Health Financing Strategy
HMIS	Health management information system
HSSP-IV	Health Sector Strategic Plan IV
IRS	Indoor residual spraying
LGA	Local government authority
LLIN	Long-lasting insecticide treated nets
MBP	Minimum benefits package
MDR-TB	Multidrug-resistant TB
MoFP	Ministry of Finance and Planning
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
MSD	Medical Stores Department
NACP	National Aids Control Program
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NMCP	National Malaria Control Program
NTLP	National TB and Leprosy Program
PFM	Public financial management
PLHIV	People living with HIV
PNFP	Private not-for-profit
PORALG	President's Office Regional Administration and Local Government
PPM	Pooled Procurement Mechanism
RBF	Results-based financing
RSSH	Resilient and Sustainable Systems for Health
R4D	Results for Development
SDG	Sustainable Development Goal
SNHI	Single National Health Insurance
TB	Tuberculosis
TNCM	Tanzania National Coordinating Mechanism
TZS	Tanzanian shilling
UHC	Universal health coverage
US$	United States dollar

Executive Summary

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund) has invested over US$1.8 billion (TZS 3.8 trillion) since 2006 in Tanzania's health sector (The Global Fund 2017) to support a wide range of prevention, care, and treatment interventions for HIV, tuberculosis (TB), and malaria. In that time, Tanzania's response to the HIV, tuberculosis, and malaria epidemics has generated great achievements. However, significant challenges remain. To sustain these gains and further strengthen epidemic control, the Government of Tanzania is increasingly exploring strategies for sustainability and eventual transition away from external funding and programmatic support for health, including the three diseases.

While Tanzania is not among the countries projected to transition from Global Fund support by 2025, The Global Fund is supporting the Government of Tanzania (GoT) to progressively assume increased programmatic and financial responsibility for the three diseases and to strengthen transition planning. Toward this end, a team of international and Tanzanian experts from Results for Development (R4D) collaborated with focal points in the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC), the Ministry of Finance and Planning (MoFP), and the President's Office Regional Administration and Local Government (PORALG). R4D conducted a thorough desk review and qualitative fiscal space analysis, 19 interviews about financing for the three diseases and the extent of alignment between public financial management systems and health policy objectives, and a validation workshop with government officials.

Tanzania's disease response faces a triple transition challenge: replacing donor funding, closing the resource gap that would exist even with donor funding, and more efficiently delivering on disease response objectives. With so many core program components so heavily supported by donor funding, and with a large resource gap remaining after available funding is estimated, concerted action is needed to meet resource needs and increase government funding as a share of total program resources, and continue to improve the efficiency of resource use.

The goal of successful transition is to ensure that past gains are protected, disease response efforts are adequately financed without undermining other government priorities, and sufficient capacity is in place for uninterrupted operations following transition. Successful transition from Global Fund support will require clear transition policies and carefully coordinated, multi-year planning and preparation.

The Global Fund can leverage efforts to ensure the sustainability of its investments in Tanzania by anchoring transition planning for the three diseases to Tanzania's plans to achieve universal health coverage through single national health insurance. Implementing this substantial health reform effort will be a long-term project, and there will be many supportive steps along the way through which the government, Global Fund, and others can collaboratively sustain — and ideally expand—Tanzania's responses to the three diseases.

Quantifying Tanzania's transition and sustainability challenge for the three diseases

Spending on the three diseases is heavily reliant on donors. In 2014/15, donor spending for the three diseases was TZS 813 billion (US$393 million). Most spending on HIV and malaria is from external sources: approximately 76 percent of HIV spending and 52 percent of malaria spending is from donors. Spending by The Global Fund accounts for 25, 17, and 27 percent of HIV, TB, and malaria spending, respectively.

Donor funding for commodities drives reliance on external financing. Across all three diseases, program components that reflect investments in commodities are among the most heavily reliant on external financing. For the 2018-2020 Global Fund grant implementation period, adult ART is expected to be the most heavily funded program component. It is also anticipated to be one of the components most reliant on external financing, with an estimated 98 percent of funding coming from donors.

Non-commodity program components are also reliant on external financing. In the coming Global Fund grant implementation period, nearly all the program components included in Tanzania's HIV and malaria response are expected to receive over 80 percent of funding from external sources.

Relative to resource needs identified in costed disease strategies, there are substantial shortfalls in available funding for the three diseases, even with donor support. To reach the ambitious goals outlined in national strategic plans, an estimated TZS 3.88 trillion (US$1.88 billion), TZS 398 billion (US$192.52 million), and TZS 1.22 trillion (US$591.41 million) are needed for HIV, TB, and malaria between 2018 and 2020, respectively. Relative to these resource needs, the unmet resource need exceeds TZS 1.2 trillion (US$590 million) from 2018-2020. Without donor funding, the unmet need would exceed TZS 5.0 trillion (US$2.44 billion). Ultimately, not all donor funding needs to be replaced shilling-for-shilling, and, as donor programs become more integrated and streamlined with national systems, some costs will increasingly be shared across health areas, lessening the burden on any one particular disease response program. Nonetheless, Tanzania's transition challenge is substantial.

Program vulnerabilities resulting from inefficiencies in the health financing and PFM systems

Interview respondents noted several potential vulnerabilities in budget formulation, budget execution, and budget monitoring.

Uneven coordination in planning among HIV, TB and malaria programs. Some respondents noted a lack of coordination in planning efforts to develop national strategic plans and to implement activities among disease programs. These challenges were indicated to include a lack of adequate planning for resource needs and clear division of implementation functions leading to duplication of activities and processes, not maximizing economies of scale, and a wastage of resources in the absence of an integrated approach and a strategy to achieve formulated policy goals.

Unpredictable availability of donor funds as previously reliable sources (Health Basket Fund) diminish. The award of Global Fund grants funding does not align with GoT fiscal year and budget planning cycles. In addition, The Global Fund's round-based system, which is on a three-year implementation period, can complicate efforts to coordinate with USG and its implementing partners which have one-year grant time horizons.

Fragmented data systems and incomplete and/or low-quality data are bottlenecks to realizing near-term improvements in budget formulation, and long-term (and potentially large-scale) efficiency gains from strategic purchasing. Accountability measures are not yet sufficient to ensure the availability of

complete, on-time, and quality data. Data is captured through the various MoHCDGEC data collection tools but not fully reported by all the players. This limits the ability to structure budgets accurately according to needs for priority populations, programs, and services, and limits the compilation of data needed to support strategic and data-informed purchasing of services.

PFM rules challenge effective allocation of resources to health needs. There is little flexibility to reallocate budgets during the fiscal year to adjust to the evolving needs of service implementers and the populations they serve. In general, different rules for different funding sources and expenditure caps at the line-item level have reduced the flexibility to allocate payments received across budget line items.

Barriers exist to efficiency and strategic purchasing of services and commodities. HIV, TB and malaria programs are funded through input-based line-item budgets which is often rigid and can create numerous inefficiencies and inequities in health service delivery and does not allow for efficiency and quality incentives to providers. Government procurement rigidities may have broader implications as Tanzania will increasingly need to negotiate prices on the global market and may face greater supplier pressure to pay the same prices as middle-income countries.

Procurement and supply chain management have improved, but challenges remain. Barriers include the lack of information on financing, procurement, weak supply chains, inadequate regulatory capacity, and lack of coordination across different stakeholders. Processes are hindered by delays in giving specifications for goods and services to be bought, in addition to significant delays in distribution and payment.

The lack of centrally defined standards in procurement do not ensure that the processes implemented at the LGA level observe at least minimum procedures and controls. Respondents noted that stock outs at the regional level are in part due to issues in ordering: stock outs lead to over stocking, which then leads to expiry, which leads to lower orders, etc.

Delays in disbursement of Global Fund monies challenges efficient spending at the health facility level. The timing of disbursements makes it difficult for facilities to spend the additional current budget. The disbursements are too late, and the timing of surrender, which is the return of funds to MoFP, is too short. In the absence of frequently updated data, The Global Fund uses burn rate as a performance indicator which has implications for the timing of subsequent disbursements. For example, cash balances are deducted from future quarters, which means that underspending in Quarter 1 and Quarter 2 may lead to deductions in Quarters 4 and 5. Respondents also noted that burn rate monitoring as a proxy for performance can encourage irrational spending.

It is difficult to comply with expenditure reporting requirements. Programs find it difficult to prepare new data on tracked indicators as often as the six-month Global Fund reporting periods require. In addition, respondents indicated that The Global Fund requires reporting on indicators for which the government does not currently track data.

Charting Tanzania's transition and sustainability path

More money for health

A comparison to regional and income-category averages suggests that there may be room for Tanzania to increase the share of government expenditure for health. Tanzania's government spending on health as a share of its government budget falls below the average of 12.3 percent for sub-Saharan Africa and below the low-income country average of 14 percent.

If Tanzania maintains the current share of government spending on health (8.6 percent) relative to government expenditure, it would generate TZS 596 billion (US$288 million) for the three diseases in 2021, which covers 73 percent of donor funding, 33 percent of the total cost of the national strategic plans, and TZS 2.0 trillion (US$ 973 million) in remaining annual funds for the health sector.

If Tanzania increases the share of government spending on health to 13 percent in 2021, it would generate TZS 902 billion (US$436 million) for the three diseases. This amounts to 111 percent of current donor funding, 50 percent of the total cost of the national strategic plans for the three diseases, and TZS 3.0 trillion (US$ 1.47 billion) in remaining annual funds for the health sector.

If Tanzania reaches the Abuja Target of 15 percent for health's share of public spending, it would generate TZS 1.04 trillion (US$504 million) for the three diseases in 2021. This equals 128 percent of current donor funding and about 58 percent of the total cost of the national strategic plans for the three diseases. There would also be an additional TZS 3.51 trillion (US$1.70 billion) in remaining annual funds for the rest of the health sector.

More health for the money

Given Tanzania's macroeconomic outlook, the potential gains in fiscal space from new revenue are likely to be modest at best. In-depth interviews identified several areas where the existing PFM system in Tanzania poses challenges for the potential success of implementation of SNHI as well as for integrating the components of the three disease programs into country systems after donors withdraw their funding. While difficult to quantify, addressing these issues could provide efficiency gains to the health sector that could contribute to closing the resource gap.

Align PFM processes with health budgeting practices and health financing objectives. The success of proposed reforms related to the implementation of SNHI will depend in large part on whether the PFM system will allow a change in how health budgets are formed, the way funds flow through the system, and how funds reach health providers. To this end, removing bottlenecks to effective implementation of SNHI are urgent priorities for the GoT.

Strengthening governance arrangements and institutional roles and relationships at all levels to support a coordinated multi-sectoral approach. National control programs for HIV, TB and malaria would benefit from increased coordination in planning and implementation of activities. Activities should be increasingly situated in the context of a well-coordinated and integrated primary health care system to benefit from important linkages to other areas of care (e.g., sexual and reproductive health).

Increasing efficiency in procurement and supply chain systems. The greatest opportunity for efficiency gains may come from enhanced procurement given the large share of expenditures allocated to commodities and the variance in prices paid. The Global Fund PPM has significantly improved procurement timelines and reduced commodity prices. Through the PPM, The Global Fund may have access to lower prices than the government. If the government could secure Global Fund prices in the long term, that could be a source of efficiency.

Utilizing integrated approaches to costing strategies for HIV, TB, and malaria programs. At the health center and dispensary level, where service delivery is integrated and health staff provide a range of services, inputs related to service delivery for HIV, TB and malaria are shared. Ensuring that costing

strategies take an integrated approach and estimate shared costs at the facility level is essential, and could be a source of efficiency gains when taking a systems approach to sustainability planning.

Looking Ahead

Meeting the replacement challenge and Tanzania's overall health sector needs will require a combination of mobilizing new revenue for health and efficiency gains: nether alone will suffice. New funding for health will largely depend on macro-fiscal conditions, GoT's overall effort to collect revenue, and the extent to which policymakers prioritize health within the government budget. To sustain current programmatic outcomes for the three diseases, the GoT will also need to look to efficiency gains that can be reinvested in the health sector. However, opportunities to increase efficiency are difficult to realize and often require up-front investment.

In addition to identifying many specific challenges and opportunities to be addressed by the Government of Tanzania and its development partners, the study offers analytical and process-minded recommendations:

1. Leverage the path to UHC.
2. Integrate sustainability and transition issues into routine health financing discussions with Health and Finance officials at the national and LGA levels.
3. Adapt the PFM-health financing framework and program component analyses to identify areas of focus.
4. Embrace a spirit of 'urgent incrementalism' to tackle transition challenges over time.
5. Convene leadership at the MoHCDGEC, MoFP, and PORALG to define next steps for sustainability and transition planning.

Ultimately, the sustainability and successful transition of externally supported programs will require prolonged commitment from national and county officials, buttressed by strategic investments from development partners—to collaboratively address the three diseases through recurrent processes to plan, implement, and monitor financing for health.

Introduction

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund) has invested over US$1.8 billion (TZS 3.8 trillion) since 2006 in Tanzania's health sector (The Global Fund 2017) to support a wide range of prevention, care, and treatment interventions for HIV, tuberculosis (TB), and malaria. While Tanzania is not among the countries projected to transition from Global Fund support by 2025[1], The Global Fund is supporting the Government of Tanzania (GoT) to progressively assume increased programmatic and financial responsibility for the three diseases and to strengthen transition planning.

Tanzania's response to the three diseases has generated great achievements over the past two decades. However, significant challenges remain. AIDS-related deaths declined by 44 percent between 1990 and 2015, but Tanzania is one of 10 countries in sub-Saharan Africa that account for over 80 percent of people living with HIV (PLHIV) in the region (United Nations Economic Commission for Africa et al. 2015). Malaria remains a leading cause of morbidity and mortality, especially in children under five and pregnant women (MoHCDGEC et al. 2016). While the death rate from TB declined by nearly 14 percent between 2005 and 2015, TB is now the 8th leading cause of death (from the 11th), largely due to high rates of HIV/TB co-infection (Ibid).

Tanzania has set ambitious targets for reducing morbidity and mortality from the three diseases in the coming years. By 2018, targets for HIV include reducing the incidence of HIV from 0.32 percent to 0.16 percent, increasing the percent of people living with HIV (PLHIV) on anti-retroviral therapy (ART) from 74 to 80 percent, and decreasing stigma and discrimination against PLHIV (Ministry of Health and Social Welfare and National AIDS Control Programme 2014). Case detection for TB is targeted to increase to 29 percent, notification of childhood TB cases is targeted to increase from 10.6 to 15 percent, and the rate of case detection and enrollment in treatment for multi-drug resistant TB (MDR-TB) is targeted to increase from 17 to 84 percent[2], all by 2020 (Ministry of Health and Social Welfare 2015b). Finally, the target for average malaria prevalence is less than one percent by 2020, down from 15 percent today (MoHCDGEC et al. 2016).

[1] The following countries are projected to become ineligible in 2017-2019 based on re-classification of income category from middle-income to upper-middle income: Armenia (HIV, TB); El Salvador (TB, malaria); Kosovo (HIV, TB); Philippines (malaria); and Sri Lanka (HIV, TB). Similarly, the following countries are projected to become ineligible in 2020- 2022: Bolivia (malaria); Egypt (TB); and Guatemala (TB, malaria). Malaysia (HIV); Panama (HIV); Costa Rica (HIV); Romania (TB); Kazakhstan (HIV, TB); and Mauritius (HIV) are projected to become high-income and become ineligible in 2017-2025.

[2] Of notified MDR-TB cases.

Tanzania, like many low- and middle-income countries, faces a multitude of sustainability and transition challenges, including limited fiscal space and competing priorities for government spending and reform efforts. Raising revenue for health means not just mobilizing new resources, but also maximizing the value of existing funds through improved budget formulation, execution, and monitoring, and reforming Public Financial Management (PFM) systems that manage public revenue flows and play a crucial role in directing money efficiently and effectively.

Box 1. Definition of sustainability and transition

The Global Fund defines sustainable programs as those that are able to maintain service coverage at a level that will provide continuing control of a health problem even after removal of external funds.

At minimum, **sustainability** involves maintaining the current level of effective coverage for donor-supported interventions as external funding decreases. Preferably, the expansion of effective coverage continues along the current *or even an accelerated* trajectory.

Transition can refer to individual programs or funding streams as well as to the whole health financing system.

This report summarizes key findings of analyses of Tanzania's health financing landscape, comparisons of available and needed resources to finance national strategies for the three diseases, and an assessment of areas of (mis)alignment between the PFM and health financing objectives. Misalignment can occur due to operational issues or challenges in implementing PFM improvements (e.g., incomplete transition to program-based budgeting), PFM policies that make it difficult to change health pooling and purchasing arrangements, and differences in policy objectives between the health sector and the PFM system (e.g., health purchasing reform in a PFM system focused on input-based line-item budgets) (Cashin, Cheryl et al. 2017). Next steps for consideration by GoT in dialogue with The Global Fund and other development partners are also identified.

More specifically, the report answers the following questions:

1. What is Tanzania's current funding landscape for the three diseases? What needs remain unmet? How reliant are various interventions on funding from The Global Fund and other external sources?
2. In the context of transition, what challenges confront efforts to mobilize domestic resources and increase efficiency? What are the main risks and vulnerabilities in Tanzania's HIV, TB, and malaria responses, particularly those related to mis-alignments between public financial management and health financing systems?
3. What options could GoT consider to increase resources and efficiency for the three diseases, and what effect might they have?

The goal of successful transition is to ensure that past gains are protected, disease response efforts are adequately financed without undermining other government priorities, and sufficient capacity is in place for uninterrupted operations following transition. Successful transition from Global Fund support will require clear transition policies and carefully coordinated, multi-year planning and preparation.

Overview of Approach

R4D's technical approach centered on the underlying premise that general government revenues will be the core of financial sustainability in Tanzania and that transition planning must be done in the context of existing country processes (e.g., the country budget cycle). The way funds flow through Tanzania's public financial management system and ultimately reach frontline service providers is critical for ensuring access to health services and the provision of high quality care (Cashin, Cheryl et al. 2017). As volumes of financing from donors decline, weaknesses in public financial management systems may be a bottleneck to achieving sustainable health financing in Tanzania. Tracing the Global Fund's investments in HIV, TB, and malaria through the budget and PFM system provided an entry point for GoT and R4D to examine the health financing system holistically, with special attention to the interplay between Tanzania's PFM systems and health budgeting processes.

To assist GoT with analysis and process facilitation, The Global Fund contracted a team of international and Tanzanian experts from Results for Development (R4D), as well as identified focal points in multiple government agencies: the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC), the Ministry of Finance and Planning (MoFP), and the President's Office Regional Administration and Local Government (PORALG).

To explore the landscape of financing for the three diseases in Tanzania, R4D conducted a **desk review** highlighting relevant macro-fiscal, health policy, and health financing trends and **a qualitative fiscal space analysis** examining potential sources of revenue and efficiency gains for the health system (Annex A). A total of 19 **in-depth interviews** with key stakeholders from GoT agencies and programs were conducted between March and May 2017, to assess PFM processes through each step of the budgeting and expenditure cycle and unpack health financing flows (Annex B). Interview respondents provided insight into a series of general and disease program-specific questions on budget formulation, budget execution, and monitoring of public and donor funds. Participants were informed that individual responses would be confidential and presented in aggregate. In addition, meetings were held with development partners to provide context and background for the health financing, PFM reform, and transition environment in Tanzania. A list of participating organizations can be found in Table 1.

Table 1. Organizations Consulted

Government of Tanzania agencies and programs	Ministry of Health, Community Development, Gender, Elderly, and Children - National AIDS Control Program (NACP) - National Tuberculosis and Leprosy Program (NTLP) - National Malaria Control Program (NMCP) President's Office Regional Administration and Local Government (PORALG) Ministry of Finance and Planning TACAIDS Tanzania National Coordinating Mechanism (TNCM)

Development partners	Danish Embassy DANIDA GIZ Tanzania Norwegian Embassy Swiss Embassy UNAIDS USG: USAID, PEPFAR, CDC WHO

The desk review and interviews enabled R4D to identify PFM system characteristics or processes that would make eventual financial or programmatic integration of donor-funded activities into the government system challenging and to identify opportunities for efficiency gains that could be leveraged through policy, managerial, or administrative process improvements.

Vulnerabilities and inefficiencies in the three disease programs were evaluated at the disease program and program component level. The 2017 Global Fund funding requests for Tanzania, submitted on May 23, 2017 and revised subsequently, are supported by funding landscape tables for HIV, TB, and malaria disaggregated by national strategic plan (NSP) cost category. These cost categories were used as program components (Table 2).

Table 2. National Strategic Plan program components

HIV	TB	Malaria
HTC VMMC STI Condom SBCC PMTCT Blood safety STI and Key Populations PEP Adult ART Pediatric ART TB-HIV CBHS Program administration and monitoring and evaluation	TB Care and Prevention Childhood TB MDR - TB HIV/ TB TB in Mining sector Leprosy Supportive Systems M & E	Vector Control: LLIN Vector Control: IRS Case management - Diagnosis Case management - Treatment Specific prevention intervention: Intermittent preventive treatment in pregnancy (IPTp) Specific prevention intervention: Seasonal malaria chemoprophylaxis (SMC) RSSH Program Management Other

Program components were considered vulnerable if they are: (i) currently financed primarily by donors or households (i.e., not domestic government sources); (ii) not identified as a government priority in health sector or disease-specific national strategic plans; (iii) at risk for being "lost" after donors withdraw their funding because, for example, there is a bottleneck with the PFM system that might complicate efforts to integrate that component into existing country systems and/or if there is not a way to provide funding for a component using existing government systems.

R4D landscaped expected medium-term composition of funding for the three diseases relying primarily on Tanzania's new funding request to The Global Fund, which includes partial estimates of resource needs and available financing for HIV, TB, and malaria during the 2018–2020 implementation period. Additionally, some estimates of medium-term domestic spending on health and the three diseases relied on a projection model that also factored in macro-fiscal forecasts from the IMF (IMF 2017b). More information is included in Annex C about the methodology used for analysis.

Inefficiencies were identified if there were duplications across programs or program components, either within government or between government and donors, based on findings from the in-depth interviews. Inefficiencies were also identified if a misalignment between the PFM and health financing system could create a bottleneck to efficient flow of funds to intended recipients.

Finally, opportunities to increase revenue and efficiencies for the health sector and HIV, TB, and malaria interventions were presented alongside priority challenges to focal points and designates at a **validation consultation** workshop in Dar es Salaam (August 23, 2017). Participants' feedback is reflected in this report.

