



FRIENDS
OF THE GLOBAL FIGHT
AGAINST AIDS, TUBERCULOSIS AND MALARIA



INNOVATION FOR GREATER IMPACT:

Exploring Resources for Domestic Health Funding in Africa



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GLOSSARY

AIDS Trust Fund (ATF): A government fund comprised of assets collected from various entities and designated to help combat HIV/AIDS within a given country. Countries establish ATFs as a response to a growing funding deficit. ATF expenditures include procurement of supplies, research, preventative measures and advocacy.

Civil Society Organizations: Organizations that advocate for the interests of their members and the populations they represent. They play an integral role in the Global Fund through resource mobilization, advocacy and policy dialogue.

Concept Notes: The mechanism for requesting financing from the Global Fund for one of the three diseases or health systems strengthening. These are generally based on the national strategic plans of a given country, and include four important sections: the country context, the funding landscape, the funding request and implementation arrangements, and risk assessment.

Country Coordinating Mechanism (CCM): Country-level, multi-stakeholder partnerships that develop and submit concept notes and grant proposals, and then oversee grant implementation. They are comprised of representatives from both the public and private sectors, as well as governments, multilateral and bilateral agencies, persons living with the diseases, and civil society and faith-based organizations, among other relevant stakeholders.

Faith-Based Organizations (FBOs): Charitable groups affiliated or identified with one or more religious organizations. They are often responsible for bringing health care and outreach to some of the most rural areas of the world. They often serve as principle recipients or sub-recipients.

Formal Employment Sector: Refers to all activities and income that are subject to government regulation, taxation and observation.

Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund): The world's largest public health financier; an international financing institution that fights AIDS, tuberculosis and malaria. The Global Fund works through partnerships on the ground with governments, NGOs, bilateral aid organizations, civil society groups and FBOs.

Health System Strengthening: Providing protection against health-related financial risks and enhancing the health sector's responsiveness to clients' needs. Examples of health system strengthening initiatives include building human resources, infrastructure, procurement and supply chain management and leadership skills.

Implementing Countries: Countries that have received Global Fund grants are referred to as implementing countries. They develop solutions to combat AIDS, tuberculosis, and malaria, and take full responsibility in executing these solutions.

Informal Employment Sector: Refers to activities and income that are partially or fully outside government regulation, taxation and observation.

Innovative Financing: A means of increasing, diversifying and complementing financial support through building new partnerships to raise additional resources from nontraditional sources.



Key Affected Populations: Groups of people that experience a high epidemiological impact from AIDS, tuberculosis or malaria, combined with reduced access to services and/or being criminalized or otherwise marginalized. Examples include men who have sex with men, injection drug users, sex workers, transgender people, incarcerated populations, migrants and refugees.

Low-Income Country: A categorization assigned to a country by the World Bank defined by per-capita gross national income (GNI). In the World Bank's 2015 fiscal year, low-income countries have a GNI per-capita less than or equal to \$1,045.

Middle-Income Country: A categorization assigned to a country by the World Bank defined by per-capita gross national income (GNI). In the World Bank's 2015 fiscal year, middle-income countries have a GNI per-capita greater than \$1,045 but less than \$12,746.

National Strategic Plans (NSPs): Developed by individual countries outlining their future efforts, plans and goals in fighting disease epidemic, these are detailed documents that include background information, current statistics and outline funding from both domestic and external aid sources. The development of a NSP is considered a strong show of political will, and provides the foundation for Global Fund concept notes (funding requests).

President's Emergency Plan for AIDS Relief (PEPFAR): An initiative of the U.S. government that is invested in saving the lives of those suffering from HIV around the world. PEPFAR partners with countries and organizations to support and fund

treatment/prevention measures, as well as provide on-the-ground technical support for HIV/AIDS.

President's Malaria Initiative (PMI): An initiative of the U.S. Government that aims to provide relief for high burdens of malaria on the African continent. PMI seeks to expand coverage of malaria prevention, treatment measures and the availability of mosquito nets, among other efforts.

Results-Based Financing (RBF): Refers to a range of mechanisms designed to enhance the performance of aid through incentive-based payments. Funding is dependent upon proven results measured against time-bound targets instead of traditional measurements of resource inputs and health service outputs.

UNAIDS: The Joint United Nations Programme on AIDS (UNAIDS) is a partnership that looks to lead, strengthen and expand the international response to AIDS. The organization's work covers all facets of the fight, from resource mobilization to monitoring and supporting efforts throughout the world.