Tanzania Policy Environment

Tanzania is about to embark on a major health financing reform process as it finalizes and implements its Health Financing Strategy (HFS)[3]. The HFS is aligned with the Fourth Health Sector Strategic Plan 2015–2020 (HSSP-IV) and outlines a path to universal health coverage (UHC) through Single National Health Insurance (SNHI). The HFS aims for sustainable and efficient health financing, equitable access to affordable health services, and protection from catastrophic health expenditures (Ministry of Health and Social Welfare 2015a). The Global Fund has the opportunity to leverage ongoing efforts to ensure the sustainability of its investments in Tanzania by anchoring transition planning for the three diseases to Tanzania's health sector priorities and the growing momentum towards achieving UHC through SNHI.

As Tanzania moves toward a SNHI, reforms by the MoHCDGEC, MoFP, and PORALG are focused on pooling funds across multiple revenue sources, addressing fragmentation in the health sector, strengthening internal audits, and aligning PFM systems to support the implementation of health financing reforms to improve efficiency and equity, such as strategic purchasing of services. Tanzania has prioritized service readiness at the frontlines of service delivery throughout the country, laying the roadmap for SNHI by increasing provider autonomy and developing a package of essential health services focused on primary healthcare.

As a mandatory contributory scheme, SNHI would expand coverage to 70 percent of the population with a minimum benefits package (MBP) by 2020/21, assuming that the national health insurance fund could begin operations in 2017/18 (MoHCDGEC 2016b). The MBP is focused on outpatient primary care provided at health centers and dispensaries, including interventions for the three diseases. Individuals

[3] Discussions about the HFS in this report are based on the draft from January 2016.

could opt to purchase an expanded benefits package (MBP+) if desired. The MBP+ would cover higher complexity outpatient and inpatient care in addition to the services covered by the MBP. With exemptions for the poor, children under five, pregnant women, and the elderly, as well as for certain diseases of public health importance – including tuberculosis – a key pillar of the HFS is to guarantee health insurance coverage for the poor and vulnerable (MoHCDGEC 2016b).

While there are many procedural steps that lie ahead before the HFS is ready for implementation, SNHI is an important milestone with opportunities and challenges for sustaining – and ideally expanding – Tanzania's response to the diseases. Expansion of health insurance coverage should provide greater financial protection to those participating in the scheme, lessening the burden of out-of-pocket spending on households and reducing the risk of catastrophic health spending. This equity component of the path to universal coverage is particularly important in low-income countries such as Tanzania, where the cost of healthcare can be a major financial barrier to access for the poor and vulnerable. Shifting non-pooled spending by households to pre-paid premium contributions has the potential to provide additional revenue for the health sector: however, based on international experience, premium contributions are not a robust source of revenue for national insurance systems and are not likely to offer a large source of new fiscal space. Provider payment reforms that will be possible in the SNHI system can shift incentives to deliver higher volumes of under-utilized services and better quality care and reward performance accordingly. As Tanzania's health financing and service delivery systems mature and become more complex, it will be critical for the Government of Tanzania to monitor and evaluate the impact of health financing reform on how the overall health system functions to deliver high-quality, cost-effective care in an efficient and sustainable manner, and for the three diseases in particular.

Discussions about which services will be included in the MBP are ongoing. Over time, the services included in the MBP and MBP+ will evolve as the SNHI risk pool grows. This provides an opportunity for gradual expansion of the services included in the scheme, including those for the three diseases, facilitating the progressive integration of components of the three disease programs currently financed primarily by donors into Tanzania's primary healthcare system.

Conclusive evidence on the impact for sustainability of including services and drugs for the three diseases in a minimum benefits package from low-income countries experiencing a transition in donor financing and pursuing universal coverage is lacking. The characteristics and levels of financing needed to adequately support disease program components must be carefully considered to identify the appropriate sources of revenue, pooling, and purchasing arrangements. While a large number of services for the three diseases will be covered implicitly by SNHI payments to providers as the contributions to the risk pool grow and the amount of financing increases for SNHI, as the scheme matures, there is also risk that some services could be crowded out, particularly preventive services that may continue to be financed by the MoHCDGEC budget (Results for Development 2017a). Crowding out can occur as the composition of financing shifts towards the SNHI pool and as providers are paid explicitly for services in the MBP or MBP+, but not explicitly for those covered by the budget.

Prevention, care, and treatment interventions carried out under the three national disease control programs should be increasingly situated in the context of a well-coordinated and integrated primary health care system to benefit from important linkages to other areas of care (e.g., sexual and reproductive health).

Synthesis of Key Findings

In this section, the implementation of Global Fund supported programs are examined to quantify Tanzania's transition and sustainability challenge and identify specific financial and programmatic vulnerabilities and areas for increased efficiency. As noted above, program components were considered vulnerable if they are: (i) currently financed primarily by donors or households (i.e., not domestic government sources); (ii) not identified as a government priority in health sector or disease-specific national strategic plans; (iii) at risk for being "lost" after donors withdraw their funding because, for example, there is a bottleneck with the PFM system that might complicate efforts to integrate that component into existing country systems. Areas of inefficiency were identified where there are duplicated, weak, or fragmented systems leading to underspent budgets, misallocated funds, or other inefficiencies.

Quantifying Tanzania's transition and sustainability challenge

A key component of financial sustainability is the level of financing provided by government relative to estimated resource needs to achieve program objectives. Heavy reliance on external financing for any disease program risks losing gains achieved in health outcomes as donors decrease their support over time. Tanzania's new funding request to The Global Fund includes estimates of resource needs based on national strategic plans for each of the three diseases, estimates of available financing from GoT, and projections of commitments from donors (excluding The Global Fund) during the 2018–2020 grant implementation period.[4] Global Fund contributions were estimated based on funding landscape and budget tables.[5]

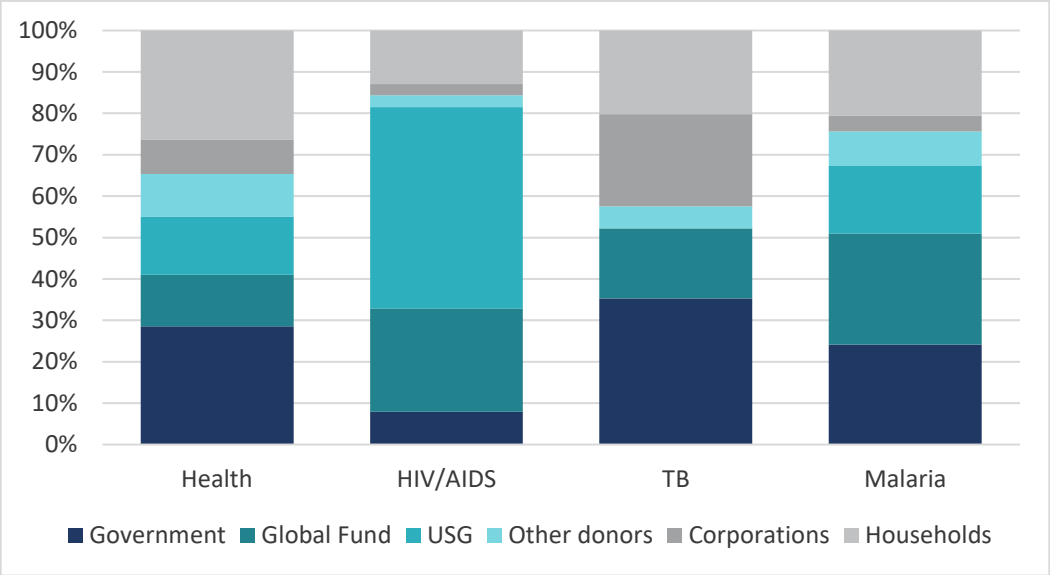
Spending on the three diseases is heavily reliant on donors. In 2014/15, donor spending for the three diseases was TZS 813 billion (US$393 million) (The United Republic of Tanzania 2017). This is approximately three times as large as the MoHCDGEC development budget for FY2016/17 and roughly 40 percent of the total health sector budget for the 2014/15 fiscal year (Health Policy Plus et al. 2016). The majority of spending on HIV and malaria is from external sources: approximately 76 percent of HIV spending and 52 percent of malaria spending is from donors (Figure 1). Spending by The Global Fund accounts for 25, 17, and 27 percent of HIV, TB, and malaria spending, respectively. The Global Fund

[4] In addition to the funding request narratives, R4D was provided with budget and landscape databases for the 2018-2020 grant submission. Until the grant agreements are signed, The Global Fund allocations are not final. Thus, the analyses presented here are based on the best data available at the time of this analysis. The allocations will change in the coming months during grant negotiations between GoT and The Global Fund.

[5] Annex C provides more information about how the data for this section were analyzed.

provides the largest share of external spending for TB and malaria, while the USG investment in HIV in Tanzania is roughly twice that of The Global Fund (The United Republic of Tanzania 2017).

Figure 1. Total health expenditures and HIV, TB, and malaria expenditures by source, FY 2014/15



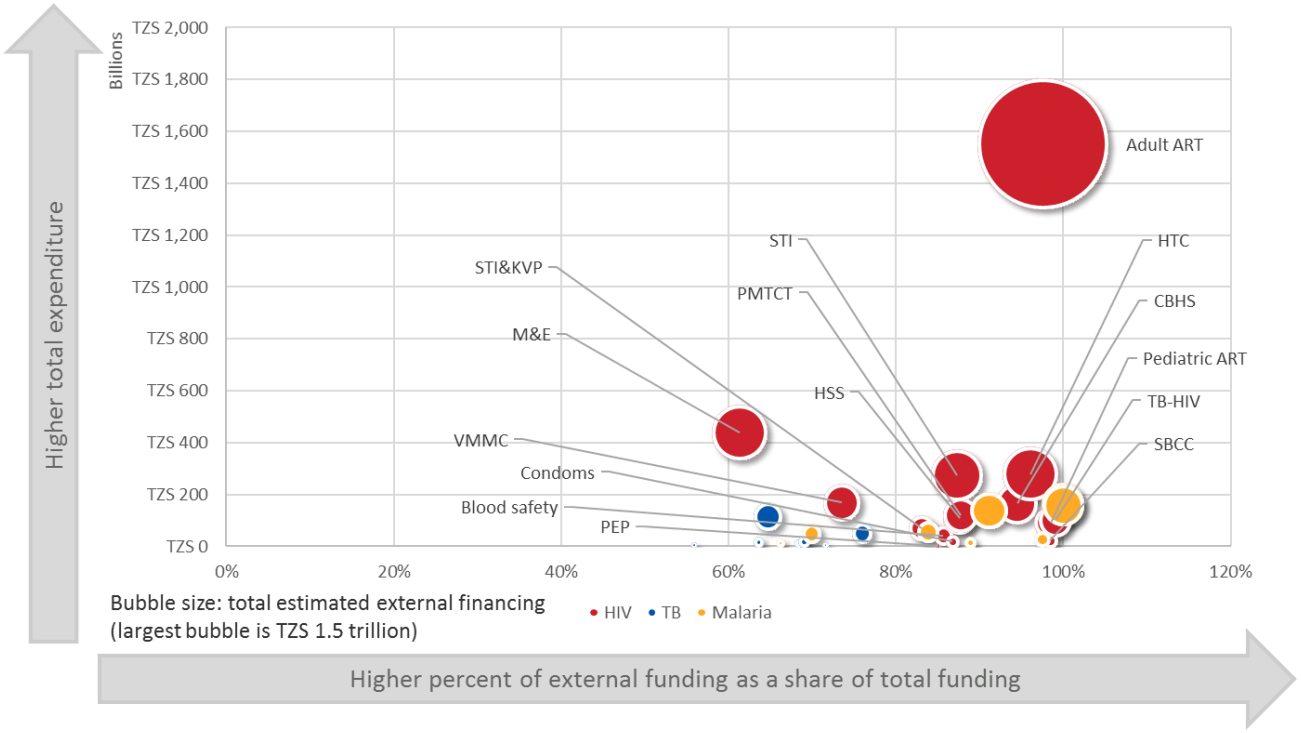
Source: The United Republic of Tanzania 2017

Donor funding for commodities drives reliance on external financing. At the program component[6] level, there are varying levels of external financing; some program components are more reliant on donor funding than others, both as a share of total funding and in absolute terms and some program components are reliant on donor funding for nearly all expenditures. Across all three diseases, program components that reflect investments in commodities are among the most heavily reliant on external financing.

For the 2018-2020 Global Fund grant implementation period, adult ART is expected to be the most heavily funded program component. It is also anticipated to be one of the components most reliant on external financing, with an estimated 98 percent of funding coming from donors (Figure 2). Expected funding for adult ART dwarfs other HIV program components and program components for TB and malaria. However, across the three diseases, all program components are expected to rely on donor financing for at least 60 percent of funding.

[6] "Program component" refers to the disaggregated NSP cost categories identified in the funding landscape of Tanzania's 2017 Global Fund concept notes as shown in Table 2. For HIV, these include Adult ART, blood safety, CBHS, condoms, HSS, HTC, M&E, pediatric ART, PEP, PMTCT, SBCC, STI, STI & KVP, TB-HIV, and VMMC. For TB, these include childhood TB, HIV/ TB, leprosy, M&E, MDR – TB, supportive systems, TB care and prevention, and TB within the mining sector. For malaria, these include LLINs, IRS, diagnosis, treatment, IPTp, SMC, RSSH, program management, and other programmatic activities/costs. Requested allocations from The Global Fund were disaggregated and cross-walked from Global Fund modules to NSP categories as described in Annex C.

Figure 2. Disease program components: total funding, percent of funding from external sources, and total estimated external funding, 2018-2020

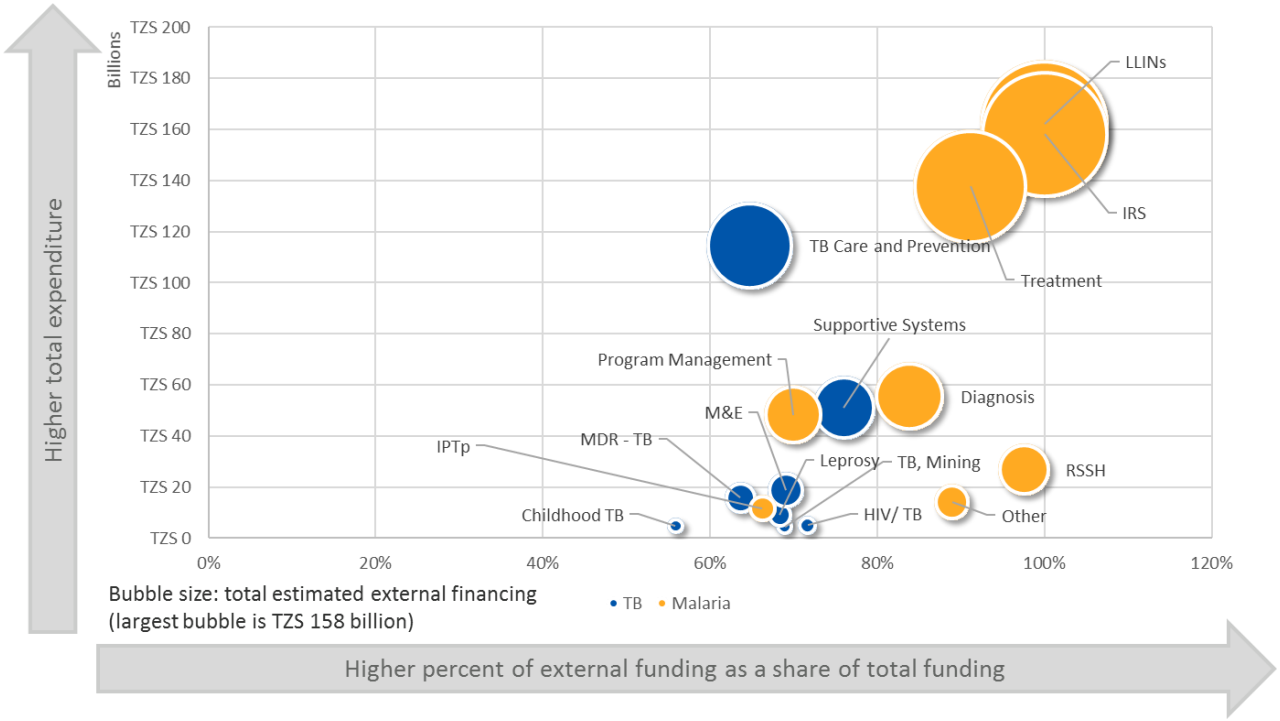


Source: R4D analysis based on Global Fund landscape and budget documents, 2017

Note: Left-axis is total expenditure per program component, right-axis is percent of external funding as a share of total funding

If HIV programming is excluded to better reveal the extent of reliance on external financing in the TB and malaria programs, it is clear that commodities drive a similar reliance on donors (Figure 3). Although The Global Fund financing landscape documents for TB do not disaggregate TB commodities as a separate program component, the largest cost component within TB care and prevention has historically been diagnostic tests for TB (Ministry of Health and Social Welfare 2015a). Within malaria programing, long-lasting insecticidal nets (LLINs), indoor residual spraying (IRS), and malaria treatment are the expected to be the largest program components with respect to estimated total funding. Each component is heavily funded by donors, with no expected GoT funding for LLINs or IRS in the coming grant period.

Figure 3. TB and malaria program components: total funding, percent of funding from external sources, and total estimated external funding, 2018-2020

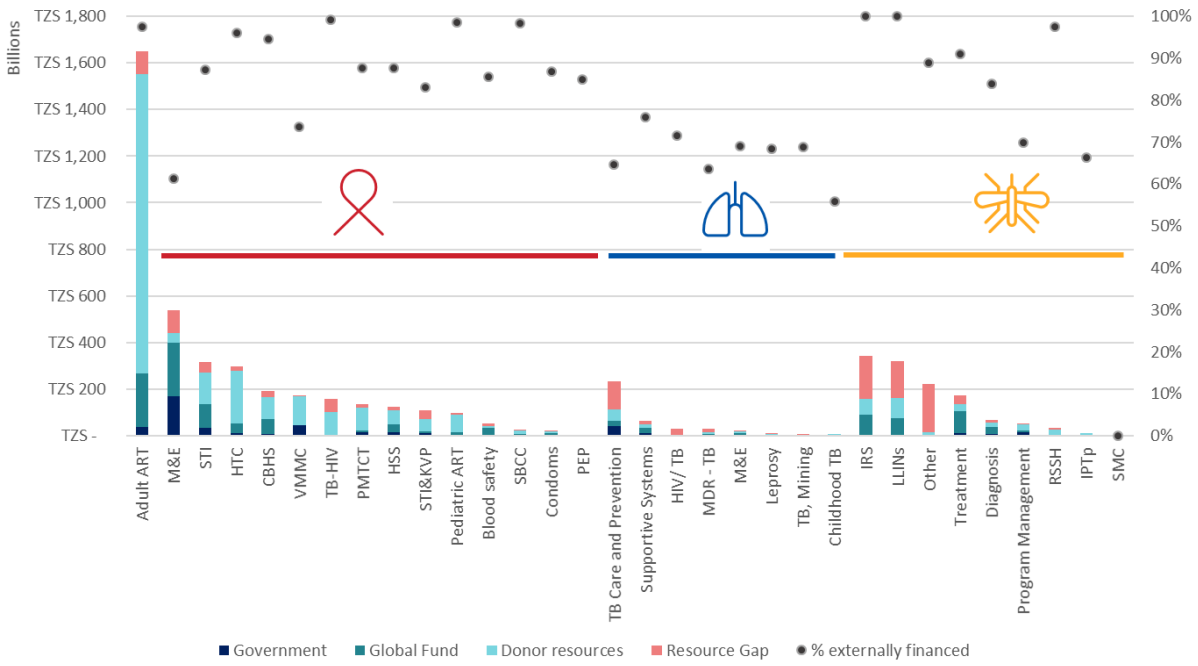


Source: R4D analysis based on Global Fund landscape and budget documents, 2017
Note: Left-axis is total expenditure per program component, right-axis is percent of external funding as a share of total funding

Tanzania's high burden of disease necessitates purchasing a large volume of commodities which in turn requires high levels of financing for commodities. The challenge for the sustainability of Tanzania's response to the three diseases in the context of transition is that funding for commodities is received primarily from external sources. Since commodities are essential for service delivery across all programs, the heavy donor reliance and large magnitude of commodity spending indicates that this component of each of the three disease programs is vulnerable as donors decrease their support. Further, for commodities, it is more than just the share of funding from donors that matters but also that donors get favorable prices, as discussed in more depth below.

Non-commodity program components are also reliant on external financing. In the coming Global Fund grant implementation period, nearly all the program components included in Tanzania's HIV and malaria response are expected to receive over 80 percent of funding from external sources (Figure 4). Many of these components are the most heavily financed across the three diseases (e.g., HIV testing and counseling (HTC), sexually-transmitted infections (STIs), and community-based HIV and AIDS services (CBHS)). By contrast, none of the individual program components for TB is estimated to receive over 80 percent of funding from external sources. TB program components, however, are also among the smallest with respect to total resource need.

Figure 4. Program components by estimated funding and percent of funding from external sources



Source: R4D analysis based on Global Fund landscape and budget documents, 2017
Note: Left axis is estimated funding. Right axis is percent of funding from external sources.

Relative to resource needs identified in costed disease strategies, there are substantial shortfalls in available funding for the three diseases, even with donor support. Even with substantial external financing, Tanzania's response to the three diseases falls short of estimated needs as detailed in national strategic plans. Relative to a total estimated need of TZS 5.5 trillion (US$2.67 billion) between 2018 and 2020, available funding from all sources is TZS 4.3 trillion (US$2.08 billion), leaving a shortfall of TZS 1.2 trillion (US$590 million) (Table 3).

Table 3. Summary of Global Fund 2018 -2020 funding landscape (TZS billions)

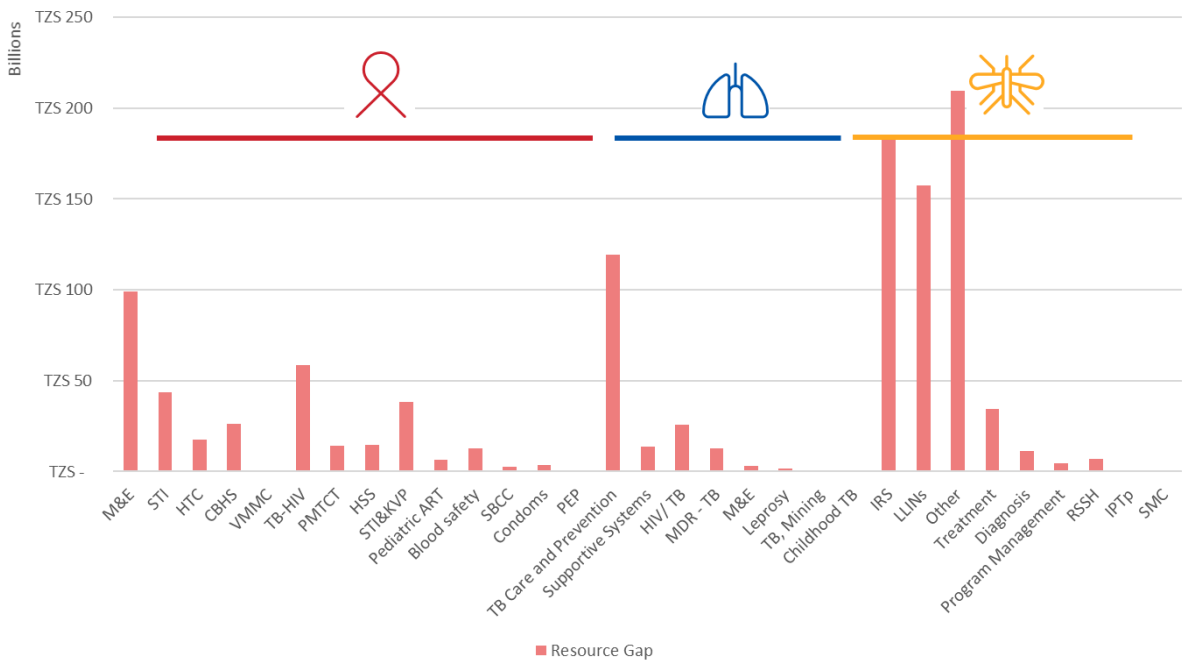
Disease Program	Total Need	GoT Funding	Global Fund Funding	Other External Funding	Unmet Need
HIV	3,887	358	776	2,316	437
TB	398	72	60	91	174
Malaria	1,222	42	300	272	608
Total	5,507	472	1,137	2,680	1,219

Source: R4D analysis based on Global Fund landscape and budget documents, 2017

At the program component level, the largest gaps between available and needed resources are for non-disagregated malaria program components (TZS 210 billion) (US$101 million), indoor residual spraying

(IRS) (TZS 183 billion) (US$ 88.6 million), long-lasting insecticidal nets (LLINs) (TZS 157 billion) (US$76.13 million), and TB care and preventon (TZS 119 billion) (US$57.70 million) (Figure 5). Combined, these three components alone contribute to over 25 percent of the total resource gap for the three diseases.

Figure 5. Resource gap by program component, 2018-2020 (TZS billions)

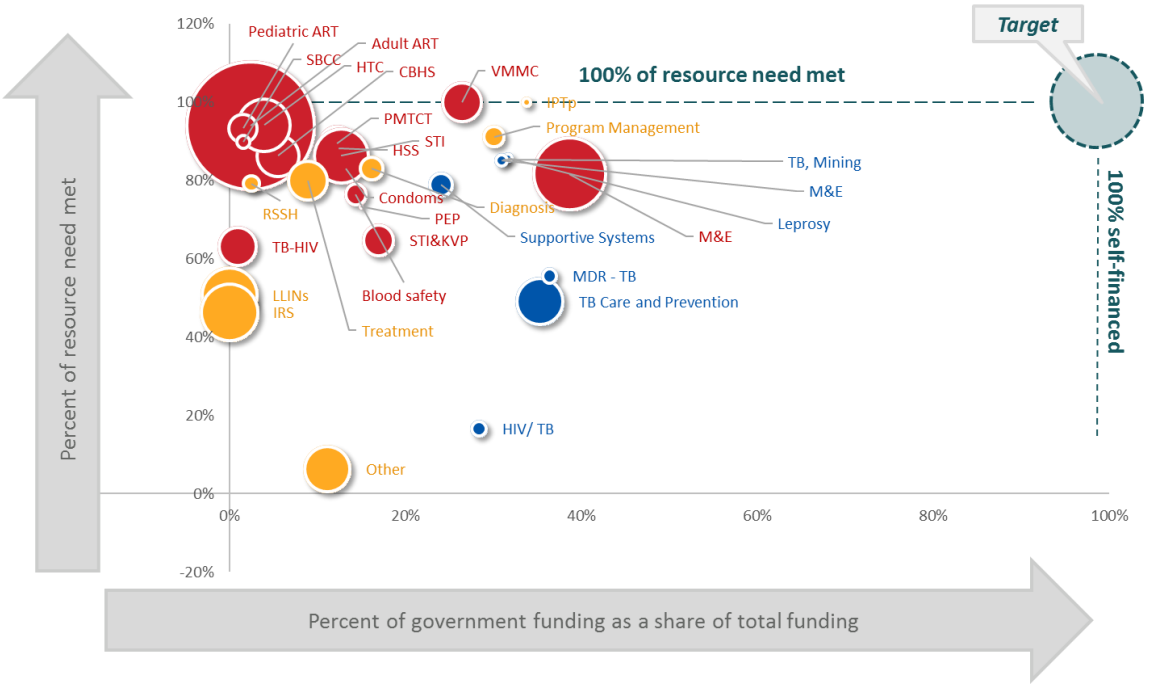


Source: R4D analysis based on Global Fund landscape and budget documents, 2017

In the absence of donor support, funding shortfalls are particularly stark. Due in large part to high levels of donor support, many of the program components within Tanzania's HIV program (and, to a lesser extent, TB and malaria) are estimated to receive nearly the full level of resources needed, based on the program costs detailed in the respective disease-specific NSPs. While this means that the current resource gap is smaller, it also means that as Tanzania approaches transition from donor financing, it will need to address much larger funding shortfalls with domestic revenue.

In Figure 6, program components are visualized by percent of government funding as a share of total funding (x-axis) against the percent of resource need met (y-axis). The "target" (bubble in the upper-right sector) for any component should be for all the NSP need to be met (y-axis = 100%) and for GoT funding to be the sole source of funding, with no external assistance (x-axis = 100%). The size of the bubble corresponds to the component's total resource need.

Figure 6. GoT financing for disease program components mapped against NSP need



Source: R4D analysis based on Global Fund landscape and budget documents, 2017
Note: Bubble size is NSP cost by program component. Largest bubble is TZS 1.7 trillion.

While many program components appear to have been allocated funding for the coming Global Fund grant implementation period to achieve (or exceed) their NSP needs, virtually none are funded primarily by GoT. HIV program components tend to be more fully funded than TB and malaria program components, due to high volumes of donor funding for components like adult ART, STI, HTC, and CBHS.

Relative to the HIV program components, TB and malaria program components are smaller with respect to resource need. However, they are less likely to be sufficiently funded. Consequently, even a small increase in GoT funding could generate sizeable changes in the extent to which the funding needs for the TB and malaria programs are met. Furthermore, a moderate increase in domestic funding for these components could help them become the first components of the three disease programs to be primarily financed by the government.

Tanzania's disease response faces a triple transition challenge: replacing donor funding, closing the resource gap, and more efficiently delivering on disease response objectives. Tanzania's unmet resource need for its HIV, TB, and malaria response exceeds TZS 1.2 trillion (US$590 million) throughout 2018-2020 (Table 3). Without donor funding, the unmet resource need would exceed TZS 5.0 trillion (US$ 2.44 billion). This figure provides an upper bound estimate for how much new revenue Tanzania would require, in the absence of external funding, to meet the national strategic objectives for HIV, TB, and malaria.

Ultimately, not all donor funding needs to be replaced shilling-for-shilling, and, as donor programs become more integrated and streamlined with national systems, some costs will increasingly be shared across health areas, lessening the burden on any one particular disease response program. Nonetheless, Tanzania's transition challenge is substantial. With so many core program components so heavily supported by donor funding, and with a large resource gap remaining after available funding is estimated, concerted action is needed to both meet resource needs and increase government funding as a share of total program resources.

Emphasizing funding shortfalls can mask vulnerability related to political economy issues. Some program components, such as those focused on providing services for key and vulnerable populations, are at risk not only because of funding shortfalls and a heavy reliance on external financing – similar to most of the program components across the three disease programs – but also because government policies do not support targeted interventions for these groups. Rather, GoT policy is for delivery of prevention, care, and treatment services some key and vulnerable populations at health centers and dispensaries instead of drop-in centers. With a higher prevalence of HIV than the general population, and a greater risk of contracting and transmitting HIV, restricting the availability of services for key and vulnerable populations to sites that serve the general population instead of specific sites designed for their unique needs and concerns may amplify the risk posed by donor reliance in the context of transition.

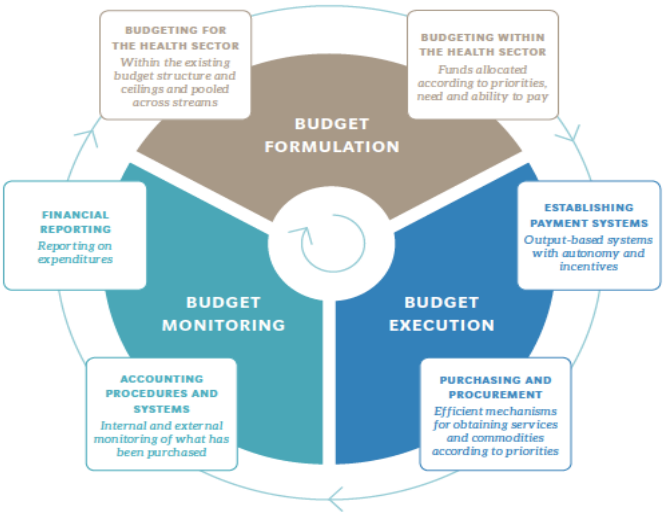
Program vulnerabilities resulting from inefficiencies in the health financing and PFM systems

Decreases in donor financing for HIV, TB, and malaria programs will ultimately require the integration of these disease-specific health programs into the broader public financing, management, and health service delivery systems. For PFM systems to be aligned with the objectives of health financing and sustained progress towards universal health coverage, sufficient and predictable resources of revenue need to be allocated to meet policy objectives within the realities of macro-fiscal constraints, funds need to be pooled to permit purchasing a package of services for priority populations and interventions, and provider payment must be structured to provide the right incentives to deliver services based on outputs.

The way funds from donors and domestic sources flow through Tanzania's public financial management system and ultimately reach frontline services providers is critical for ensuring access to health services and the provision of high quality of care. PFM rules and government institutions greatly impact the allocation of public health funding, the flexibility with which funds can be used, the effectiveness of spending, and the way health sector results are accounted for. The PFM system can be defined as the set of rules and institutions governing all processes related to public funds. Additionally, the PFM system provides all sectors, including the health sector, with a domestic, integrated platform to manage resources from all sources and across national and sub-national entities (Cashin, Cheryl et al. 2017).

Achieving alignment between PFM and health programs requires examining how core health financing functions intersect with the budget cycle. Typically, PFM processes are structured around the annual budget cycle, which can include three stages: budget formulation, budget execution, and budget monitoring (
Figure 7). Budget formulation involves projecting macroeconomic conditions to assess the level of government expenditure that will be feasible and what portion of total expenditure will be allocated to sectors based on strategies and priorities. Budget execution involves releasing funds to line ministries according to the approved budget and making payments for goods and services. Budget monitoring involves verifying compliance with laws and regulations, implementing reliable internal controls and financial reporting mechanisms, and achieving budgetary objectives (Cashin, Cheryl et al. 2017).

Figure 7. The public financial management system



Source: Cashin, Cheryl et al. 2017

The information below synthesizes the findings from in-depth interviews with stakeholders to identify challenges or bottlenecks in Tanzania's PFM system that affect funding levels and flows for the three diseases. Data from individual interviews were analyzed for common themes on system vulnerabilities and inefficiencies in the context of transition. The highest priority challenges, along with revenue and efficiency options for increasing the likelihood for sustainability, were presented to focal points (and/or their delegate) from the MoHCDGEC, MoFP, PORALG, NACP, NMCP, and NTLP for feedback and validation at a validation workshop in Dar es Salaam in August 2017. Where possible, the insights from this analysis are oriented towards sustaining effective coverage of HIV, TB, and malaria interventions. However, when appropriate, we have drawn generalizations to the broader health system.

Vulnerabilities in budget formulation

Uneven coordination in planning among HIV, TB and malaria programs. Some respondents noted a lack of coordination in planning efforts to develop national strategic plans and to implement activities among disease programs. These challenges were indicated to include a lack of adequate planning for resource

needs and clear division of implementation functions leading to duplication of activities and processes, not maximizing economies of scale, and a wastage of resources in the absence of an integrated approach and a strategy to achieve formulated policy goals. While NTLP and NACP submit a joint funding request to The Global Fund, which has enhanced coordination and planning between these two programs, they have separate national strategic plans with overlapping periods of implementation but different expiry dates. Therefore, synchronization of interventions and implementation which are managed from different program management platforms poses a challenge. To more effectively facilitate joint budgeting, monitoring and program reviews, further harmonization of TB and HIV strategic planning could be considered. Respondents noted that efforts are underway to map the implementation of program activities by geographic region in Tanzania to reduce duplication.

Some respondents cited overlapping roles and responsibilities between health sector implementation arrangements related to the disease programs. For example, some respondents cited the retention of control by the MoHCDGEC over the externally-funded programs when ultimately, the disease programs are implemented in a decentralized setting at the LGA level. This has the potential to disempower local governments that hold the primary responsibility for service delivery. More specifically, some respondents noted effective planning and budgeting for the three diseases is limited by a lack of real-time data due to fragmented health management information systems (HMIS) that collect data in the aggregate, are not standardized, are largely manual-entry, and do not extend to the health facility level. The Global Fund is investing in the improvement of the HMIS in Tanzania by focusing on the integration of disease-specific programs into the HMIS and the utilization of the DHIS2 platform for reporting on all program data in the country. Some elements of disease program data, including for malaria and HIV, have already been incorporated into the DHIS2 platform, and there is current support for the alignment of TB reporting.

Unpredictable availability of donor funds as previously reliable sources (Health Basket Fund) diminish. The award of Global Fund grants funding does not align with GoT fiscal year and budget planning cycles. In addition, The Global Fund's round-based system, which is on a three-year implementation period, can complicate efforts to coordinate with USG and its implementing partners which have one-year grant time horizons. However, there is some coordination at the planning stages to avoid duplication of activities and USG participates in The Global Fund funding request process. In addition, donor funds for the three diseases are fragmented, with all USG funding channeled off-budget directly to programs or facilities, and both The Global Fund and USG funding channeled outside of the Heath Basket Fund. The GoT ties donor financing to the costed national strategic plans which helps to align external and national priorities. However, significant donor dependency exits, and donors fund the major components of programs for the three diseases, as described above, while GoT generally funds HR and infrastructure costs. Funding predictability is also a challenge for planning and budgeting.

Fragmented data systems and incomplete and/or low-quality data are bottlenecks to realizing near-term improvements in budget formulation, and long-term (and potentially large-scale) efficiency gains from strategic purchasing. Accountability measures are not yet sufficient to ensure the availability of complete, on-time, and quality data. Data is captured through the various MoHCDGEC data collection

tools but not fully reported by all the players. This limits the ability to structure budgets accurately according to needs for priority populations, programs, and services, and limits the compilation of data needed to support strategic and data-informed purchasing of services.

Vulnerabilities in budget execution

PFM rules challenge effective allocation of resources to health needs. While budget execution is somewhat decentralized, with some health facilities having their own bank accounts and partial authority to manage budgets, there is little flexibility to reallocate budgets during the fiscal year to adjust to the evolving needs of service implementers and the populations they serve. In general, different rules for different funding sources and expenditure caps at the line-item level have reduced the flexibility to allocate payments received across budget line items. This type of fragmentation has led to different PFM rules for different funding sources – which are often in the same bank account – which greatly increases the administrative burden on clinical staff and decreases efficiency.

The rigidity of the PFM rules extends to programs for the three diseases. While the disease programs have full authority over purchasing within budget parameters, there is a spending threshold beyond which the MoFP and Global Fund's approval is needed. For example, if a potential reallocation across line items within the budget amounts to no more than 10 percent of the budget total, the disease program has the discretion to reallocate the funds internally within the same cost categories. To reduce the inefficiencies around reprogramming, The Global Fund has introduced a regular period each year to review reprogramming requests, but this review process can take four to five months.

Barriers exist to efficiency and strategic purchasing of services and commodities. HIV, TB and malaria programs are funded through input-based line-item budgets—giving health facilities specific budgets for staff, utilities, equipment, etc. Line-item budgeting is often rigid and can create numerous inefficiencies and inequities in health service delivery and does not allow for efficiency and quality incentives to providers. Currently, there is movement to shift the definition of service outputs, matching payment accordingly, and making provider autonomy more visible. This has the potential to create opportunities to use strategic purchasing and provider payment systems as incentives for health care providers. Respondents noted poor fulfillment of service agreement contracts, which are not optimized in the Comprehensive Council Health Plans (CCHP) planning process due to a lack of clarity defining criteria and what types of facilities are eligible. As a result, service level agreements are not fully utilized, even though they could potentially direct LGA funding to facilities that extend high-quality, priority services for HIV, TB and malaria services.

Integration of HIV, TB, and malaria purchasing functions into government systems is also an opportunity to examine existing rigidities within procurement regulations. Government procurement rigidities may have broader implications as Tanzania will increasingly need to negotiate prices on the global market and may face greater supplier pressure to pay the same prices as middle-income countries. Legislative controls on the price of medicines in Tanzania are significantly underdeveloped, which has resulted in the wide price variation observed in the health sector and across the country. Price control of essential

medicines only takes place as part of the Medical Stores Department (MSD) tender process, and as such does not guarantee the lower price will be passed on to consumers in retail settings.

Procurement and supply chain management have improved, but challenges remain. Challenges in procurement and supply chain management in Tanzania have been well documented by The Global Fund Office of the Inspector General, which our respondents reiterated. Barriers include the lack of information on financing, procurement, weak supply chains, inadequate regulatory capacity, and lack of coordination across different stakeholders (Office of the Inspector General, The Global Fund 2016). Processes are hindered by delays in giving specifications for goods and services to be bought, in addition to significant delays in distribution and payment. For example, it was reported that MSD takes an average of 65 days to distribute antiretroviral opportunistic infection medicines and laboratory commodities after a request is received. The stipulated target for distribution post-request is 21 days. Furthermore, inadequate planning and coordination by key stakeholders (e.g., MSD, MoHCDGEC) in making appropriate distribution decisions have resulted in stock-outs and expired health products of varying magnitudes at different levels of the supply chain. Due to capacity issues and lead time delays beyond six months, the Permanent Secretary of the MoHCDGEC revoked the responsibility of procuring lab commodities from MSD until it demonstrates improved capacity. During the validation consultation, respondents indicated that MSD performance has improved in recent months. Currently, The Global Fund PPM procures lab commodities. In addition, MSD does not manage the logistics and coordination of malaria bed net distribution, which are managed by the procurement office within the MoHCDGEC through a competitive bidding process.

The lack of centrally defined standards in procurement do not ensure that the processes implemented at the LGA level observe at least minimum procedures and controls. The Global Fund's Pooled Procurement Mechanism (PPM) procures all health commodities for the three diseases except for laboratory reagents, which are bought by MSD based on GoT specifications. Interview respondents cited several reasons why there is sometimes an irregular MSD drug supply, such as insufficient or inconsistent budget allocations for MSD procurement, poor contract management, overly cumbersome procurement procedures, and inaccurate forecasting by MSD. This has encouraged many public and private-not-for profit (PNFP) facilities to ration pharmaceuticals and other commodities through the supply chain or to over-order when stock is available at MSD. The result is fluctuations in demand that make efforts to accurately forecast extremely difficult for MSD to manage. Furthermore, shortages of key commodities at the facility level are significantly and negatively impacting the efficacy of HIV, TB and malaria programs. Respondents noted that stock outs at the regional level are in part due to issues in ordering: stock outs lead to over stocking, which then leads to expiry, which leads to lower orders, etc. Since government budget allocations for pharmaceutical procurement are held on account at MSD, public health facilities have only a limited degree of control over the use of their procurement budgets. MSD stock-outs force public and PNFP facilities to source drugs from the private sector, complicating private sector forecasting efforts. During MSD stock-outs, public facilities have little or no discretionary funding to procure drugs outside of MSD. Instead, they rely on funding from other budget sources, such as user fees, to procure medicines usually from a private source at high cost.

Delays in disbursement of Global Fund monies challenges efficient spending at the health facility level. All Global Fund grants are integrated into Tanzania government systems. Funding flows from the MoFP, as the Principle Recipient, to the MoHCDGEC, as the lead sub-recipient. The MoHCDGEC then disburses funds to implementing sub-recipients such as the national disease control programs and targeted regions and councils for administration of Global Fund grant-approved activities at lower administrative levels, including communities. As noted in the 2009 and 2016 OIG audit and other reports, there are significant delays (on average 150 days) in the disbursement of funds by the Principal Recipient to implementing entities (Office of the Inspector General, The Global Fund 2016). The timing of disbursements makes it difficult for facilities to spend the additional current budget. The disbursements are too late, and the timing of surrender, which is the return of funds to MoFP, is too short. Additionally, in the absence of frequently updated data, The Global Fund uses burn rate as a performance indicator which has implications for the timing of subsequent disbursements. For example, cash balances are deducted from future quarters, which means that underspending in Quarter 1 and Quarter 2 may lead to deductions in Quarters 4 and 5. Respondents also noted that burn rate monitoring as a proxy for performance can encourage irrational spending.

Vulnerabilities in budget monitoring and accountability

Vulnerabilities in budget monitoring and accountability can arise if there is weak compliance with laws and regulations, there is unreliable financial reporting or weak internal controls and audits, and if budgetary objectives are not achieved. Respondents indicated that in Tanzania, challenges with misalignment between the PFM system and health financing objectives are primarily in the budget formulation and execution stages. However, monitoring the implementation of Global Fund budgets is complicated by misalignments between the type of data required to report on Global Fund indicators and the data collected by GoT.

It is difficult to comply with expenditure reporting requirements. Under the current structure, Global Fund grants for the three diseases can be traced and linked to government expenditure, since these funds go through government systems and are audited by the Controller and Auditor General (CAG). However, programs find it difficult to prepare new data on tracked indicators as often as the six-month Global Fund reporting periods require. In addition, respondents indicated that The Global Fund requires reporting on indicators for which the government does not currently track data. Respondents reported challenges to collecting routine health facility data on consumption of commodities. As the number of facilities reporting indicators increase, the data quality has been seen to improve. Monitoring can also be a challenge if responsibility for implementing programs is fragmented or if the program components themselves are not integrated.

Charting Tanzania's Transition and Sustainability Path

Meeting Tanzania's considerable resource needs for the three diseases will require concerted efforts to mobilize more domestic resources for health, utilize health funds more efficiently, and strengthen systems to monitor performance to improve services and inform future planning. This section examines

a range of options for increasing revenue and efficiency, as well as notes other important considerations related to health financing and PFM alignment.