Public-Private Partnership: These partnerships come to pass when the private sector is involved in provision of infrastructure and services that have traditionally been provided by governments. Private companies finance projects and provide expertise to ease fiscal constraints and increase efficiency. By engaging the private sector and giving it defined responsibilities, governments broaden their options for delivering services.





INTRODUCTION

Impressive global progress has been made in the fight against HIV/AIDS, tuberculosis and malaria: AIDS-related deaths have fallen 35 percent since their peak in 2005¹; global mortality from tuberculosis has fallen by 45 percent since 1990²; and malaria mortality rates dropped 47 percent globally between 2000 and 2013.³ But the fight is not yet over; the key to winning it will be maintaining — or even accelerating — our momentum.

In the early part of the millennium, institutions like the Global Fund to Fight AIDS, Tuberculosis and Malaria and, in the United States, the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI) were established as emergency responses to three devastating diseases. As a result of the progress achieved by these organizations and their partners — including implementing countries — donor aid is now transitioning to a more sustainable approach.

Domestic expenditures for health, in particular, will become increasingly vital as international funding plateaus. Implementing countries are already making greater investments in their own health systems and playing an important role in the fight against HIV/AIDS, tuberculosis and malaria. Between 2006 and 2011, global domestic investment doubled spending on the three diseases.⁴ In addition, African countries are working toward reaching the agreed-upon Abuja target of allocating 15 percent of their total government expenditure to health. In [The Abuja Declaration: 10 Years On](#), the World Health Organization reports that, although only Rwanda and South Africa have achieved the target, 27 countries have increased the proportion of total government expenditures allocated to health since 2001.

At the Global Fund's November 2014 board meeting, Executive Director Dr. Mark Dybul noted the importance of increasing domestic financing for health in implementing countries. By the end of 2014, through the Global Fund's concept note development process, countries had committed

“Despite significant progress in the battle against HIV/AIDS, TB and malaria, these epidemics continue to impose a devastating human and economic toll. Without sufficient resources to support the prevention, care and treatment for these diseases, the world is at risk of losing ground in this fight.”

- The Global Fund to Fight AIDS, Tuberculosis and Malaria Fourth Replenishment (2013-2016) Needs Assessment



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to seeking \$3.4 billion in domestic financing for 2015-2017, a 62 percent increase from pledges in the 2012-2014 grant period. Dr. Dybul also noted at the meeting that he anticipated domestic financing commitments will continue on an upward trajectory as additional concept notes are submitted and approved.⁵

However, as noted in a 2013 Results for Development Institute report, “While there may be scope for ... countries to increase (their) domestic financial contribution to the national AIDS effort, the political and fiscal challenges of doing so should not be underestimated.”⁶ The same can be said for both tuberculosis and malaria. To that end, several implementing countries are analyzing innovative ways to mitigate these challenges; some are assessing opportunities to redirect existing budget allocations while others are evaluating ways to mobilize new revenue through innovative financing mechanisms.

The potential exists, through innovative financing

methods, to raise significant levels of funding — as much as \$15.5 billion annually, if implemented correctly — for AIDS, tuberculosis and malaria.⁷ To achieve this, implementing country governments are considering ways of using tax revenues, reprogramming existing funds, generating more revenue from profitable sectors like tourism, or involving the private sector in partnerships or trust funds to increase resources to combat the three diseases.

Zimbabwe, as highlighted later in this report, is making strides in this direction. In 1999, the country introduced an AIDS levy which has grown significantly. Between 2009 and 2012, it grew from \$5.7 million to \$26.5 million and projections indicate that it will grow to \$47 million in 2016. Other countries in sub-Saharan Africa, including Kenya and Tanzania — both of which are also included in this report — are looking into similar mechanisms and trust funds.



Rwanda provides another interesting example of progress. With a track record of effective use of international funding and a steadfast commitment to health, Rwanda was a forerunner in developing mechanisms that leveraged disease-specific funding to build a national health system. Today, the country, in partnership with the Global Fund, is pioneering a results-based financing (RBF) model. This approach is designed to align with existing national systems and strategies, base future disbursements on outcome and impact indicators, and lessen administrative burdens and costs. This model provides more flexibility as to how the Global Fund resources are used and allows for savings to be placed back into the response.

Today, more than a decade since the Global Fund, PEPFAR and PMI were established, programs supported by international funding are helping to build healthier communities and enabling countries to take greater control of their health systems in a sustainable way. We can now foresee a future where

AIDS, tuberculosis and malaria are no longer threats to public health. But it will only be achieved through partnership, collaboration and shared responsibility.