Opportunities for increasing revenue for health and the three diseases

Sources of fiscal space include favorable macroeconomic conditions; prioritization of health in the government budget; increases in health sector-specific resources; external grants and foreign aid for health; and increases in the efficiency of health expenditures (Tandon and Cashin 2010). Tanzania's ambitious development goals and aspirations to achieve universal health coverage have prompted several fiscal space analyses in recent years (Dutta 2015; James et al. 2014; Lee, Dutta, and Idama 2015), culminating with a costing and fiscal space assessment in the health financing strategy focused on fiscal space specifically for the National Health Insurance Fund (NHIF), which would become the risk pool that consolidates existing health insurance finance pools in Tanzania.

Favorable macroeconomic conditions are often looked to as an important source of fiscal space for all sectors, health included. Economic growth in Tanzania has been strong since 2000 but is expected to decline to below the 2000-2015 average by 2021 (IMF 2017b; The World Bank 2017b). Relative to GDP, the responsiveness, or elasticity, of government health expenditure provides an indication of whether favorable macroeconomic conditions are likely to translate into more public expenditure on health. In low-income countries, the elasticity of government spending to GDP is estimated to be about 1.16 (implying that a one percent rise in income on average leads to a 1.16 percent rise in government health spending, on average) (Tandon and Cashin 2010). In Tanzania, the elasticity of government health expenditure relative to real GDP is 2.32, indicating that a one percent rise in income would lead to a 2.32 percent increase in government health spending. However, the elasticity of government health spending relative to real total government expenditure is lower, at 1.4, suggesting that health spending is less responsive to increases in government spending (Fleisher, Leive, and Schieber 2013).

Tanzania's general government debt-to-GDP ratio, which is an important consideration for the sustainability of government finance, has increased steadily since 2008, from 22 percent to 37 percent in 2015 (IMF 2017b) due to new borrowing and depreciation of the shilling. Since 2009, Tanzania's tax revenue as a share of GDP has hovered between 12 and 13 percent (The World Bank 2017b) but the 2021 target is 17 percent (The United Republic of Tanzania 2016).

Apart from favorable macroeconomic conditions, other options to inject new revenue into the health sector include re-prioritizing health within the government budget, increasing health-sector specific resources, such as earmarked taxes, and foreign aid for health. Earmarking revenue via sin taxes or airtime levies for a narrow expenditure purpose (e.g., a specific disease) is unlikely to bring additive funds and introduce rigidities into the overall budget and within the health budget that can ultimately undermine funding for service delivery (United Nations Economic Commission for Africa et al. 2015; Results for Development 2017b). Further, in the context of transition from donor financing, new sources of revenue from external grants and foreign aid are likely to diminish over time. Overall, the outlook for

Tanzania's capacity to identify and capture substantial increases in revenue from the sources of fiscal space described above are limited (Table 4).

Table 4. Revenue options for fiscal space for health

Source of fiscal space	Outlook in Tanzania	Source(s)
Conducive macroeconomic conditions	• GDP forecasted to grow between 6.5-6.9% annually through 2021	(IMF 2017b)
	• Gov't debt is 37% of GDP • Tax revenue is 12-13% of GDP • Fiscal balance is -5.56% of GDP	(IMF 2017b, 2017a)
Re-prioritization of health in the gov't budget	• Gov't spending on health is 8.6% relative to total gov't expenditure • HFS sets target of 13% by 2021 • FYDPII sets target of 15% by 2021 (Abuja Target)	(MoHCDGEC 2016a; The United Republic of Tanzania 2016; MoHCDGEC 2016b)
Increase in health sector-specific resources	• HFS references earmarked taxes/levies on alcohol and tobacco, mobile communication/airtime, and a surplus of public corporations • Int'l experience shows earmarks may not be additive and can introduce (sometimes severe) rigidities	(Cashin, Sparkes, and Bloom 2017; Results for Development 2017c)
Health sector-specific grants and foreign aid	*Availability of external funding assumed to be steady or diminishing.*	

Currently, health spending is 8.6 percent of total government expenditures (MoHCDGEC 2016a). The 2021 target is set at 13 percent in the Health Financing Strategy and 15 percent (the Abuja Target) in the FYDP-II (MoHCDGEC 2016b, 2016b; The United Republic of Tanzania 2016). Since 2011/12, prioritization of health in the GoT budget has declined (MoHCDGEC 2016a). Even though the share of the health budget going to LGAs increased from 35 percent in 2011/12 to 39 percent in 2012/13, it declined to 34 percent in 2014/15. Further, actual spending decreased from 37 percent in 2011/12 to 35 percent in 2013/14. At the region-level, expenditures have fluctuated but have remained below 10 percent of the total health spending.

A comparison to regional and income-category averages suggests that there may be room for Tanzania to increase the share of government expenditure for health. Tanzania's government spending on health as a share of its government budget falls below the average of 12.3 percent for sub-Saharan Africa and below the low-income country average of 14 percent (The World Bank 2017a). However, the decision to shift resources within the existing budget envelope to health from other sectors at either the national or local level is ultimately a political one. Reallocation of the budget also can involve tradeoffs for health outcomes if the sector from which resources are pulled implements interventions with direct or indirect effects on health outcomes (e.g., education). Similarly, the decision to re-channel resources within health at any level of government is also political.

Assuming IMF medium-term forecasts for GDP growth and public spending, GoT's choices regarding prioritization will greatly affect the availability of resources for the health sector overall and for the three diseases in particular (IMF 2017b).[7] Figure 8 shows the effects of different prioritization choices on annual publicly pooled funding for HIV, TB, and malaria in 2021.[8]

The 'Status Quo' scenario assumes Tanzania maintains the current share of government spending on health (8.6 percent) relative to government expenditure. This would generate TZS 596 billion (US$288 million) for the three diseases in 2021, which covers 73 percent of donor funding, 33 percent of the total cost of the national strategic plans, and TZS 2.0 trillion (US$ 973 million) in remaining annual funds for the health sector, which could be allocated to a variety of needs, including any or all of the three diseases.

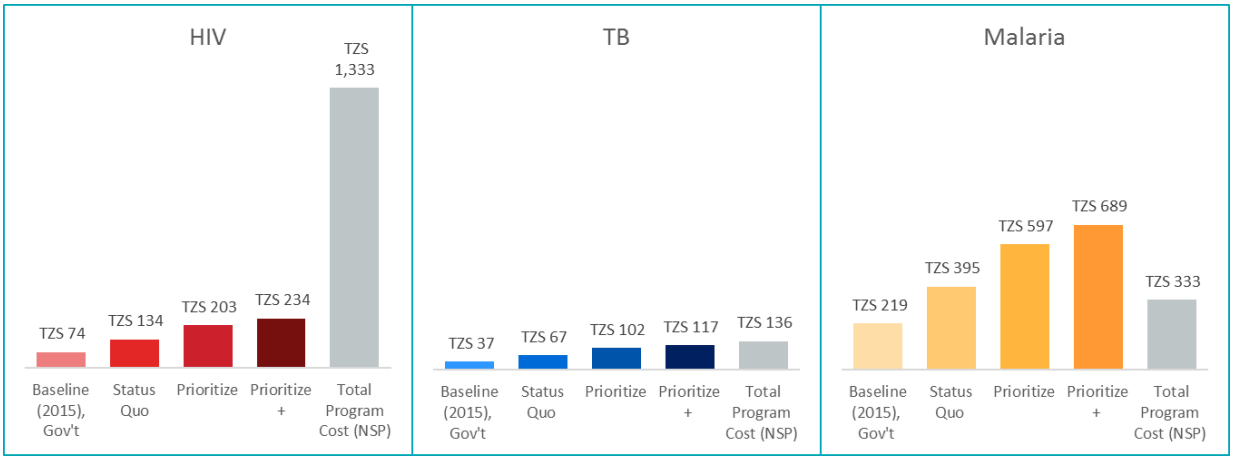
The 'Prioritize' scenario, which assumes GoT reaches the HFS target of 13 percent in 2021 for government expenditure on health relative to government expenditure, would generate TZS 902 billion (US$436 million) for the three diseases. This amounts to 111 percent of current donor funding, 50 percent of the total cost of the national strategic plans for the three diseases, and TZS 3.0 trillion (US$ 1.47 billion) in remaining annual funds for the health sector, which could be allocated to a variety of needs, including any or all of the three diseases.

The 'Prioritize+' scenario, in which GoT achieves the FYDP-II target of 15 percent for health's share of public spending by 2021, results in TZS 1.04 trillion (US$504 million) for the three diseases in 2021. This equals 128 percent of current donor funding and about 58 percent of the total cost of the national strategic plans for the three diseases. There would also be an additional TZS 3.51 trillion (US$1.70 billion) in remaining annual funds for the rest of the health sector, which could be allocated to a variety of needs, including any or all of the three diseases.

[7] Estimates of medium-term domestic spending on health and the three diseases relied on a simple projection model that also factored macro-fiscal forecasts from the IMF.

[8] Annex C provides more details on the projection model used to generate these estimates. Each disease's share projected government health expenditure is assumed to be the same as the 2014/15 NHA data indicate (The United Republic of Tanzania 2017).

Figure 8. Effects of prioritization scenarios on annual public funding for HIV, TB, and malaria in 2021 (TZS billions)



These estimates suggest that Tanzania is currently far from meeting the financial cost of the HIV national strategic plan and will be in 2021 regardless of the health budget re-prioritization scenario pursued. Tanzania is also far from meeting the costed need for tuberculosis at current levels of spending, but could fund nearly all of the resource need with the 'Prioritize+' scenario. Tanzania is already close to meeting its financial needs for malaria and even if the status quo is maintained, the total program cost would be met and exceeded in 2021.

Greater prioritization of health within the government budget will require collaboration between finance and health officials at the national and LGA levels to identify appropriate revenue sources. The HFS identifies several potential sources of revenue specifically for the NHIF and refers to economic growth and increased efficiencies in the tax administration system as potential sources of revenue more generally for the health sector overall. Other revenue sources, such as the HIV/AIDS Trust Fund, are identified in the HFS as a possible source of revenue that would be folded into the NHIF revenue pool, along with funding for other vertical programs.

Opportunities for increasing efficiency in the health system and the disease responses

Given Tanzania's macroeconomic outlook, the potential gains in fiscal space from new revenue are likely to be modest at best. For many of the countries planning for financial and programmatic sustainability in context of transition from donor financing, weak public financial management systems can be a major bottleneck to provider payment reform and achieving UHC. Tanzania's goal to achieve UHC will require a provider payment reform and concomitant reforms in the PFM system. In-depth interviews identified several areas where the existing PFM system in Tanzania poses challenges for the potential success of implementation of SNHI as well as for integrating the components of the three disease programs into country systems after donors withdraw their funding. While difficult to quantify, addressing these issues could provide efficiency gains to the health sector that could contribute to closing the resource gap.

Align PFM processes with health budgeting practices and health financing objectives. The success of proposed reforms related to the implementation of SNHI will depend in large part on whether the PFM

system will allow a change in how health budgets are formed, the way funds flow through the system, and how funds reach health providers. To this end, removing bottlenecks to effective implementation of SNHI are urgent priorities for the GoT. The focus of reforms has been to build PFM capacity at the central and LGA level for better planning, budget formulation, increasing transparency in fund flows, better accounting of expenditures, and timely and quality reporting. The MoHCDGEC is working closely with the MoFP, PORALG, and key agencies leading the government-wide PFM and health financing reforms. It will be critical for GoT to continue this coordination and joint policy dialogue to sustain these efforts.

Routine data verification systems (facility, council, region, national) need to be defined and institutionalized. The unification of information systems is a key step towards strategic purchasing and successful implementation of SNHI. In collaboration with USAID and PS3, GoT is embarking on re-designing PlanRep, the LGA-level planning and budgeting system. The process is directly linked to many other information systems improvements by integrating service provider codes and service outputs into the planning and budgeting system, and linking to the Epicor accounting system, expenditure management and PFM rules. This reform is ongoing across all sectors, and is strengthening the positioning of regional implementation and MoFP policy dialogue, and links strongly to sustainability by allowing for better planning and budgeting at the LGA level.

Direct-to-Facility Financing (DFF) is enhancing flexibility of health facilities to adapt, respond, and be accountable for community needs**.** DFF encompasses a shift to output-based payment direct to facility bank accounts, and has come to encompass heath basket funds, results-based financing (RBF), and the improved Community Health Funds (CHF). This initiative is a shift from the traditional approach, where funds were disbursed to the LGAs. The objective behind this change is to allow some degree of autonomy at the service provider level to decide and match financial resources to priority service outputs. These reforms increase the potential for sustainability by creating the shift to definition of service outputs, matching payment to them, and making provider autonomy more visible.

Strengthening governance arrangements and institutional roles and relationships at all levels to support a coordinated multi-sectoral approach. National control programs for HIV, TB and malaria would benefit from increased coordination in planning and implementation of activities. Activities should be increasingly situated in the context of a well-coordinated and integrated primary health care system to benefit from important linkages to other areas of care (e.g., sexual and reproductive health). There is an inconsistent exchange of information from national to LGA level and a lack of clarity on operational processes for the planning and budgeting of programs for the three diseases. The GoT should continue to prioritize program areas to develop comprehensive business management processes from central to LGA level, and enhance coordination between all levels. Furthermore, the GoT should continue to operationalize existing coordination structures, particularly between PORALG and MoHCDGEC.

Increasing efficiency in procurement and supply chain systems. The greatest opportunity for efficiency gains may come from enhanced procurement given the large share of expenditures allocated to

commodities and the variance in prices paid. Strengthening processes and institutions for decision making, including use of information systems, can also help. The Global Fund PPM has significantly improved procurement timelines and reduced commodity prices. Through the PPM, The Global Fund may have access to lower prices than the government. If the government could secure Global Fund prices in the long term, that could be a source of efficiency.

The GoT has prioritized interventions to increase efficiency in procurement and supply chain management, which include improving all elements of supply chain and facility business processes to support decision making, such as quantification and forecasting. Aligning MoHCDGEC, MSD, and PORALG roles and relationships in supply chain management and strengthening coordination of supply chain activities to ensure synergy for procurement and distribution decisions and streamlining of procurement guidelines.

Utilizing integrated approaches to costing strategies for HIV, TB, and malaria programs. The costs of disease programs can be difficult to disentangle because they occur at different levels of the health system, from centralized coordination agency to the point of service delivery, and include several major components that may be financed differently. At the health center and dispensary level, where service delivery is integrated and health staff provide a range of services, inputs related to service delivery for HIV, TB and malaria are shared. Ensuring that costing strategies take an integrated approach and estimate shared costs at the facility level is essential, and could be a source of efficiency gains when taking a systems approach to sustainability planning.

Recommendations and Next Steps

As one of the largest beneficiaries of Global Fund grants, Tanzania has a unique vantage point from which strategic planning for the process of transition from Global Fund financing can be initiated. Tanzania faces similar sustainability and transition challenges to other low-income countries, including limited fiscal space for health and competing priorities for government spending and reform efforts. However, the volume of financing Tanzania receives from external sources for the three diseases as well as its disease burden underscores the critical importance of deepening the dialogue on transition planning within government and among development partners. Tanzania plans to implement single national health insurance, offering a critical policy window that could facilitate the Government of Tanzania to stay ahead of the curve by engaging early in the transition process with The Global Fund and other development partners. Even if all services and commodities for the three diseases are not included in the SNHI system initially, dialogue and planning for future integration should take place early on. Successful transition from Global Fund – and other development partner – support will require clear transition policies and carefully coordinated, multi-year planning and preparation.

The government and development partners are aligned in perspectives on the goals of transition, namely that past gains should be protected, disease response efforts should be adequately financed without undermining other government priorities, and sufficient capacity should be in place for uninterrupted operations following transition. Ultimately, successful transition will require that general

government revenues are at the core of financial sustainability and that transition planning be done in the context of Tanzania's budget cycle. The way funds flow through Tanzania's public financial management system and ultimately reach frontline service providers is critical for ensuring access to health services and the provision of high quality care (Cashin, Cheryl et al. 2017). As volumes of financing from donors decline, weaknesses in public financial management systems may be a bottleneck to achieving sustainable health financing in Tanzania.

Based on Tanzania's unique health policy environment and the results of the analyses described above, the following recommendations and next steps can be considered by government and The Global Fund:

Leverage the path to UHC. The Government of Tanzania and The Global Fund have the opportunity to leverage ongoing efforts to ensure the sustainability of its investments in Tanzania by anchoring transition planning for the three diseases to Tanzania's growing momentum towards achieving UHC. To support the implementation and successful functioning of SNHI, PFM processes associated with collecting and pooling revenue, purchasing services, and monitoring service delivery at all levels of the health system will likely need reform to support the delivery of services included in the MBP and MBP+. These changes can be leveraged to improve equitable, effective, and sustainable financing for the three diseases to reduce fragmentation and improve financial protection, strengthen internal audits, and aligning PFM systems to support provider payment based on outputs.

Integrate sustainability and transition issues into routine health financing discussions with Health and Finance officials at the national and LGA levels. There is a strong appetite among key government stakeholders as well as development partners for data and information about the extent to which disease programs – especially at the component level – are reliant upon external financing. However, because Tanzania is not among the countries projected to transition from Global Fund support by 2025, perceptions about the urgency of planning early for transition vary. While some stakeholders agreed with the rationale for conducting analyses related to transition, others were not convinced that there was value in elevating discussions about transition above other existing priorities. The Global Fund has the opportunity to leverage its convening power as one of the two major donors for the three diseases to encourage greater collaboration across the three disease programs in planning efforts and to expand what future funding requests should include with respect to transition and sustainability, at the national level, and to further encourage active dialogue between the national and LGA levels about how this transition and sustainability plan would be operationalized at the point of service delivery.

Adapt the PFM-health financing framework and program component analyses to identify areas of focus. The analyses provided here offers a framework that can be adapted on an annual basis as donor commitments are actualized as disbursements and as domestic revenue budgets are actualized as expenditures. Health needs evolve over time (and even within a single annual budget cycle). Tracking expenditures within the NHA methodology provides critical information for policymakers on trends in health financing over time. Supplementing such expenditure tracking with an understanding of how budgeting and expenditures align with the components outlined in Tanzania's national strategic plans could further the alignment of donor investments to country priorities. Further, such analyses can

identify program components that are at risk for being "lost" during transition because of reliance on external or household financing, because program beneficiaries are vulnerable populations, or because a bottleneck in the PFM system complicates efforts to integrate that component into existing country systems.

Embrace a spirit of 'urgent incrementalism' to tackle transition challenges over time. As much as there is a risk of losing gains achieved in health outcomes and health systems if there is not adequate planning for transition, there is a risk to sustainability if externally-financed programs are integrated too quickly into country systems. Assuming responsibility for a greater share of the financing for HIV, TB, and malaria services from general government revenue and delivering those services through a benefits package under SNHI will require careful consideration of the characteristics and financing needs of program components to identify the appropriate source of funds, pooling, and purchasing arrangements. For example, in the short-term, donors will likely need to continue to provide financing for commodities across the three diseases or risk collapsing the financial solvency of the NHIF. However, the GoT could consider a phased approach to building the payment mechanisms for drugs: discussions of integrating malaria drugs under SNHI are already underway, and could be an option for a first step towards sustainability.

Convene leadership at the MoHCDGEC, MoFP, and PORALG to define next steps for sustainability and transition planning. Throughout the course of this work, stakeholders indicated the importance of convening high-level officials from across the government to discuss the key messages generated by the analyses, identify and prioritize key areas for focus, and generate further ownership and buy-in. Identification of barriers and areas for potential realignment of the PFM and health financing system will require continued strong communication between MoHCDGEC and MOFP, and development of plans specifically targeting these barriers.

This study offers a framework for examining the challenges of transitioning and sustaining Tanzania's HIV, TB, and malaria programs. It also proposes priority areas to be addressed through policy reform and dialogue among government and other health sector stakeholders at the national and LGA levels. The inevitable transition of externally funded programs creates an opportunity to refine key aspects of Tanzania's public financial management and health financing systems so they are suitably aligned to achieve the country's development and health sector goals, including control of the HIV, TB, and malaria epidemics. Ultimately, the successful transition of externally supported programs and sustainability of the outcomes those programs have helped to achieve will require prolonged commitment from health officials at all levels of government, buttressed by strategic investments from development partners—to collaboratively address the three diseases through recurrent processes to plan, implement, and monitor financing for health.

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Annexes

Annex A. Desk Review and Qualitative Fiscal Space Analysis [updated]

Introduction

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund) has invested over US$1.8 billion (TZS 3.8 trillion) since 2006 in Tanzania's health sector (The Global Fund 2017) to support a wide range of prevention, care, and treatment interventions for HIV, tuberculosis (TB), and malaria. While Tanzania is not among the countries projected to transition from Global Fund support by 2025[9], The Global Fund is supporting the Government of Tanzania (GoT) to progressively assume increased programmatic and financial responsibility for the three diseases and to strengthen transition planning. This early dialogue is consistent with the Global Fund's emphasis on supporting country governments to plan for transition regardless of where they sit on the development continuum (The Global Fund, 2016b).

Tanzania's Development Vision 2025 (TDV 2025), adopted in 2000, provides the philosophical direction and long-term vision for the country's economic and social development (The United Republic of Tanzania, 2000). Underpinned by the goal of becoming a middle-income country by 2025, the Development Vision serves as the overarching framework under which Tanzania has developed its five-year development strategies and sector-specific strategic plans for the past 15 years.

Across the Government of Tanzania's (GoT) development strategy documents, human development – and health in particular – feature prominently. Health outcomes in Tanzania have improved dramatically over the past two decades, particularly in child health (MoHCDGEC, Zanzibar Ministry of Health, National Bureau of Statistics, & ICF, 2016a). The incidence and prevalence of HIV in adults have declined over the past 20 years (TACAIDS & UNAIDS, 2016) and the death rate from tuberculosis (TB) has declined. Life expectancy for males and females has increased steadily over the past several decades (MoHCDGEC, Zanzibar Ministry of Health, National Bureau of Statistics, & ICF, 2016b).

However, challenges remain. Geographic and gender disparities in HIV prevalence are extreme (TACAIDS & UNAIDS, 2016). A recent survey of TB prevalence found that prevalence is higher than expected. Malaria is a leading cause of morbidity and mortality (MoHCDGEC et al., 2016b). Maternal mortality remains high relative to regional neighbors and unmet need for family planning has not improved since 1999 (MoHCDGEC et al., 2016b). Rising rates of non-communicable diseases over the past 15 years indicate that Tanzania is progressing quickly through the epidemiological transition (Ministry of Health and Social Welfare, 2015a). The dual burden of disease – as well as potential outbreaks of emerging infectious diseases – will further strain the health system, which is already stretched beyond capacity to deliver high quality healthcare to the population. Households continue to bear a significant burden of health financing, contributing nearly a quarter of total health spending in 2014 (The United Republic of Tanzania, 2017b). Implementation of single national health insurance will hopefully address this long-standing issue, but this remains a distant prospect.

[9] The following countries are projected to become ineligible in 2017-2019 based on re-classification of income category from middle-income to upper-middle income: Armenia (HIV, TB); El Salvador (TB, malaria); Kosovo (HIV, TB); Philippines (malaria); and Sri Lanka (HIV, TB). Similarly, the following countries are projected to become ineligible in 2020- 2022: Bolivia (malaria); Egypt (TB); and Guatemala (TB, malaria). Malaysia (HIV); Panama (HIV); Costa Rica (HIV); Romania (TB); Kazakhstan (HIV, TB); and Mauritius (HIV) are projected to become high-income and become ineligible in 2017-2025.

The improvements in Tanzania's health outcomes have been achieved with substantial investment from GoT and donors, but dependence on donor funds has grown. Since 2002, donor spending as a share of total health expenditure increased from 27 percent to a high of 48 percent in 2012. This desk review and qualitative fiscal space analysis reviews funding trends for HIV, TB, and malaria and assesses the viability of potential sources of new revenue and efficiency gains that could supplement existing resources from the Government of Tanzania. As Tanzania continues its dialogue on transition and sustainability with the Global Fund and other donors, the analyses presented here can serve as an initial framework to inform GoT.

Summary of approach and methodology

The Global Fund contracted Results for Development (R4D) to assist the GoT to identify opportunities and challenges for sustaining effective coverage of HIV, TB, and malaria services. At the center of R4D's analytical approach is a focus on the implications of the transition from donor funding for sustaining gains in health outcomes as assessed through the lens of public financial management (PFM). Tracing the Global Fund's investments in HIV, TB, and malaria through the budget and PFM system provided an entry point for GoT and R4D to examine the health financing system holistically, with special attention to the interplay between Tanzania's PFM systems and health budgeting processes at the national and local government authority (LGA) levels.

R4D's approach is participatory in nature, through formal engagement with GoT-designated focal points in the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC), the Ministry of Finance and Planning (MoFP), and the President's Office Regional Administration Local Government (PORALG). In addition, numerous stakeholders were consulted on the design and scope of the approach based on the recommendations of the Global Fund Tanzania portfolio team and the GoT focal points.

Based on the recognition that weak PFM can compromise effective transition, R4D's approach in Tanzania:

- Emphasizes a country-led process that can be ongoing after the activity ends;
- Recognizes that general government revenue as the core of financial sustainability;
- Maintains a holistic view that leverages efficiencies and considers the broader context of health policy and UHC goals; and,
- Embeds a framework for sustainable health financing that is in the government PFM system, so that spending is allocated according to priorities, deployed effectively, and can be monitored at all levels alongside results.

R4D supported the country-led process described above with this desk review of Tanzania's macro-fiscal, health policy, and health financing context and qualitative fiscal space analysis examining potential sources of revenue and efficiency gains for the health system. Sustainability scenarios will be developed as an input to GoT deliberations and planning and will represent a living plan that can be updated iteratively by the GoT in consultation with relevant stakeholders, including the Global Fund and other development partners.

Desk Review

This desk review builds on ongoing work by GoT to develop a new Health Financing Strategy (HFS) (MoHCDGEC, 2016)[10] and other existing analyses of the health sector in Tanzania, including but not limited to recent studies such as the fiscal space analysis conducted by Oxford Policy Management (James, Lievens, Murray-Zmijewski, Aikaeli, & Booth, 2014) and the sustainable health financing study conducted by the Health Policy Project (Dutta, 2015).

Government of Tanzania policy framework

Macro-fiscal overview

Tanzania is a low-income country with a projected population of over 48 million people in 2016. As outlined in more detail below, Tanzania has benefited from strong economic growth over the past 15 years: the average annual GDP growth rate has exceeded six percent. However, while Tanzania has outpaced its regional and income category peers, GDP growth is expected to decline to below the 2000-2015 average by 2022 (IMF, 2017). With a GNI per capita (Atlas method) of US$920 in 2015, Tanzania is close to reaching the lower-middle income (L-MIC) threshold (by World Bank classifications) of US$1,026 within the next eight years (The World Bank, 2017a). General government debt-to-GDP ratio provides a measure of the economy's health and is an important consideration for the sustainability of government finance: due to new domestic and foreign borrowing (at concessional and non-concessional rates) and from currency depreciation (The United Republic of Tanzania, 2016a), IMF staff projections indicate that by 2022, Tanzania's general government debt will account for 43 percent of its GDP (IMF, 2017). Since 2009, Tanzania's tax revenue as a share of GDP has hovered between 12 and 13 percent (The World Bank, 2017b). Achieving the primary development goal of reaching middle-income country (MIC) status by 2025 seems a distant prospect (The United Republic of Tanzania, 2000).

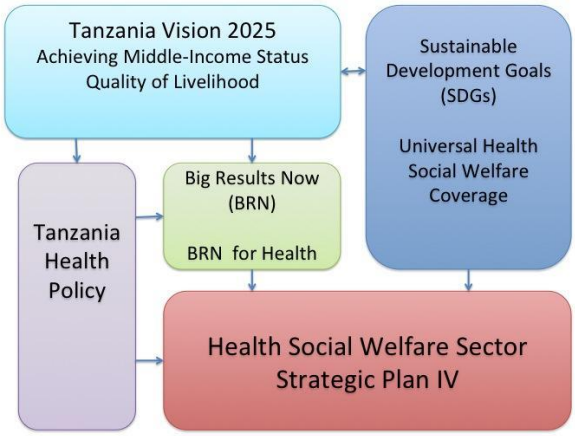
Tanzania's development goals

Since 2000, and under the umbrella objectives of TDV 2025 – including human development, good governance, and economic growth – GoT has developed several national strategies to guide the implementation of the TDV 2025 goals (Ministry of Finance, 2012; The United Republic of Tanzania, 2011, 2013a, 2016a). At the core of each is a focus on poverty reduction and economic growth along with the recognition that significant challenges exist that could hinder Tanzania's mission to achieve middle-income status by 2025 and by extension, to achieving the related goals of improving the quality of life and wellbeing for Tanzanians. Within their respective scopes, the plans detail indicators and targets indirectly (e.g., human development, poverty reduction, and social protection) and directly (e.g., reducing disease prevalence and health systems strengthening) related to health. Thus, even Tanzania's general policy frameworks recognize the importance of monitoring specific indicators and goals relevant to Tanzania's prospects for sustaining effective coverage of health services – including those for the three diseases.

[10]Note: The version of the Health Financing Strategy referred to in this desk review is dated January 2016. It remains to be seen whether the HFS as drafted will be implemented and what might be the effects on sustainable financing for the health system overall as well as the three diseases.

Figure 1 provides a visualization of the relationship among Tanzania's general policy framework, the global development agenda as articulated by the Sustainable Development Goals (SDGs), and health sector policies and strategic plans. Health sector priorities are guided by Tanzania's Health Sector Strategic Plan 2015-2020 (HSSP IV) (Ministry of Health and Social Welfare, 2015a). The Tanzania Health Policy, revised in 2007, defines the Vision 2025 Goals for the health sector while Big Results Now (BRN) details results-based objectives and targets for public sector health service delivery. BRN is relevant primarily to the LGA level given that LGAs have been mandated to manage the delivery of social services under decentralization. BRN was intented to re-invigorate focus on the quality of primary health care, balanced distribution of human resources for health, 100 percent stock availability of essential commodities for all health facilities, and accelerating gains in reproductive, maternal, neonatal, and child health (RMNCH) (BRN Healthcare NKRA Lab, 2015). However, its prominence has diminished. The SDGs provide the context for international development, and more specifically universal health coverage (UHC).

Figure 1. Strategic framework for HSSP IV



Source: Ministry of Health and Social Welfare, 2015a

HSSP IV includes four strategic objectives, including:

- Improve the quality of primary health care services, delivering a minimum benefits package
- Ensure equitable access to services, based on geographical and vulnerability criteria
- Engage in community partnership in service delivery and management
- Apply modern management methods and engage in innovative partnerships
- Address the social determinants of health through intersectoral collaboration

Tanzania also develops medium-term strategic plans to guide the national response for specific health priorities, including HIV, TB, Malaria, neglected tropic diseases (NTDs), human resources, and non-communicable diseases (NCDs)(Table 1). Each plan details disease- or issue-specific objectives, activities, a monitoring framework, and estimated resource needs. The approaches outlined in the priority-specific strategies are all intended to support and complement HSSP IV and align with the overall direction articulated in Tanzania's general development policies. For HIV, the NMSF3 guides Tanzania's response across sectors and the HSHSP-III guides the health sector-specific response to HIV.

Table 1. Strategic plans for health priorities

Health Priority	Strategic Plan	Timeframe	Institutional Home
HIV	National Multi-sectoral Strategic Framework for HIV/AIDS 3 (NMSF3)	2013/14 – 2017/18	NACP
	Third Health Sector HIV and AIDS Strategic Plan (HSHSP-III)	2013 – 2017	MoHCDGEC
Malaria	National Malaria Strategic Plan (NMSP)	2014 – 2020	NMCP
TB	National TB and Leprosy Strategic Plan V	2015 – 2020	NTLP
NTDs	National Master Plan for Neglected Tropical Diseases (NTDs)	2012 – 2017	MoHCDGEC
Human resources	Human Resource for Health and Social Welfare Strategic Plan	2014 – 2019	MoHCDGEC
NCDs	Strategic and Action Plan for the Prevention and Control of Non-Communicable Diseases in Tanzania	2016 – 2020	MoHCDGEC

Sources: Ministry of Health and Social Welfare, 2013, 2014, 2015b; Ministry of Health and Social Welfare & National AIDS Control Programme, 2014; The United Republic of Tanzania, 2016b, 2013b

Tanzania's goals for HIV include a 50 percent reduction in HIV incidence, a significant reduction in AIDS-related deaths, and reduced stigma and discrimination against people living with HIV (PLHIV) by 2018. For Malaria, the goal is to reduce average malaria prevalence to 1 percent by 2020. Progress in TB is measured against two targets: reduce the incidence of TB by 20 percent and reduce TB mortality by 35 percent by 2020.

Each strategic plan emphasizes the participatory and consultative processes involved in its development. However, the overlapping timeframes and mandates, competing resource needs, intervening agendas at the global level (e.g., the Sustainable Development Goals and the 90/90/90 targets for HIV) that set the context for development at the country level and the need to coordinate planning and funding requests with development partners beg the question of whether the benefits of having detailed plans for each health priority – in terms of emphasis of the issue's importance across government, civil society, and development partners, for example – outweigh the tradeoffs for efficiency and effectiveness of implementation and ultimately, progress towards achieving health outcomes. This question becomes particularly salient in light of Tanzania's draft health financing strategy (HFS), which outlines the path to achieving UHC (MoHCDGEC, 2016).

The Government of Tanzania's (GoT) policy priorities for the health sector related to health financing are reflected most recently in the final draft of the health financing strategy (MoHCDGEC, 2016) which is described in more detail below.

Health system performance

Tanzania has made impressive gains in health outcomes over the past 15 years. Since 1999, there has been a consistent decline in neonatal, post-neonatal, infant, child, and under-five mortality rates (MoHCDGEC et al., 2016b). Tanzania met two of the Millennium Development Goals by reducing its under-five mortality rate from 153 to 67 per 1,000 live births, and infant mortality rate from 95 to 46 per 1,000 live births in the decade leading up to 2012 (Tanzania National Bureau of Statistics, 2015). Life

expectancy for males and females has increased steadily over the past several decades (MoHCDGEC et al., 2016b).

However, reductions in neonatal mortality fell short of the level needed to achieve the MDG targets (Ministry of Health and Social Welfare & National AIDS Control Programme, 2014). Maternal mortality in Tanzania remains high relative to its regional neighbors, at 556 deaths per 100,000 live births and has increased since 2010. Unmet need for family planning among currently married women has hovered between 22 and 24 percent since 1999 (MoHCDGEC et al., 2016b). Rising rates of non-communicable diseases such as diabetes and cardiovascular disease (Ministry of Health and Social Welfare, 2015a) indicate that Tanzania is progressing quickly through the epidemiological transition: premature mortality from each of the four main non-communicable diseases (cancers, diabetes, cardiovascular disease, and chronic respiratory disease) has increased over the past 15 years (WHO, 2014). The dual burden of disease – as well as potential outbreaks of emerging infectious diseases – will further strain the health system, which is already stretched beyond capacity to deliver high quality healthcare to the population. Households continue to bear a significant burden of health financing, contributing nearly a quarter of total health spending in 2012 (MoHCDGEC, 2016).

With respect to the three diseases[11], AIDS-related deaths declined by 44 percent between 1990 and 2015, but Tanzania is one of 10 countries in sub-Saharan Africa that account for over 80 percent of people living with HIV (PLHIV) in the region (United Nations Economic Commission for Africa, African Union, African Development Bank, & United Nations Development Programme, 2015). Similarly, declines in average HIV prevalence rates in Tanzania mask considerable heterogeneity across regions, age, and gender (TACAIDS & UNAIDS, 2016). Geographic and gender disparities in HIV prevalence are extreme, with adult prevalence ranging from 0.3 percent in Pemba to 14.8 percent in Njombe, and prevalence in women ages 15-29 is more than double that of their male counterparts (TACAIDS & UNAIDS, 2016).

Malaria remains a leading cause of morbidity and mortality, especially in children under five and pregnant women and prevalence increased from 9 to 14 percent between 2011 and 2016 (MoHCDGEC et al., 2016b). 93 percent of the population live in malaria-endemic zones (MoHCDGEC et al., 2016b). While the death rate from TB declined by nearly 14 percent between 2005 and 2015, TB is now the 8th leading cause of death (from the 11th), largely due to high rates of HIV/TB co-infection (Ibid).

A health system assessment conducted in 2010 indicated that Tanzania's health system had mixed performance during the first decade of the 21st century (Musau et al., 2011). Many of the challenges identified in that assessment linger today (The World Bank, 2014b; West-Slevin, Barker, & Hickmann, 2015): in addition to an overall shortage in human resources for health, health workers are not equitably distributed across the country and there is an imbalance in some cadres. Similarly, health facilities – and by extension, healthcare services – are not geographically distributed to adequately meet population needs. Procurement remains a challenge: as noted above, BRN identified 100 percent stock of essential commodities as a key indicator for its health sector performance monitoring.

The process of decentralization by devolution has shifted considerable responsibility for public service delivery in many sectors to Local Governments (LGs) or Councils, which are now the most important administrative and implementation unit for the delivery of health services. The devolution process has

[11] Detailed profiles of the status of each epidemic, the gains and remaining challenges in mounting national responses, and estimates of resource needs are thoroughly documented in the plans listed above (see Table 1) and elsewhere (Ministry of Health and Social Welfare, 2015a; PEPFAR, 2016; PMI, 2017; TNCM, 2014, 2015).

added a layer of complexity and management to health service delivery and there remains room for improvement in budget execution, accountability, and transparency (Ministry of Health and Social Welfare, 2015a).

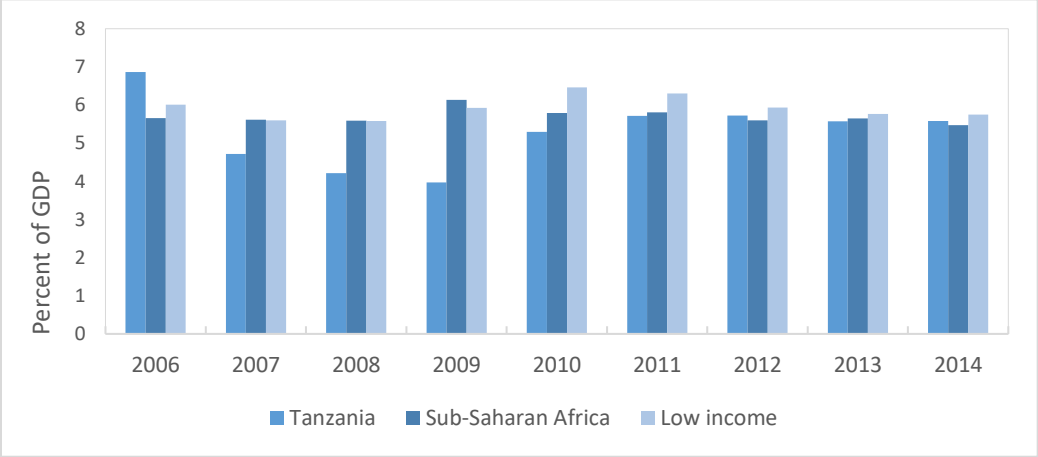
Improving the performance of the health system at the LGA level is a key health sector priority. The Star Rating and Improvement system, introduced via BRN in 2014, outlines a stepwise facility accreditation process (The World Bank, 2014a). A baseline assessment of facility-level quality of care in 5,326 health facilities in 20 regions was conducted in 2015 (Global Financing Facility, 2016). Health facilities were assigned a rating of one to five stars based on performance against indicators of health service delivery and support systems. Only one percent of evaluated facilities (67 facilities) received a rating above three stars (2016). Performance improvement plans will be developed for the 5,259 facilities rated below three stars. Facilities ranked above three stars will be accredited by an independent accreditation body, which has yet to be developed.

Health financing overview

Motivated by a pattern of financing common in many low-income countries, where households and donors contribute large shares of total health spending and expenditures from domestic sources – especially government – remain low, Tanzania developed a health financing strategy (HFS) that prioritizes achieving universal coverage through mandatory health insurance. However, the most recent draft of the HFS is from January 2016.

Total health expenditure in Tanzania increased steadily over the past decade, reaching US$52 per capita in 2014 (The World Bank, 2017b). This is well above the low-income country average of US$37, but below the regional average of nearly US$98 (The World Bank, 2017b). As a share of GDP, total health spending in Tanzania has increased steadily from a low of 4 percent in 2009 to 5.6 percent in 2014 bringing Tanzania on par with its regional and income-category peers (Figure 2). However, as noted in more detail below, the share of total health spending originating with donors has increased over time.

Figure 2. Total health expenditure as a share of GDP in Tanzania, Sub-Saharan Africa, and Low-Income Countries



Source: The World Bank, 2017b

Between 2013 and 2015, the GoT increased its health expenditure by TZS 129 million to TZS 972 million (The United Republic of Tanzania, 2017a, 2017b). The source of government spending on health[12] is predominantly transfers from central government revenue: regional/local levels of government contributed only 1.4 percent of total government spending and the National Health Insurance Fund (NHIF) contributed 6.4 percent in 2014 (The United Republic of Tanzania, 2017b).

In per capita terms, government spending (including budget support from donors) increased from US$8 to US$24 while external financing increased from just over US$1 to US$18 per capita over the same time period (The World Bank, 2017b). In 2014, public spending accounted for over 46 percent of per capita spending while donor spending accounted for nearly 36 percent of per capita spending (The World Bank, 2017b).

Trends in the composition of health spending

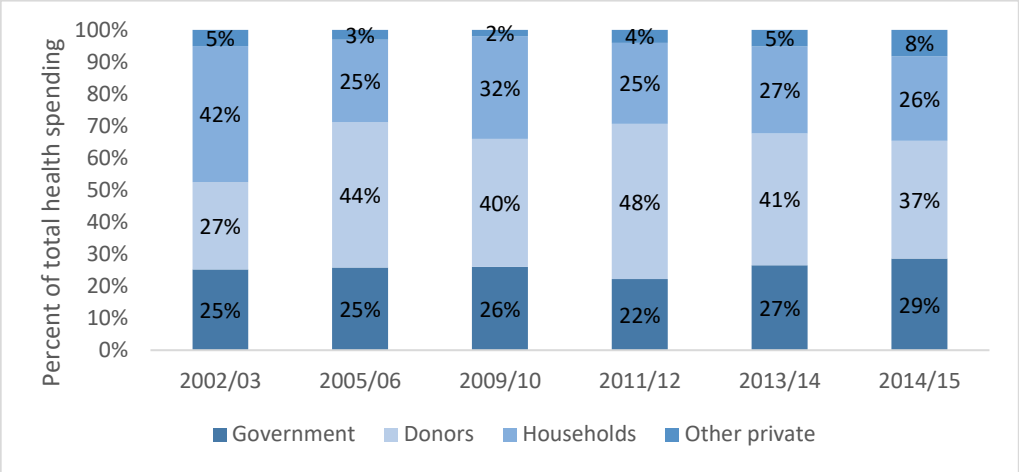
The composition of total health expenditure in Tanzania has remained relatively consistent over time, aside from the major shift between 2002/03 and 2005/06 in the role of donors and households in health financing (Figure 3). Between 2002 and 2014, government spending as a percent of total health expenditure increased from 25 percent to 29 percent while external resources for health increased from 27 percent to 37 percent of total health expenditure. Over that same period, household spending as a share of total health expenditure decreased substantially from 42 to 26 percent, but in the era of large volumes of funding from development partners (i.e., since 2005/06) has remained within a range of 10 percentage points.

While the substantial decrease in household spending and concomitant increase in the proportion of donor financing between 2002/03 and 2005/06 seems to suggest donor monies were providing increased financial protection for households, there remains much progress to be made: less than one percent of total health spending in 2014/15 originates with voluntary pre-payment from individuals or households, which reflects the low (22 percent) enrollment rate in contributory health insurance schemes[13] in Tanzania (MoHCDGEC, 2016; The United Republic of Tanzania, 2017b). This is far from the 30 percent enrollment target by 2015 set out in the previous health sector strategic plan (MoHCDGEC, 2016). Nearly all household spending is out-of-pocket (The United Republic of Tanzania, 2017b). Further, spending by households and donors combined accounts for over 60 percent of total health spending in 2014/15, 68 percent in 2013/14, and around 70 percent in each National Health Accounts estimation since 2002 (Health Policy Project, 2016; The United Republic of Tanzania, 2017a, 2017b).

[12] Note: Detailed analyses of Government of Tanzania's estimated health budget allocations for 2015/16 published elsewhere (Bryant Lee, Arin Dutta, Hope Lyimo, & Rosemary Silaa, 2015) indicate that as a share of the national budget, the health budget was 11.8 percent. However, this includes on-budget funding from development partners. Estimates of GoT budgets or expenditures independent of budget support can be obtained from focal points during the validation consultation.

[13] There are five main health insurance schemes in Tanzania with the following coverage: the National Health Insurance Fund (NHIF) (7 percent); National Social Security Fund-Social Health Insurance Benefit (NSSF-SHIB) (12 percent); the Community Health Fund (CHF/Tiba Kwa Kadi (TIKA) (0.12 percent); private health insurance (1.02 percent); and community-based insurance (CBHI) (1 percent) (MoHCDGEC, 2016).