These case studies — compiled through interviews with Global Fund staff, officials at other aid organizations, and in-country leaders — are intended to highlight some of the ways countries are increasing domestic investments through innovative approaches. The countries we have included in this report tell a story of collaboration, partnership and, most importantly, progress toward a healthier, more sustainable future. ■



KENYA

Charting the Course toward innovative and sustainable financing

INTRODUCTION

With the world's fourth largest HIV/AIDS epidemic, Kenya is committed to improving its national response to the disease — even as it addresses challenges and changes, including a transition to a decentralized system of governance. The country is working to address projected flat-lining in external donor funding by exploring innovative domestic health financing options.

BACKGROUND AND HISTORY

Like many countries in sub-Saharan Africa, Kenya is working to accelerate economic growth and reduce poverty. It recently achieved a significant milestone by becoming a middle-income country.⁸ The government is seeking to continue this positive trajectory by implementing the Kenya Vision 2030 development strategy, a five-part series of plans launched in 2008. This strategy outlines goals to provide a high quality of life to all of Kenya's citizens "in a clean and secure environment."⁹

Critical to achieving this vision is a focus on health. According to a Lancet Commission report, decreased mortality accounts for 11 percent of recent economic growth in low- and middle-income countries.¹⁰ As such, improving the quality of health services is integral not only to achieving Kenya's Vision 2030 but also to meeting the Millennium Development Goals.

Kenya's 2010 Constitution established a system of devolved government, creating a two-tier system at both the national and local level. After new leadership was elected in March of 2013, the 47 county governments became responsible for service delivery and resource allocation for health. These structural changes subsequently led to the development of a health bill, currently being considered by Parliament, to ensure alignment of health governance and health care delivery systems with the Constitution.¹¹



Photo © The Global Fund / John Rae

In addition to Kenya's broader efforts to improve and streamline health services and accessibility, the fight to control communicable diseases such as HIV/AIDS, tuberculosis and malaria is of particular concern. Kenya has one of the highest HIV prevalence rates in east Africa, at 6.0 percent,¹² and, as of 2013, ranked 13¹³ out of the 22 high-burden countries for tuberculosis. In addition, the Malaria Control Program of Kenya estimates that 70 percent of the country's population is at risk for the disease and 66 percent is at risk in endemic highlands and seasonal transmission areas.¹⁴

Although Kenya is facing challenges with all three diseases, this case study focuses on the government's response to HIV/AIDS and its efforts to get to zero new HIV infections.

THE HISTORY OF HIV/AIDS IN KENYA

Since the first AIDS case was reported in Kenya in 1984, the disease spread rapidly, and, by the mid-1990s, prevalence reached its peak of 10.5 percent.¹⁵ The HIV epidemic has become a major cause of mortality and has placed tremendous demands on the country's health system and economy.¹⁶

One of the Kenyan government's first responses to the epidemic was to educate the public and raise awareness through informative articles in the press and poster campaigns.¹⁷ Despite these efforts, the epidemic continued to grow. Addressing the issue at an AIDS-awareness symposium in 1999, then-President Daniel Arap Moi declared the epidemic a national disaster and a public health emergency, and announced the launch of Kenya's National AIDS Control Council (NACC).¹⁸

Since it was established, the NACC has coordinated the development and implementation of the Kenya National HIV/AIDS Strategic Plans (KNASP); organized the development of policies to help drive an effective fight against the disease;¹⁹ and led efforts to explore sustainable financing solutions to address the growing costs of the AIDS response.

In addition, legislation such as the 2006 HIV and AIDS Prevention and Control Act — which formally protects the rights of people living with HIV, prohibits mandatory HIV testing and authorizes various measures to mitigate the epidemic's impact — demonstrates the country's political will to fight the disease.²⁰ Other notable responses include the government's willingness to implement the UNAIDS Strategy 2011-2015: "Getting to Zero," which aims to advance global progress in achieving country set targets for: universal access to HIV prevention, treatment, care and support; halting and reversing the spread of HIV; and contributing to the achievement of the Millennium Development Goals by 2015.²¹