Figure 3. Total health spending by source in Tanzania, 2002-2014



Source: 2013/14 and 2014/15 data from The United Republic of Tanzania, 2017a, 2017b. Earlier data re-created from Health Policy Project, 2016.
Note: Totals may not sum to 100 due to rounding.

Of the donors providing financing for health in Tanzania in 2014, bilateral donors account for 51 percent of all donor spending and multilateral donors account for 47 percent of all donor spending (Table 2). Spending by these sources dwarfs expenditures from the Bill and Melinda Gates Foundation and other sources of external expenditures.

Table 2. Donor funding in Tanzania, 2014/15

Donor Funding	TZS Million	Percent of donor spending
Bilateral (including PEPFAR)	639,642.88	51.05%
Multilateral	590,706.96	47.15%
Bill and Melinda Gates Foundation	793.62	0.06%
Unspecified	21,757.34	1.74%
TOTAL	**1,252,900.79**	**100.00%**

Source: The United Republic of Tanzania, 2017b

The United States (including PEPFAR) is the largest donor, providing 38 percent of all donor spending, 75 percent of all bilateral funding, and 14 percent of total health spending in 2014/15. The Global Fund is the follows closely behind: in 2014/15, the Global Fund accounted for 34 percent of all donor funding, 72 percent of all multilateral funding, and 12 percent of total health spending (The United Republic of Tanzania, 2017a, 2017b).

Overall, and even in the absence of information about the proportion of government expenditure on health originating from government revenue (i.e., excluding on-budget donor support), health financing trends indicate that the health sector in Tanzania has been heavily reliant on donors for over a decade. Although the government has increased its spending on health in recent years, there remains a significant burden of financing that falls to households. Neither donors nor household out-of-pocket spending are sustainable sources of financing, particularly in an era when donors are initiating plans to decrease the volume of financial assistance provided. The government has increased its spending on health in absolute terms, but with the ambitious plans to meet internationally- and domestically-determined targets for health outcomes and service delivery coverage, and given the parallel – though

nascent – planning for phasing out donor assistance, the GoT will need to identify options for generating additional revenue for health, either from new or existing sources.

Trends in financing for HIV, Tuberculosis, and Malaria

Expenditures on specific diseases largely reflects the disease burden in Tanzania, with infectious and parasitic diseases[14] accounting for 56 percent of total health spending, and reproductive health and non-communicable diseases accounting for 14 percent and 10 percent of total health spending, respectively. The remaining 20 percent of total health spending is accounted for by other and unspecified diseases/conditions (13 percent), nutritional deficiencies (3 percent), non-disease specific (2 percent), and injuries (1 percent) (The United Republic of Tanzania, 2017b).

Among the eight infectious and parasitic diseases, spending on HIV and Malaria account for over 65 percent of all spending in the category, with tuberculosis spending accounting for 3.7 percent of spending in the category, ranking seventh (Table 3)

Table 3. Infectious disease spending priorities, ranked by expenditure in 2014/15 (TZS million)

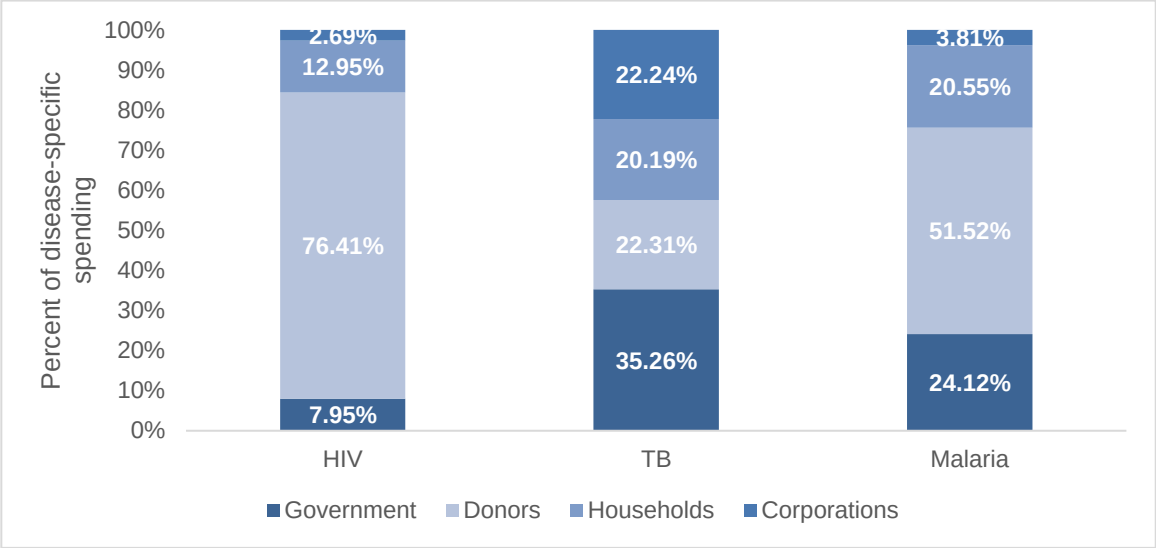
Rank	Disease	TZS Million	Percent of total infectious and parasitic disease spending	Percent of total health expenditure
1	HIV	630,625.12	33.0%	18.5%
2	Malaria	611,114.96	32.0%	17.9%
3	Respiratory infections	207,949.74	10.9%	6.1%
4	Vaccine preventable diseases	205,922.78	10.8%	6.0%
5	Diarrheal diseases	80,186.04	4.2%	2.4%
6	Other and unspecified infectious and parasitic diseases (n.e.c.)	76,437.53	4.0%	2.2%
7	Tuberculosis	71,086.22	3.7%	2.1%
8	Neglected tropical diseases	24,860.62	1.3%	0.7%
	TOTAL	**1,908,183.00**	**100.00%**	**56%**

Source: The United Republic of Tanzania, 2017b

There is considerable variation in the composition of spending across HIV, TB, and malaria (Figure 4) While donors provide most spending for HIV and malaria (76 percent and 52 percent, respectively), external financing accounts for 22 percent of spending for TB, which is roughly equivalent to the spending from households and corporations. The Government of Tanzania is the largest source of funding for tuberculosis, accounting for just over 35 percent of TB spending, but the absolute value of this spending is half of GoT spending on HIV and less than 20 percent of GoT spending on malaria. GoT financing for both HIV and malaria, at 8 percent and 24 percent, respectively, is dwarfed by donor financing, indicating that sustaining coverage for these two diseases is particularly at risk as donors decrease support. Household spending on HIV is larger in relative and absolute terms than GoT spending on HIV and for malaria, is only four percentage points lower than GoT spending. Corporations play a marginal role in financing for the three diseases in absolute terms.

[14] This category includes spending on HIV, tuberculosis, malaria, respiratory infections, diarrheal diseases, neglected tropical diseases, vaccine preventable diseases, and other and unspecified infectious and parasitic diseases.

Figure 4. Spending on HIV, TB, and Malaria by source, 2014/15



Source: The United Republic of Tanzania, 2017b

The composition of spending by source within HIV and malaria[15] has persisted over the past decade (Tables 4 and 5). After an initial and substantial increase in spending by government between 2002 and 2005, government expenditure on HIV has declined markedly. In contrast, government spending on malaria has increased steadily since 2002. Donors have been the primary financiers of the response to HIV and malaria, particularly since PEPFAR, the Global Fund, and the President's Malaria Initiative (PMI) were launched, and have steadily increased expenditures since 2005. Spending by households on HIV in 2014/15 quadrupled relative to 2002/03, but decreased since 2009/10[16], whereas household spending on malaria has decreased steadily since 2005. Spending by private sources other than households has remained marginal across the two diseases.

Table 4. Spending on HIV by source, 2002-2015

Financing Source	2002/03		2005/06		2009/10		2013/14		2014/15	
	TZS million	percent	TZS million	percent	TZS million	percent	TZS million	percent	TZS million	percent
Government	6,956	12.4%	137,441	26.6%	71,258	11.4%	82,566	12.4%	50,157	8.0%
Donors	25,694	45.8%	320,351	62.0%	437,151	70.2%	468,769	70.8%	481,858	76.4%
Households	22,328	39.8%	25,318	4.9%	107,410	17.2%	97,199	14.6%	81,676	13.0%
Other Private	1,222	2.2%	33,585	6.5%	6,425	1.0%	12,959	1.9%	16,933	2.7%
Total	**56,100**	**100%**	**516,695**	**100%**	**622,243**	**100%**	**661,493**	**100%**	**630,625**	**100%**

Source: 2014/15 data from The United Republic of Tanzania, 2017a, 2017b. Earlier data re-created from MoHCDGEC, 2012.

[15] Similar time series analysis for tuberculosis is not feasible given lack of TB-specific NHA subaccounts prior to 2012/13.
[16] Further investigation is needed into the massive increase in household spending for HIV between 2005/06 and 2009/10.

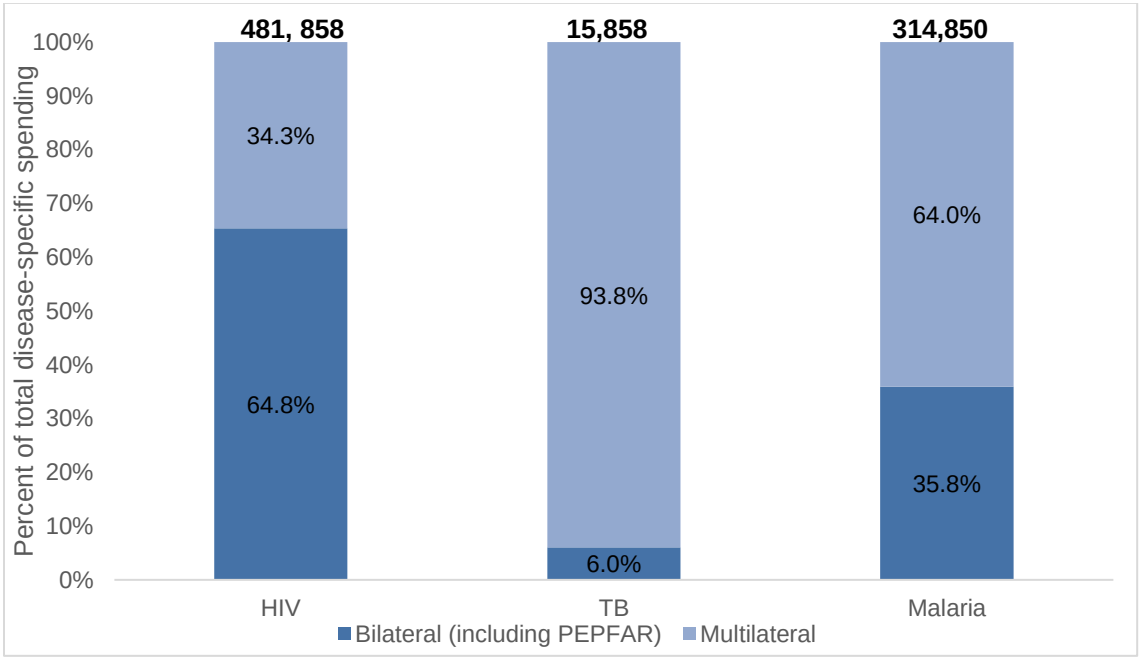
Table 5. Spending on malaria by source, 2002-2015

Financing Source	2002/03		2005/06		2009/10		2013/14		2014/15	
	TZS million	percent	TZS million	percent	TZS million	percent	TZS million	percent	TZS million	percent
Government	56,067	36.5%	88,238	21.50%	87,653	19.4%	116,172	21.3%	147,392	24.1%
Donors	17,972	11.7%	72,232	17.60%	180,349	40.0%	259,164	47.6%	314,850	51.5%
Households	73,117	47.6%	239,432	58.34%	177,370	39.3%	148,241	27.2%	125,576	20.5%
Other Private	6,452	4.2%	10,506	2.56%	5,963	1.3%	20,684	3.8%	23,295	3.8%
Total	**153,607**	**100%**	**410,407**	**100%**	**451,334**	**100%**	**544,261**	**100%**	**611,114**	**100%**

Source: 2014/15 data from The United Republic of Tanzania, 2017a, 2017b. Earlier data re-created from MoHCDGEC, 2012.

Among donors, spending on the three diseases in 2014/15 comes primarily from multilateral and bilateral donors (Figure 5). For both TB and malaria, multilateral sources provide most funding, with the Global Fund providing more resources than any other donor. For HIV, the opposite is the case: bilateral sources provide most funding, with the President's Emergency Plan for AIDS Relief (PEPFAR) providing the highest volume of resources.

Figure 5. Donor spending on HIV, TB, and Malaria, 2014/15 (TZS million)



Source: The United Republic of Tanzania, 2017b
Note: For each disease, spending by private and unspecified sources is less than one percent of the total.

Qualitative Fiscal Space Analysis

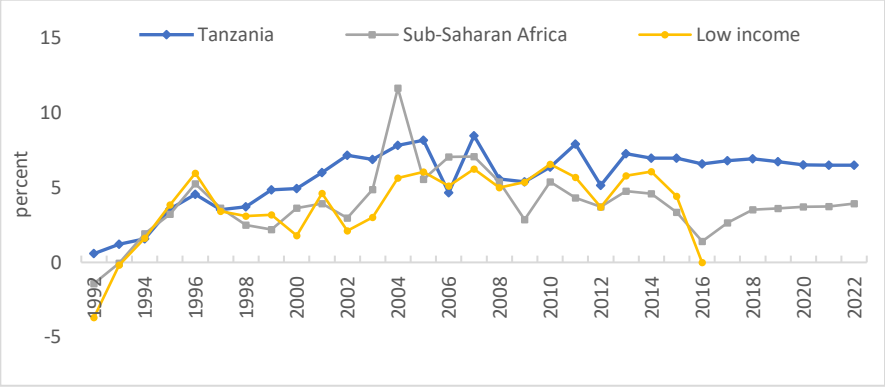
Tanzania's ambitious development goals and aspirations to achieve universal health coverage have prompted several fiscal space analyses in recent years (Dutta, 2015; James et al., 2014; Lee, Dutta, & Idama, 2015), culminating with a costing and fiscal space assessment in the health financing strategy[17]. The analysis included in the draft HFS focuses on fiscal space specifically for the NHIF. By 2021, an estimated TZS 1,652 billion will be needed to finance scale up of coverage to 70 percent of the population, assuming coverage with a basic minimum benefit package (i.e., not the MBP+). Innovative sources of financing, such as sin taxes, will be necessary to finance this needs estimate: current pooling options are not sufficient. An assessment of fiscal space for the overall health sector is included in HSSP IV alongside estimates of financing needs through 2020.

Sources of fiscal space include favorable macroeconomic conditions; prioritization of health in the government budget; increases in health sector-specific resources; external grants and foreign aid for health; and increases in the efficiency of health expenditures (Tandon & Cashin, 2010).

Potential sources of revenue

Macroeconomic conditions: As noted above, the primary development goal for Tanzania is to reach middle-income country (MIC) status by 2025 (The United Republic of Tanzania, 2000). With a GNI per capita (Atlas method) of US$920 in 2015, Tanzania is close to reaching the lower-middle income (L-MIC) threshold (by World Bank classifications) of US$1,026 within the next eight years (The World Bank, 2017a). However, while Tanzania's average annual GDP growth has been high since 2000, at 6.6 percent, and has outpaced its regional and income category peers, GDP growth is expected to decline to below the 2000-2015 average by 2022 (Figure 6). This projection differs from the ambitious target of increasing GDP growth to 10 percent and per capita income to US$1,500 by 2021 set in Tanzania's most recent five-year development plan (The United Republic of Tanzania, 2016a), particularly given that Tanzania is the largest country in east Africa, with a projected population of over 50 million in 2015 (Tanzania National Bureau of Statistics, 2017).

Figure 6. GDP growth in Tanzania, Sub-Saharan Africa, and Low-Income Countries



Source: IMF, 2017; The World Bank, 2017b
Note: IMF staff projections from 2016 for Tanzania and Sub-Saharan Africa.

[17] The final draft of Tanzania's new Health Financing Strategy includes a qualitative assessment of domestic revenue possibilities and efficiency gains. The revenue possibilities portion of the assessment is replicated in Annex 1.

Relative to GDP, the responsiveness, or elasticity, of government health expenditure provides an indication of whether favorable macroeconomic conditions are likely to translate into more public expenditure on health. In low-income countries, the elasticity of government spending to GDP is estimated to be about 1.16 (implying that a one percent rise in income on average leads to a 1.16 percent rise in government health spending, on average) (Tandon & Cashin, 2010). In Tanzania, the elasticity of government health expenditure relative to real GDP is 2.32, indicating that a one percent rise in income would lead to a 2.32 percent increase in government health spending. However, the elasticity of government health spending relative to real total government expenditure is lower, at 1.4, suggesting that health spending is less responsive to increases in government spending (Fleisher, Leive, & Schieber, 2013).

Tanzania's general government debt-to-GDP ratio provides a measure of the economy's health and is an important consideration for the sustainability of government finance. While lower than Kenya's debt-to-GDP ratio of 52 percent and while on par with the regional average, Tanzania's debt-to-GDP ratio has increased steadily since 2008, from 22 percent to 37 percent in 2015 (IMF, 2017). This results from new domestic and foreign borrowing (at concessional and non-concessional rates) and from currency depreciation (The United Republic of Tanzania, 2016a). IMF staff projections indicate that by 2022, Tanzania's general government debt will account for 43 percent of its GDP (IMF, 2017). While the debt sustainability analysis ranks Tanzania's risk of debt distress as low, deficit spending will be limited by the rising debt-to-GDP ratio (IMF, 2016).

Tax revenue as a share of GDP provides another measure of the economy's health, based on the assumption that with economic growth comes an increase in revenue from taxes, which in turn permits more spending. Additionally, this measure offers an indicator of the extent to which a government has control over its resources: as a more reliable source of revenue tax revenue could help avoid volatility in public expenditure and pro-cyclical fiscal policy (Lagarde, 2016). Since 2009, Tanzania's tax revenue as a share of GDP has hovered between 12 and 13 percent (The World Bank, 2017b).

Overall, the revenue potential of the government is low—economic growth is stagnating, tax revenue is low, and deficit spending will be limited by the increasing debt-to-GDP ratio.

Prioritizing health within the government budget: The decision to shift resources within the existing budget envelope to health from another sector at either the national or local level is ultimately a political one that can involve tradeoffs for health outcomes if the sector from which resources are pulled implements interventions with direct or indirect effects on health outcomes (e.g., education). Similarly, the decision to re-channel resources within health at any level of government is also political. Priorities are fluid and can shift annually based on any number of factors: the extent to which a sector is prioritized for additional resources over another, or how priorities are balanced for intra-sectoral budget allocation at the budget formulation stage is subject to change with each budget cycle. The draft Health Financing Strategy calls for general government spending on health to be "re-channeled" to the NHIF, which suggests pulling resources from another area within the health sector (e.g., government and civil servant contributions to social security), but also calls for increased general government revenue, which suggests pulling from another sector (MoHCDGEC, 2016). The draft HFS evaluates the political feasibility and revenue potential from increasing general government budget as high (see Annex 1) noting that the health sector "expects to benefit" from economic growth and ongoing tax reform efforts that will increase overall government revenue (MoHCDGEC, 2016).

Given that health is the third priority for government financing (behind education and infrastructure), it remains to be seen whether the health sector will indeed be the recipient of any additional revenue from the general government budget, particularly given stagnating GDP growth projections. Currently, as a share of total public expenditure, government spending on health is 12 percent. This is high relative to other countries in sub-Saharan Africa, which spend as little as four percent and as much as 17 percent of general government expenditure on health (WHO, 2017). However, over the past two decades, this share has decreased from a high of 28 percent in 2006. At the LGA level, the potential to increase own-source revenues will depend substantially on poverty rates. The draft HFS notes potential fiscal space from LGA own-source revenue is low and that it may be necessary to develop an equalization mechanism across LGAs to ensure that those with higher numbers of fully-subsidized beneficiaries are not unduly penalized and that cross-subsidization will occur at the individual and geographic area levels. The draft HFS suggests that one potential use of LGA own-source revenue could be health worker incentives, indicating that the potential volume of new revenue from LGAs would be important but not substantial (MoHCDGEC, 2016).

Health-sector specific sources: The draft HFS calls for implementing levies and earmarking associated revenue for the NHIF. More specifically, the draft HFS identifies three specific possibilities for earmarked taxes or levies (but provides no assessment of their potential revenue gains or political feasibility): taxes on alcohol and tobacco; a mobile communication/airtime levy; and a surplus of public corporations. These three options were previously proposed in HSSP IV as innovative financing mechanisms for increasing fiscal space. Earmarking for a narrow expenditure purpose (e.g., a specific disease) is unlikely to bring additive funds and introduce rigidities into the overall budget and within the health budget that can ultimately undermine funding for service delivery (Results for Development, 2017; WHO, 2017). The AIDS Trust Fund is also noted as a source of fiscal space in HSSP IV but the draft HFS proposes to fold revenue from this fund into the NHIF.

External grants and foreign aid: In the context of transition, where, by definition, donors are initiating plans to reduce volumes of financing, and in especially in low-income country settings such as Tanzania where economic growth is stagnating, new sources of revenue from external grants and foreign aid have limited potential to relieve the transition burden. The projections of donor financing included in the fiscal space assumptions of HSSP IV seem to take this into account: apart from the World Bank, which is projected to double its support for the health sector between 2017 and 2018 (likely for the results-based financing program), financing from all other donors is projected to flat line or decrease between 2017 and 2021 (Ministry of Health and Social Welfare, 2015a). Global Fund support is projected to decrease from TZS 558 billion in 2017/18 to TZS 479 billion by 2020/21.

Potential sources of efficiency

Given the low to modest potential for new fiscal space on the revenue side, Tanzania will need to look to efficiency gains that can be reinvested in the health sector to expand fiscal space to meet health sector objectives. There are numerous ways to increase health system efficiency by bolstering outputs and outcomes for a given level of investment, reducing costs to produce a given level of outputs or outcomes, or both. Importantly, cutting costs alone does not automatically increase efficiency; quality must concurrently endure or improve.

As noted above, Tanzania's draft HFS identifies options for generating efficiency gains, noting that the "need for revenue can be decreased" if such gains are realized (Table 6)(MoHCDGEC, 2016).

Table 6. Options for achieving efficiency gains identified in Tanzania's draft health financing strategy

1	Better targeted health care services, effective gate-keeping mechanisms, enforcement of referral mechanisms, and other priority service delivery improvements
2	Improved human resource distribution and management
3	Productivity gains from a variety of mechanisms (e.g., results-based financing)
4	Implementation of effective and harmonized data management systems (especially related to resources management)
5	Lower administrative costs and other efficiency increases especially related to fixed costs and infrastructure
6	Enhancing PFM including ensuring that full health allocations are spent and per capita allocations of resources across LGAs are improved, improving transfer of funds from central to district level, improving the disbursement of funds by eliminating complicating disbursement procedures, and clarifying who is accountable at all levels
7	Increased external aid coordination (e.g., resource tracking, bringing development partner funding increasingly on budget)

The draft HFS does not assess each potential efficiency gain, but rather provides an overall assessment of efficiency gains generally as having very positive/large political feasibility, no effect on equity, a positive/large effect on revenue potential and incentive effects, and would provide a new source of revenue for health. Broadly, the categories of efficiency levers noted in the draft HFS are appropriate and provide a useful starting point for how to enhance the sustainability of effective coverage for the three diseases.

In addition to the efficiency levers identified in the draft HFS, several relate to the architecture of funds flow from various sources, including:

- *Addressing bottlenecks in the PFM system and aligning PFM processes* with health budgeting practices and health financing objectives at the central and LGA levels. This could help to improve budget execution, which in many counties is low due to the unpredictability of inter-fiscal transfers and unrealistic budget estimates (PwC, 2016). Improving the transfer of funds from central to district and facility levels, streamlining and simplifying disbursement procedures, and clarifying accountability will also be important.
- *Reducing fragmentation* in funding channels and financing processes. The HFS proposes decreasing the fragmentation of risk pools into a single pool that would merge NHIF, CHF, NSSF-SHIB, GoT subsidies for the poor, general revenue from the health budget, parallel funding flows, and other funds for the entire population (MoHCDGEC, 2016). This is a tall order given the political economy of devolution and the complexity of funds flow between national and LGA levels. In addition, HSSP IV calls for further decentralization of responsibilities to the health facility level to enhance efficiency.
- *Eliminating redundancies, overlaps, and other excess costs* driven by external funding, including verticalization of funds and other components for individual diseases or health issues (Sparkes, Duran, & Kutzin, 2017). Not every program component can be integrated right away—and there may be good reason to selectively retain verticalization through the medium term—but continuing to invest in parallel or duplicative systems is not an efficient long-term solution. Progress has been made with financial management of development partners fund flows, but non-basket partners remain challenging to align (MoHCDGEC, 2016). Bringing aid increasingly on budget is identified as a priority in the draft HFS.

Strategic purchasing also features prominently in the draft Health Financing Strategy's discussion of efficiency. Options for promoting efficiency through purchasing include:

- *Strategically procuring key commodities*, which will require further capacitation of the Medical Stores Department (MSD) to integrate vertical program commodities processes and systems, including budgeting, procurement forecasting, quantification, regulation, and ordering and delivery.
- *Priority setting to promote allocative efficiency.* HSSP IV indicates that the Ministry of Health will allocate resources based on geography, age, sex, and income groups to improve allocative efficiency. Additionally, the MoHCDGEC will review allocative efficiency periodically to understand allocation, disbursements, and expenditures.
- *Strategically paying providers for outputs and outcomes*. Reforming provider payment is among the most powerful ways to promote efficiency by creating incentives for quality and cost containment. Such reforms are also difficult to implement and can be politically contentious. The draft HFS indicates that there will be a gradual transition from input-based to output-based provider payment whereby capitation would be used in concert with RBF at the primary healthcare level and case-based or fee-for-service would be used at the district hospital and above. A unified provider payment framework is proposed that would indicate how line-item budgeting, output-based payment systems, and results-based financing are aligned and can be leveraged for strategic purchasing of the minimum benefits package.

Finally, initiatives beyond the health financing system can help to increase efficiency, including several relating to human resources and modalities of service delivery:

- *Improved human resource distribution and management.* Based on the findings of the mid-term review of the previous health sector strategy, the draft HFS and BRN both note that in addition to an overall shortage of health workers, facilities in remote and rural areas are particularly understaffed, resulting in inefficient use of resources and delivery of sub-standard care.
- *Streamlining in-service training.* Continuing Professional Development activities, currently offered through academic institutions and professional associations will be coordinated and streamlined across Tanzania and will be regulated by the Ministry of Health. HSSP IV establishes a goal of requiring accreditation for all CPD activities by 2020.
- *Shifting tasks so workers operate 'to the top of their license.* Like many countries facing shortages of health workers, Tanzania could seek to train and empower less skilled cadres to assume greater community outreach and clinical responsibilities. HSSP IV refers to task shifting as a possible approach to be implemented after the Ministry of Health reviews job profiles and recommends revisions to legislation and regulations, if needed.
- *Integrated service delivery*. The HSSP IV proposes a "one-stop-shop" model of service delivery that would integrate the provision of RMNCAH, ART, and TB services.
- *Improving information management procedures*. HSSP IV proposes to reduce the burden of the health management information system (HMIS) on health workers by prioritizing certain data elements and expanding the use of Information and Communication Technology (ICT), including the electronic Logistics Management Information Systems (e-LMIS) and web-based and mobile data transmission (e.g. DHIS-2, LMIS, HRIS, PlanRep).

In summary, the potential gains in fiscal space from new revenue are likely to be modest at best: while GDP growth has been strong and tax revenue has increased, growth is expected to plateu in the coming few years. Further, the decision to allocate additional resources to the health sector is ultimately a political one. Health does feature prominently as a priority in Tanzania's overall policy framework documents, but falls behind education and infrastructure as major GoT priorities. Thus, while the health sector should continue to receive its share of any increases in revenue, it is not the government's

highest priority sector for any potential additional resource allocation. It is not yet clear whether the additional own-source revenue for health at the LGA level that theoretically will be generated will supplement or replace health spending by the central level and regardless, own-source revenue comprises less than 10 percent of LGA resources and is hindered by poor budget execution. Similarly, and as noted above, decision to re-prioritize health within the existing government resource envelope would involve tradeoffs for other sectors, some of which (e.g., education) are associated with substantial impacts on health outcomes. By definition, in the context of transition from donor financing, new grants or loans from external sources are likely to diminish over time. Earmarking is estimated to be politically feasible, but has drawbacks that may ultimately work at cross-purposes to overall efforts by governments to sustain health outcomes.

Efficiency gains in the existing resource envelope may prove to be a more promising way to find more money and more value. Efficiency gains that could be achieved by PFM reform – particularly in how funds flow between the central and LGA levels – could be promising in the context of devolution, but it is too early to assess the potential order of magnitude of such gains. The analysis of data collected for this study should allow for an assessment of the types of PFM reform measures that could offer promising efficiency gains in budget formulation, allocation, execution, and monitoring. While strategic purchasing is a priority in the draft Health Financing Strategy, the potential success of measures such as provider payment reform require substantial political will. Renewing focus on human resources for health and efficiency in service delivery could provide potential gains if extended to other health services.

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Annexes

Annex 1. Tanzania Health Financing Strategy qualitative analysis of potential revenue sources

Source	Political feasibility	Equity implications	Revenue potential	Incentive effects	Existing/new source for health
Government Sources					
General government budget	++	+	++	0	Existing
NSSF	++	+	+	0	Existing
LGA own-source revenues	-?	+	+	0	Existing
HIV/AIDS Trust Fund	+?	+	?	0	New
Earmarked taxes	?	+	+	?	New
Private Sources					
NHIF employer and employee contributions	++	+	++	0	Existing
TIKA and CHF contributions	++	+	+	0	Existing
Investment revenues from insurance funds	++	+	+	0	New
User copayments	+	-	+	-	Existing
Private contributions for start-up infrastructure	?	++	+	0	New
Corporate Social Responsibility contributions from sectors such as mining, gas, and tourism	+	++	+	0	New
++ (very positive/large); + (positive/large); - (negative); 0 (no effect); ? (undetermined effect)					

Source: Replicated Table 5.1 from (MoHCDGEC, 2016). See p. 38.

The strategy summarizes the qualitative analysis, noting that political feasibility is highest for increased general government budget allocations, the rechanneling of both public and private insurance contributions, and earnings from investments of insurance funds. The largest potential sources of funding are the general government budget, the NHIF insurance premium contributions, NSSF-SHIB Benefits and CHF/TIKA contribution rechanneling. As expected, user co-payments have negative implications for equity and would generate a low amount of revenue.

Annex B. Findings from Stakeholder Interviews and Mapped Funding Flows

Introduction

As outlined in the corresponding report and desk review and qualitative fiscal space analysis for this work, Results for Development's (R4D) analytic approach is centered on examining opportunities, from a public financial management (PFM) perspective, to sustain gains in health outcomes as country governments transition away from external support and continue to assume greater financial and programmatic responsibility for their health programs. Under this approach, interviews were conducted with national-level and LGA leadership working in health financing or relevant health programs within the Tanzanian government and development partner organizations. The objective of these interviews was to identify bottlenecks within the PFM system, fragmented financing channels, duplicative processes, or excess costs, particularly those associated with or supported by external funding, that create inefficiencies in channeling funding for HIV, TB and malaria to providers of priority interventions.

Our team utilized a tool originally designed as a "process guide"[18] for aligning PFM and health financing objectives and adapted it for the Tanzanian context. Respondents provided insight into a series of questions on budget formulation, budget execution, and monitoring of public and donor funds, and the level of integration and alignment of the different financing sources.

Questions sought to understand if:

1. Health needs and priority services, specifically those related to HIV, TB, and malaria, are reflected as budget priorities in budget documents;
2. The budget is structured in a way that ensures that money is actually going to these priorities;
3. There are issues with budget execution that would hinder the ability of funds for HIV, TB, and malaria to get to providers of priority interventions; and
4. There are ways to trace and monitor where the money went and account for its effective use.

To this end, 19 interviews were conducted between December 2017 and May 2017. A full list of participating government and development partner organizations can be found in Table 1, below. Interviews were guided using questions from the adapted process guide, with probing to understand perspectives on whether and why challenges related to the questions listed above exist and persist, and possible solutions that could be applied. Respondents were informed that individual responses would be confidential and presented in aggregate to facilitate an environment of openness during the interviews.

[18] WHO and R4D created a process guide to assess how health budgeting practices and PFM systems align with health financing policy objectives. The process guide is a peer-reviewed, piloted analytical tool that builds off of questions from an existing OECD budget survey and PEFA indicators, and is structured as a participatory exercise that helps both health and finance actors to identify how PFM systems can enable sustainable health financing, including for sustainable transition from global health programs. The guide is oriented to the phases of the budget cycle with questions tailored to assess how health financing functions are impacted at each phase. Specific modules also assess sustainability, program budgeting, donor financing, social health insurance, and decentralization.

Additional detail on data collected to date is outlined below in the output tables. This information is a synthesis of interview data which has been integrated into the final report and reviewed with government officials in a consultation meeting held on August 23, 2017 to shape and validate key inputs and assumptions.

Table 1. Organizations consulted for in-depth interviews

Government of Tanzania agencies and programs	Ministry of Health, Community Development, Gender, Elderly, and Children - National AIDS Control Program (NACP) - National Tuberculosis and Leprosy Program (NTLP) - National Malaria Control Program (NMCP) President's Office Regional Administration Local Government (PORALG) Ministry of Finance and Planning TACAIDS Tanzania National Coordinating Mechanism (TNCM)

Summary of Findings

Budget Formulation

The national budget process is both a top-down and bottom-up process, however, the bottom-up design is to some extent neutralized by the late definition of sector ceilings by the MOFP that in the end define budget level and allocation according to historical trends, additionally LGA and facility committees are not functioning sufficiently well to provide oversight or engage citizens and communities and respond to need.

The national government sets the priorities and the national strategies which should be aligned to by the individual implementing institutions and the national government sets the funding ceilings for service delivery across sectors. MOHCDGEC is responsible for developing a three-year MTEF and the annual budget within defined MOFP ceilings, including costed programs for the 3Ds. The health sector is heavily dependent on foreign funding, GOT tie the donors to the common national strategic plan. Significant donor dependency exits, and donors fund the major components of the plans, with the government generally funding HR or infrastructure.

The resource allocation formula (60% population, 10% U5 mortality, 10% poverty, 20% cap land) determines budget funding at the district level, but the LGA determines how much is put into health and within health how much is put into each facility. At the district level, the health budget is captured in Comprehensive Council Health Plans (CCHPs). At the beginning of the calendar year, the Council Health Management Teams (CHMTs) are informed about the MoHCDGEC priorities based in the National Package of Essential Health Interventions for the coming Financial Year and a ceiling for the District budget. Ward and village governments identify local needs (through O&OD) for their inclusion in the CCHP, dispensaries and Health Centres develop their plans using the planning templates under the support of the CHMTs. Then Council Health Planning teams collate these plans and identify priorities,

the planning Team then analyses these priorities within the health facility plan, then ranks them in order of priority for inclusion in the CCHP. Draft CCHPs are forwarded to the Regional Health Management Teams (RHMTs) for their scrutiny for quality assurance and consultations with CHMTs. The CCHPs are finally consolidated into the PO - RALG budget.

Donor funds for the three diseases are fragmented, with all USG funding channeled off-budget directly to programs or facilities, and both The Global Fund and USG funding channeled outside of the Heath Basket Fund. The GoT ties donors to the costed national strategic plans. However, significant donor dependency exits, and donors fund the major components of programs for the three diseases, while GoT generally funds HR and infrastructure costs. Funding predictability is also a challenge for planning and budgeting. The Global Fund's round-based system makes it difficult to predict upcoming opportunities to apply for funding, and to coordinate with USG donors who have one year grant time horizons. However, there is some coordination at the planning stages to avoid duplication of activities. In addition, the announcement of rounds and their associated deadlines and the awarding of grant funding generally fall outside government budget planning cycles.

Challenges to preparing Global Fund funding requests (from Programs):

- Respondents noted the budgeting and fund request process is complicated process, as each grant has its own structure of how to request funding which may change from subsequent grant cycles.
- There are multiple conditions to be met during proposal development including technical and political issues. The process, requires long preparatory work that includes gathering information from different sectors and the involvement of technical staff, community representatives and other stakeholders.

Budget Execution

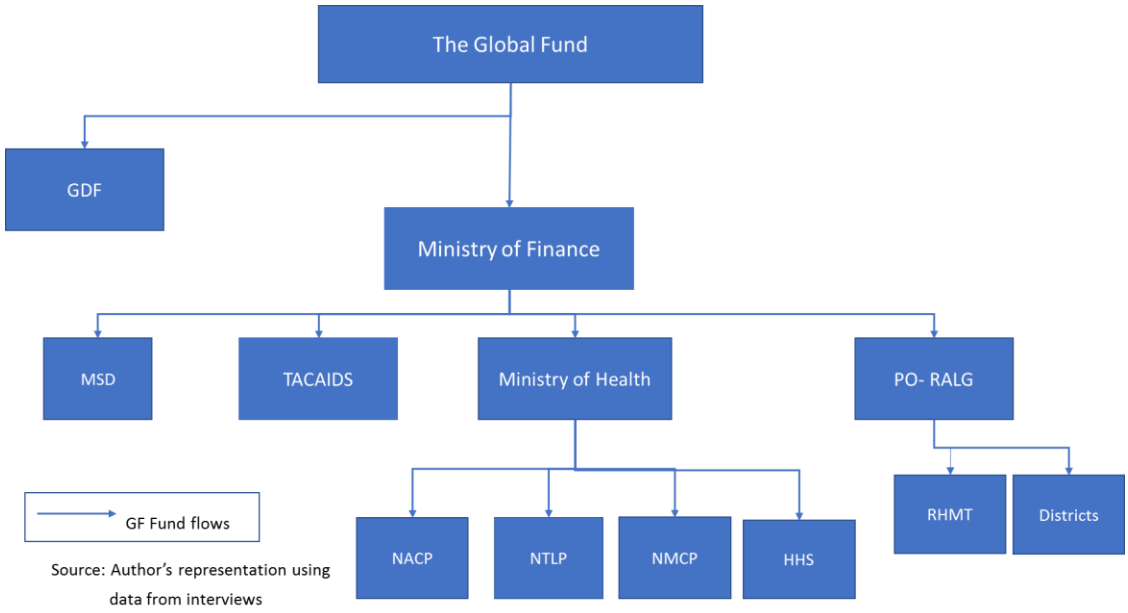
There is a good working relationship between the MoH and MOFP. Clear procedures and rules are in place on how funds flow and accountability is undertaken within various functions. However, at times these rules cause delayed execution of some budget functions, and in general, there is limited flexibility of health facilities to adapt, respond and be accountable for community need.

Government spending on health is dominated by the central level. Centrally, the MoHCDGEC is responsible for national referral hospitals and procurement of the majority of drugs and commodities. LGAs are responsible for primary healthcare and district, but not regional, hospitals. Most government spending on health (60–68%) is on recurrent items, such as salaries, commodities, and other charges, indicating less funding for capital improvements and additions. The MOH is responsible for health guidelines, policies, and regulations, while PO-RALG is responsible for policy interpretation, coordination, and implementation, as well as decentralization and devolution. In its capacity as the office responsible for decentralization and vertical coordination, PO-RALG encourages funds for service

delivery to be sent straight to the regional and district levels, however, a limited stream of money is retained at the central level, which is used to fund the Office's supervisory and oversight functions.

While budget execution is somewhat decentralized, with some health facilities having their own bank accounts and partial authority to manage budgets, there is little flexibility to reallocate expenditure during the fiscal year to adjust to the evolving needs of service implementers and the population they serve. In general, different rules for different funding sources and expenditure caps at the line-item level have reduced the flexibility to allocate payments received across budget line items. This type of fragmentation has led to different PFM rules for different funding sources – which are often in the same bank account – which greatly increases the administrative burden on clinical staff and decreases efficiency.

Figure 1. Mapped Fund Flows



All Global Fund grants are integrated into Tanzania government systems. Funding flows from the MoFP, as the Principle Recipient to the MoHCDGEC, as the lead sub-recipient. The MoHCDGEC then disburses funds to implementing sub-recipients such as the national disease control programs and targeted regions and councils for administration of Global Fund grant-approved activities at lower administrative levels, including communities.

Delays were noted in several places in the disease programs:

- **Limited Flexibility/Burn rate challenges.** As noted in the 2009 and 2016 OIG audit and other reports, there are significant delays (on average 150 days) in the disbursement of funds by the Principal Recipient to implementing entities.[19] The timing of disbursements

[19] Audit of Procurement and Supply Chain Management at The Global Fund, 2016.

makes it very difficult for facilities to spend the additional current budget. The disbursements are too late, and the timing of surrender, which is the return of funds to MoFP, is too short. Additionally, in absence of strong data on outcomes, The Global Fund uses burn rate as a performance indicator which has implications for the timing of subsequent disbursements.

- For example, cash balances are deduced from future quarters, underspending in Quarter 1 and Quarter 2 may lead to deductions in Quarters 4 and 5. Sometimes, conditionalities for disbursements are difficult to meet, thus delaying disbursements. For example, in the previous concept note, trainings were proposed for community health workers. If you put a training activity into a concept note, a separate plan for the training activity is required, even if the concept note (with training included) is approved. The delay in getting training plans prepared and submitted delayed disbursement meant for training supports.
- Disbursements can also be delayed due to implementation of key population activities (or lack thereof); there may be delayed approval to implement these activities from the PS level due to the political situation – if that money is delayed, the other programs will feel the consequences.

Budget Monitoring / Accountability and Oversight

Global Fund reports are routinely audited, by both internal and external audits

- Reports are compiled at the regional level. Before the 15th of every 3 months, the district authorities must send their reports to the regional authority (e.g., for the reporting period January – March, the district has until the 15th of April to submit the report to the regional authority). The reports are then compiled and submitted to the national level before the 20th / 25th of every 3 months.
- The Global Fund monies, however, have conditionalities, which exist across all levels. Reports need to be produced, both technical and financial. Disbursements are tied to reporting, so in order for disbursements to be made, these reports need to be prepared in a timely manner. However, the conditions are negotiated by the government and The Global Fund.
- Fragmented, aggregated, not standardized, and largely manual information systems not extended to health facility level and/or not asking the right questions.
- Programs find it difficult to prepare new data on tracked indicators as often as the 6-month Global Fund reporting periods require and reported challenges to collecting routine health facility data on consumption of commodities. As the number of facilities reporting indicators increase, the data quality has been seen to improve. For example, knowing and reporting how many people receive ACTs in a given health facility was previously a challenge for the NMCP. The program did not have a system for capturing

how many people were receiving drugs, and The Global Fund did not accept substitution of number of new cases for number of people receiving ACT, however, the NMCP now has visibility into how many drugs are dispensed (though not into how many are prescribed), which provides a good proxy for the number of patients receiving ACT.

OUTPUT TABES

Health Budget Formulation

Budget Allocation to the Health Sector

OUTPUT TABLE Description of Budget Allocation to the Health Sector

The purpose of this table is to determine if allocations to health match stated priorities relative to other sectors.

Characteristic of the Budget Formulation Process	Current Situation	Key Issues and Challenges
Transparency of national health sector budget ceiling	Cabinet approves expenditure ceilings proposed for each MDA by MoFP and POPC prior to their dissemination to MDAs (PEFA 2013)	Delayed definition of budget ceilings Expenditure ceilings tend to be lower than budget requests
Link between health sector budget ceiling and policy priorities	The MOFP and the Cabinet sets ceilings for each Ministry	Poor linkages with programmatic priorities
Transparency of sub-national health sector budget ceilings	Previous year's approved budget is used as the ceiling for preparing the budget for the ensuing financial year. (LGA PEFA 2015)	Final definition on actual budget levels and allocation lies with the MOFP, and information on this final allocation is not well passed on down to the facility level. The approved budget is often modified substantially, and irregular disbursement patterns over the year make it generally a poor reflection of the original plan developed by local authorities and facilities

Equity and adequacy of sub-national health sector budget ceilings	Budget allocation rules and formulae have been in place for several years, seeking to redress historical inequities.	Allocation formulas encompass a small portion of the total health budget

Allocation of the Budget within the Health Sector

In this section, please discuss how the allocations of public funds are made within the health sector and ultimately reach priority populations, programs and services.

OUTPUT TABLE Description of Allocation of Within the Health Sector

The purpose of this output table is to characterize allocations within the health sector.

Characteristic of the Budget Formulation Process	Current Situation	Key Issues and Challenges	Integrated/not integrated
Basis of budgets within the health sector	Historical	Usually values from last year are taken and a percentage added on.	
Integration/fragmentation of Global Fund grants in the health budget	On-budget - during the identification of interventions in the GF proposal, programs consult the strategic plan. Most all of the strategic plans are costed, and there are targets set for coverage.	** (MOFP) once GF has finalized terms of agreement, NDMC review all agreements and changes may further delay disbursements.	Integrated
Allocation of Global Fund grants for AIDS, TB and Malaria to the health sector	Annual plans (bottom-up plans) are usually finished around March, May – January, it has to reach the ministry. Then it goes to the MOFP, for tabling in the budget.		

OUTPUT TABLE Description of Allocation of Donor Resources

The purpose of this table is to assess if donor resources for health are transparently accounted from in the total government envelope for health.

Characteristic of the Role of Donor Funds in the Budget Formulation Process	Current Situation	Key Issues and Challenges	Integrated/ not integrated
Integration of donor resources for AIDS, TB and Malaria into the overall budget and health budget ceiling	stronger coordination and alignment over the years	Coordination among donors in planning process can be challenging due to different time horizons (i.e. PEPFAR/PMI 1 year),	Integrated
Effect of donor resources for AIDS, TB and Malaria on allocations to the health sector	HIV funding comes from different partners (e.g., USG, other countries). The main funding comes from PEPFAR and GF. USG/CDC provide technical support.	USG money comes off budget, and both USG/GF are out of the HBF - Not all donors active in the sector participate in the HBF – however, there is some coordination at the planning stages to avoid duplication	Not integrated (specific to donor fund flows)
Portion of global fund grants for AIDs, TB and Malaria integrated into health budgets at the local government level	See 2017 concept note	See 2017 concept note	See 2017 concept note
Portion of global fund grants for AIDs, TB and Malaria integrated into health budgets at the health facility	Need more information	Need more information	Need more information
Role of RBF	PO-RALG/ World Bank, USAID implementing RBF - health facilities are benefiting from standard accounting and financial reporting system and other small systems strengthening surrounding financial management of service delivery payments and expenditures through facility bank accounts.		

Assessment of Budget Formulation

This purpose of this output table is to assess if budget allocation of funds to the health sector are sufficient and directed to priority population, programmes and services.

Good practices	**Progress and Bottlenecks**
Stated health need for AIDs, TB and Malaria reflect stated budget priorities	Health sector heavily dependent on foreign funding, GOT tie donors to the common national strategic plan. Significant donor dependency exits, and donors fund the major components of the plans (the government generally funds HR or infrastructure)
Sufficient and stable resources to meet stated health sector objectives ensuring the domestic sources of funds that are relied upon for AIDs, TB and Malaria are robust and sufficient to, over time, cover the part of the transitioning donor programs that are currently externally funded.	
Multi-year perspective in fiscal planning, expenditure policy and measurement used ensuring the objectives of the transitioning AIDs, TB and Malaria program are well reflected in the overall sector strategy.	Funding predictability is also a challenge. The Global Fund's round-based system makes it difficult to predict upcoming opportunities to apply for funding. In addition, the announcement of rounds and their associated deadlines and the awarding of grant funding generally fall outside budget planning cycles
Health sector ceilings set based on strategic planning and transparent priority-setting across sectors	Ceilings are set late by MOFP, not transparent and often lower than estimated budget, which often lead to arbitrary cuts across the board rather than policy/evidence based rational budget choices
Global Fund grants for AIDS, TB and Malaria are pooled then allocated across populations by mechanisms that allow the transfer of funds between administrative levels and health revenue sources (i.e. SHI) according to health need	Inability to pool funds and reduce fragmentation in health sector or increase financial risk protection at both national and service delivery level.
Global Fund grants for AIDS, TB and Malaria are classified and formed based on population health needs and the resources required to meet those needs	Planning and budget structure and process based on inputs rather than service outputs. Does not allow good definition of health programs or service outputs.

Budget Execution and Provider Payment

Process of Budget Execution and Provider payment

OUTPUT Description of Budget Execution Process and purchasing arrangements of Global Fund grants for AIDS, TB and Malaria by Program Component

The purpose of the following output table is to describe who has the authority to make spending decisions once budgets are finalized, how funds are allocated across program components and the purchasing arrangements.

Population Based Disease [HIV/AIDS]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Social enabler	TACAIDs	Integrated
Social contracting	TACAIDs	TACAIDs
key population interventions 1. Men who have Sex with Men (MSM) 2. Commercial Sex Workers (CSW)	Government is deprioritizing these target programs, community based "drop-in centers" most effected, GOT believes key populations will be reached through general outreach (small and not drivers of the epidemic)	

Prevention Disease [HIV/AIDS]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
BCC	NACP/TACAIDS	Integrated
Blood Safety	NACP	Integrated
PMTCT	NACP	Integrated
Voluntary Medical Male Circumcision VMMC	NACP	Integrated
Comprehensive condom programming	NACP/TACAIDS	Integrated
HTC (testing and counseling)	NACP	Integrated

Service Delivery Disease [HIV/AIDS]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
In patient: Treatment, care, & Support	NACP	Integrated
Outpatient: Community based care, treatment and support	TACAIDS/NACP	Integrated

Support Functions Disease [HIV/AIDS]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Human Resources (salaries)	MOFP	Integrated
Training	NACP	Integrated
Supervision	NACP	Integrated
Administrative	NACP	Integrated

Infrastructure (facilities, equipment)	NACP	Integrated

Drugs and Commodities Disease [HIV/AIDS]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Procurement (ARVs)	NACP is responsible for drug procurement. MOH does forecasting and it is the MOH and NACP responsibility to instruct the procurement entity (pooled procurement Global Fund facility) to issue the orders.	Integrated
Procurement (commodities and Lab reagents)	NACP	Integrated
Supply chain (stock maintenance, forecasting, tenders, redistribution)	MSD – Coordinated closely w/ programs.	Integrated
Logistics	MSD	Integrated
Storage	MSD	Integrated
Distribution	MDS	Integrated

Surveillance Disease [HIV/AIDs]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Health Information Systems	NACP	Integrated
Operational research	More information needed	

Prevention, Treatment and Care Disease [TB]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
TB Care and Prevention	NTLP	Integrated
MDR TB	NTLP	Integrated

Support Functions Disease [TB]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Human Resources (salaries)	MOFP	Integrated
Training	NTLP	Integrated
Supervision	NTLP	Integrated
Administrative	NTLP	Integrated
Infrastructure (facilities, equipment)	NTLP - beds, equipment, and salaries are all provided by the government, as are other infrastructure and shared costs	Integrated

Drugs and Commodities Disease [TB]	**Current governance and oversight center for the program**	**Integrated/ not integrated**

Procurement (Drugs)	Most TB Dugs are procured through GF. Other drugs procured by MOH, WHO pre-qualified (which are integrated).	Integrated
Procurement (commodities and Lab reagents)	Formerly MSD, now GF	Integrated
Supply chain	MSD	Integrated
Logistics	MSD	Integrated
Storage	MSD	Integrated
Distribution	MSD	Integrated

Surveillance Disease [TB]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Health Information Systems	NTLP	Integrated
Operational research	NTLP	Integrated

Treatment and Care Disease [Malaria]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Malaria in Pregnancy	Procured centrally, paid for by GF	Integrated

Procurement and Treatment Disease [Malaria]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Case Management commodities	Procured centrally, paid for by GF - The largest components of the malaria program are long-lasting nets, ACT, and testing kits	
Case Management Drugs	Procured centrally, paid for by GF - The PPM, The Global Fund procurement mechanism, manages the procurement of all ACT commodities, based on GOT specifications.	

Prevention Disease [Malaria]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Long-lasting Insecticidal Nets (LLINs)	Get bed nets through GF PPM, but distribute outside of NCMP – arranged by MOH. Nets not distributed through MSD/NMCP. Individual organizations are hired through competitive bidding to handle the logistics and coordination for bed net distribution The transport company for the distribution of nets is also independent of the NCMP; MOH contracts this out. Procurement section within the MOH handles all of these contracting logistics and coordination for bed nets – nets are NOT distributed through MSD	Integrated
Larviciding	NMCP	Integrated
Indoor Residual Spraying (IRS)	NMCP	Integrated
Behavior Change Communication (BCC)	NMCP	Integrated

Support Functions Disease [Malaria]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Human Resources (salaries)	NMCP	Integrated
Training	NMCP	Integrated
Supervision	NMCP	Integrated
Administrative	NMCP	Integrated
Infrastructure (facilities, equipment)	NMCP	Integrated

Surveillance Disease [Malaria]	**Current governance and oversight center for the program**	**Integrated/ not integrated**
Monitoring and Evaluation	NMCP	Integrated
Entomological research	NMCP	Integrated

OUTPUT TABLE Description of Budget Execution and Purchasing and Provider Payment Arrangements

The purpose of the table is to describe how funds are allocated across expenditure items and the purchasing and provider payment arrangements.

Characteristic of Purchasing and Provider Payment	**Current Situation**	**Key Issues and Challenges**	**Integrated/not integrated**
Decentralization of budget execution authority for Global Fund grants for AIDS, TB and Malaria at different levels (agencies, providers, etc.)	At the sub-national level, the regional level, and the district level the programs are integrated into the health delivery systems (the programs are vertical at the national level, but they are more integrated closer to the service delivery level)	Direct Facility Financing reforms currently underway to address challenges of provider autonomy, flexibility to respond to need etc.	Integrated
Expenditure tracking and accounting systems for Global Fund grants for AIDS, TB and Malaria	**GF** separate account *** (much easier for the purposes of accounting) This is fully integrated with the government processes. The LFA also plays the observer role in the monitoring of GF grants.		Integrated

Authority for commodity procurement	**Highly centralized system**, public health facilities are required to go through MSD, leading to stock outs. Lack of clarity of procurement guidelines - When can you go outside MSD to prime vendor? i.e. MSD is first point; MSD give note out-of-stock; take note to prime vendor. Then circular from PO-RALG; first MSD procure other vendors; if can't then go prime vendor.	Envisioned SNHI - purchase MBP through output-based payment where funds go to service provider who then use funds to procure drugs through MSD How incorporate SNHI/MBP vision into evolution of drug procurement and availability and the role of MSD? Forecasting capacity is limited. Buffer stock? Could SNHI invest in advance payments or buffer stock? Categorize issues: money vs. logistics	
Flexibility for expenditure of Global Fund grants for AIDS, TB and Malaria	In order to reduce the inefficiencies around reprogramming, GF has introduced a regular period each year to review reprogramming requests, so that it's less ad hoc.	Sometimes, GOT is forced to reprogram/change activities, which causes delays in implementation. Procedures to approve reprogramming for GF grants, but this can take 4-5 months, which then delays the burn rate	
Processes for transfer of funds from Global Fund grants for AIDS, TB and Malaria	GF monies have conditionalities, which exist across all levels. Conditions are negotiated by the government and The Global Fund	There has been a lot of improvement in disbursement delays. Monies and budgeted assets flow steadily from the central government to regional and district governments.	
Bank accounts and rules for accessing funds for Global Fund grants for AIDS, TB and Malaria	To protect against currency losses, helps for auditing Separate bank accounts for GF monies. Direct Facility Financing reforms,-		

	payment directly to facility bank accounts, linked to outputs and accountability systems		
Rules related expenditure over-runs, and surpluses at the provider level for Global Fund grants for AIDS, TB and Malaria	In absence of strong data on outcomes, burn rate is used Unspent monies go back to The Global Fund. If they are within the annual plan, they can be used in the following year.	There are no penalties, formally. Apart from the targets, burn rate is used as performance indicator. If you don't have capacity to absorb, this can cause delays.	

OUTPUT TABLE Description of Provider Autonomy

The purpose of this table is to describe who has the authority to make spending decisions at the provider level.

Aspect of Provider Autonomy	Current Situation	Key Issues and Challenges	Integrated/not integrated
Autonomy over budgeting and financial management for grants related to AIDS, TB and Malaria	DFF is increasing provide autonomy- Implementation underway Manual and automated info systems - i.e. PHC capitated rate has been approved (worksheets for 5K facilities and amount they will get paid) roles and responsibilities between MOH to set up formula and PORALG as the manager of the facilities has been set.		Integrated
Autonomy over allocating funds internally for Global Fund grants for AIDs, TB and Malaria	The program has the full authority over purchases within the budget, but there is a certain threshold beyond which The Global Fund's approval		

	is required. If the monies within the budget are no more than 10% of the budget, they can be reallocated internally within the same cost categories.		
Autonomy over staffing levels, personnel compensation (salary and bonus) for Global Fund grants for AIDS, TB and Malaria	None, salaries paid directly by GOT Does GF pay for salary top off?		
Autonomy over equipment purchases and physical assets for Global Fund grants for AIDS, TB and Malaria	Some commodities, such as vehicles, are procured at the central level (more cumbersome to procure locally, harder to get commodities that meet specific requirements at local level, etc.)		

Assessment of Health Budget Execution and Purchasing/Provider Payment

Budget Execution and Purchasing/Provider Payment

The purpose of this output table is to assess key aspects of the health budget execution process against a set of benchmarks.

Good Practices	**Progress or Bottlenecks**
Global Fund grants for AIDS, TB and Malaria Program are released in a way that directly **links** them to government health priorities	There is a good working relationship between the MoH and MOFP. However, at times rules cause delayed execution of some budget functions, and in general, there is limited flexibility of health facilities to adapt, respond and be accountable for community need.
Global Fund grants for AIDS, TB and Malaria Programs are received in a way that can be flexibly allocated to government health priorities	
There is a mechanism for providers and/or the health sector to retain and reinvest savings and efficiency gains in the current year and from year to year	Clear procedures and rules are in place on how funds flow and accountability is undertaken within various functions. The program has the full authority over purchases within the budget, but there is a certain threshold beyond which the MOFP and GF's approval is required. Savings are not retained, and surpluses are returned to the GF

Budget Accounting and Reporting

Process of Budget Monitoring

This section examines the process for how the budget is monitored, information systems and flows, and audit processes are described.

OUTPUT TABLE Description of Budget Monitoring Process

The purpose of the output table below is to describe the process for how the budget is monitored.

Characteristic of Budget Monitoring Process	Current Situation	Key Issues and Challenges	Integrated/ not – integrated
How budget execution of Global Fund grants for AIDS, TB and Malaria are monitored (responsible institution and information flows)	Implementers monitor the targets, • MOH, program M&E systems, Coordinators of MOH, Principal recipient MOFP, • Checks and balances by internal and external auditors • GF supervision support role	Programs find it difficult to prepare new data on tracked indicators as often as the 6-month Global Fund reporting periods require and reported challenges to collecting routine health facility data on consumption of commodities.	Integrated
Main indicators monitored for budget execution of Global Fund grants for AIDS, TB and Malaria	Spending linked to objectives and targets, reports for execution	Timely reports and quality of information	
Consequences for under-spending or over-spending budgets of Global Fund grants for AIDS, TB and Malaria	Base is the budget by likelihood of foregoing other objectives / items		
Budget audit processes of Global Fund grants for AIDS, TB and Malaria	reports are routinely audited, by both internal and external audits		Integrated

Process for monitoring program budgets of Global Fund grants for AIDS, TB and Malaria	Annual process to each program/ grant by Special audit teams from GF or PwC, a report for The Government uses Control and Auditor General to audit the GF grants for adherence to needs under the request Audit report is issued for discussion	Audit period is different from the government audit time CAG is March by GF is by September / December instead is 9 months streamlining donor reporting requirements, which are currently diverse. Donors' reporting periods can also be inconsistent with national reporting and budgeting cycles.	integrated
Relationship between targets and policy objectives of Global Fund grants for AIDS, TB and Malaria	Fund request is prepared to respond and meet requirements of the GF		
Use of ex-post evaluation of Global Fund grants for AIDS, TB and Malaria	Application of ex-post evaluation to improve fund low challenges	Improved timing of disbursement from GF to recipient. Separate units to oversee the functioning of the GF monitoring	Integrated

Accountability

This section examines how spending agencies in the health sector are held accountable for meeting objectives.

Description of Accountability Mechanisms

The purpose of this output table is to describe how spending agencies are held accountable for meeting objectives

Characteristic of Accountability Mechanisms	Current Situation	Key Issues and Challenges	Integrated / not integrated
Process and indicators tracked for effective use of budget funds for Global Fund grants for AIDS, TB and Malaria	Budgets form programs or sectors, financial reports, programmatic reporting, execution	Inflation effects	integrated

	reports		
How monitoring outputs are used for Global Fund grants for AIDS, TB and Malaria	Reviews and solutions are recommended for consideration		Integrated
Process and indicators tracked for effective use of donor funds	indicators from audit reports are tracked to improve use of donor funds Also reports to GF	Strategies put to improves	Integrated
Types of information used to hold spending units accountable	Quantitative and qualitative from audit reports		Integrated

Assessment of Health Budget Monitoring

Budget Monitoring

The purpose of this output table is to assess the accountability mechanisms to monitor the budget against benchmark criteria.

Good Practices	Progress or Bottlenecks
Global Fund grants for or AIDS, TB and Malaria can be traced and linked to government expenditure on populations, programs, and services with accountability measures	GF grants/monies go through government systems, and the Controller and Auditor General (CAG) audits them. Information systems are fragmented, aggregated, not standardized, and largely manual. Programs find it difficult to prepare new data on tracked indicators as often as the 6-month Global Fund reporting periods require and reported challenges to collecting routine health facility data on consumption of commodities.

Annex C. Note on methodology and data availability

Expenditure analyses

All figures that report expenditures were obtained from Tanzania's National Health Accounts for FY 2014/15, using the FS.RI X DIS 2014-15 table, provided to the R4D team in May 2017 (The United Republic of Tanzania 2017). The NHA estimates of expenditures are reported in TZS millions by source (e.g., Global Fund, Government of Tanzania, etc.) and by disease (e.g., HIV, TB, and malaria).

Data for HIV response expenditures were obtained from NHA data reflecting estimates for "HIV/AIDS and Other Sexually Transmitted Diseases (STDs) (DIS.1.1)." Data for TB response expenditures were obtained from NHA data reflecting estimates for "Tuberculosis (TB) (DIS.1.2)."Data for Malaria response expenditures were obtained from NHA data reflecting estimates for "Malaria" (DIS.1.3.)

Estimating disease response funding by program component

The 2017 Global Fund funding requests for Tanzania, submitted on May 23, 2017 and subsequently revised, are supported by funding landscape tables for HIV, TB, and malaria (Government of Tanzania 2017b). These tables report, per year, the 2018-2020 resource need for each disease response, by national strategic plan cost category. Estimates of domestic and non-Global Fund external funding are similarly provided in these tables.

The NSP cost categories included in the funding landscape tables are:

HIV	TB	Malaria
HTC	TB Care and Prevention	Vector Control: LLIN
VMMC	Childhood TB	Vector Control: IRS
STI	MDR - TB	Case management - Diagnosis
Condom	HIV/ TB	Case management - Treatment
SBCC	TB in Mining sector	Specific prevention intervention:
PMTCT	Leprosy	Intermittent preventive treatment
Blood safety	Supportive Systems	in pregnancy (IPTp)
STI and Key Populations	M & E	Specific prevention intervention:
PEP		Seasonal malaria
Adult ART		chemoprophylaxis (SMC)
Pediatric ART		RSSH
TB-HIV		Program Management
CBHS		Other
Program administration and monitoring and evaluation		

Within the 2017 Global Fund funding requests, the requested Global Fund allocations are disaggregated by program module (Government of Tanzania 2017a). The program modules listed in the submitted budgets are:

HIV	TB	Malaria
• Comprehensive prevention programs for MSM • Comprehensive prevention programs for people who inject drugs (PWID) and their partners • Comprehensive prevention programs for sex workers and their clients • PMTCT • Prevention programs for adolescents and youth, in and out of school • Prevention programs for general population • Prevention programs for other vulnerable populations • Program management • Programs to reduce human rights-related barriers to HIV services • RSSH: Health management information systems and M&E • RSSH: Procurement and supply chain management systems • TB/HIV • Treatment, care and support	• MDR-TB • Program management • TB care and prevention • TB/HIV • Treatment, care and support	• Case management • Program management • Vector control • RSSH: Health management information systems and M&E

The program modules used in the budgets and the NSP cost categories used in the funding landscape are not identical. While there is some overlap between categories, it was necessary to crosswalk the categories in order to have estimates of government, Global Fund, and non-Global Fund external financing by program component. The methodology for the cross walking is described below:

1. Directly cross walking of Global Fund program modules to NSP cost categories in cases where modules were: a) identical to cost categories or b) fell within them (e.g., comprehensive prevention programs for sex workers fell within the NSP cost category of "STI and Key Populations").
2. Distribute any remaining Global Fund allocation requests not yet assigned to NSP cost categories according to the magnitude of the remaining resource need (defined as resource need less domestic and non-Global Fund external revenue).
    2.1. For the program module "Vector control," Global Fund allocation was split to the matching NSP costs of "Vector control: LLIN" and "Vector control: IRS" according to the magnitude of the remaining resource need for these two interventions.

Estimating unmet resource need by program component

Program components were defined by NSP cost categories. Estimates of total need, domestic funding, and non-Global Fund external funding were drawn from the 2017 Global Fund funding request supporting funding landscape tables for HIV, TB, and malaria. Global Fund allocation estimates by program component were calculated using the methodology described above.

Projecting Government of Tanzania spending by disease response

Baseline expenditures for the Government of Tanzania by disease response were estimated using figures from the National Health Accounts for FY 2014/15, as described above. Using these data, it was possible to calculate the share of government expenditure for health directed to the HIV, TB, and malaria responses. These were estimated to be 5.2%, 2.6%, and 15.2% of government health expenditure, respectively.

Estimates of Tanzania's GDP growth rate and general government expenditure as a share of GDP (GGE/GDP) forecasts from 2015 to 2021 were obtained from the International Monetary Fund. The estimates of GDP, GDP growth rate, and GGE/GDP for the given years were:

	2015	2016	2017	2018	2019	2020	2021
GDP (current prices, trillions)	TZS 94.3	TZS 97.5	TZS 105.8	TZS 115.0	TZS 125.2	TZS 136.0	TZS 147.7
GDP growth	6.96%	6.58%	6.80%	6.92%	6.73%	6.53%	6.49%
GGE/GDP	17.81%	19.64%	20.98%	21.18%	21.36%	21.12%	20.52%

To estimate spending for a given year for a given disease program, the following formula was used:

$$S_{d,t} = GDP_t * \left(\frac{GGE}{GDP}\right)_t * X_t * \frac{S_{d,t_0}}{GGHE_{t_0}}$$

where $S_{d,t}$ is spending for disease *d* in year *t* and t_0 is 2015. X_t is gross government health expenditure as a share of gross government expenditure, in a given year *t*, or:

$$X_t = \left(\frac{GGHE}{GGE}\right)_t$$

An estimate of Tanzania's gross government health expenditure as a percent of gross government expenditure (GGHE/GGE) was obtained from the 2014 Ministry of Health Public Expenditure Review. This estimate (8.6%) was used to establish projections for 2021 within the "Status Quo" scenario (X_{2021} = 0.085). For "Priority" and "Priority +", targets for GGHE/GGE reflected goals for health spending in 2021 within the Health Financing Strategy (13%) and the Five-Year Development Plan II (15%).