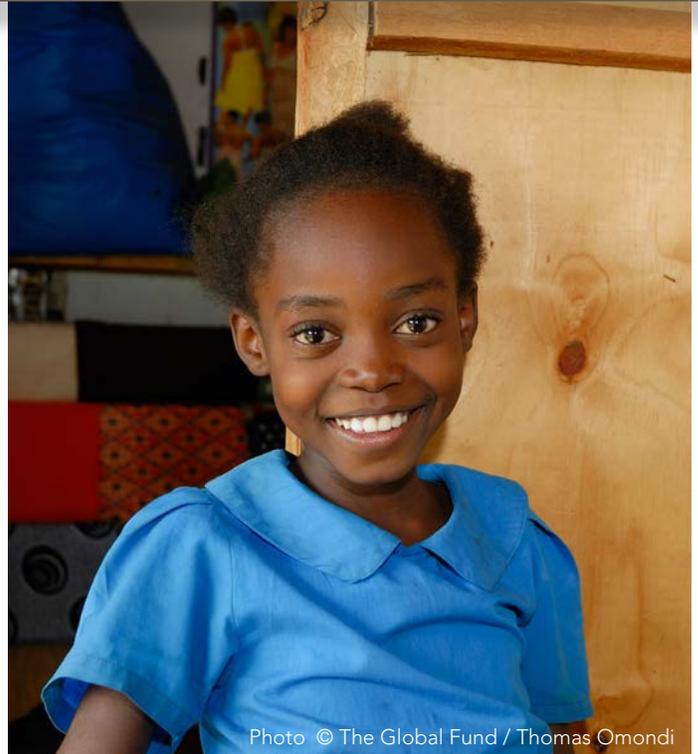


Photo © The Global Fund / Thomas Omondi

WHAT'S HAPPENING NOW

Today, Kenya has a generalized epidemic, with 6.0 percent of people ages 15-49 testing positive for HIV.²² Prevalence is higher in women (8 percent) than in men (4.3 percent)²³ and also varies widely by county, from a low of 0.2 percent in Wajir County to a high of 25.7 percent in Homa Bay County.²⁴ And, though the country has scaled up prevention of mother-to-child transmission services over the last five years, HIV infection among children remains stable around 14 percent, and only half of women who tested positive receive antiretroviral (ARV) medication.²⁵ Also of paramount concern is a concentration of high prevalence among key populations, including sex workers (29.3 percent), men who have sex with men (18.2 percent), and people who inject drugs (18 percent).²⁶

Although Kenya's HIV/AIDS burden remains high, there has been notable progress over the years as a result of increased counseling, testing and a scale-up of preventive services. Three out of four facilities in Kenya (74 percent) report having an HIV testing



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system, including almost all hospitals (99 percent) and health centers (95 percent). In addition, Kenya's Voluntary Medical Male Circumcision (VMMC) program has increased the number of procedures performed each year from 8,000 in 2008 to 190,000 in 2013.²⁷ Preventive services such as VMMC have helped to reduce the rate of female-to-male transmission of HIV by 60 percent.²⁸

Prevalence has dropped significantly since peaking in the mid-1990s and has remained relatively stable since 2003. While decreased prevalence before 2003 was attributed to high mortality rates, stabilized prevalence since that time has been linked to education and awareness as well as the rapid scale-up of antiretroviral therapy (ART) and a decrease in the number of new HIV infections.²⁹ This progress is a result of early government-led efforts to coordinate public and private sector activities to combat the disease, as well as the arrival of significant donor funding.

EXTERNAL AID: MAXIMIZING INVESTMENTS FOR IMPACT

As two of the largest donors for Kenya's HIV/AIDS response, the Global Fund and PEPFAR have been integral to fighting the epidemic and have partnered closely with the national government.

The Global Fund, in particular, has 13 active grants in Kenya, including a grant provided to the Ministry of Finance to scale up the number of people on ART, target most-at-risk populations, and improve technical and programmatic capacity. As a result of Global Fund-financed programs, Kenya has placed 340,000 people on ART.³⁰

The value and impact of these investments are evidenced by the government's willingness to make financial contributions to the Global Fund's replenishment. In the lead-up to the Global Fund's Fourth Voluntary Replenishment Conference in December 2013, the Government of Kenya pledged \$2 million to the organization. This important contribution, though modest, demonstrated the



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country's desire to achieve long-term sustainability in the fight against AIDS, tuberculosis and malaria.

Complementing the work of the Global Fund, PEPFAR funds a wide range of activities in Kenya. The framework of its most recent four-year partnership with the country was aligned with Kenya's National AIDS Strategic Plan (KNASP) III, and focused on: HIV service delivery; sectoral mainstreaming of HIV/AIDS in prevention, care and treatment, and health systems strengthening; community-based HIV programs; and governance. PEPFAR also worked to improve the supply chain management systems of the Kenya Medical Supplies Agency (KEMSA), which supports the entire sector, helping the country strengthen its health systems. PEPFAR is working to transition procurement responsibilities increasingly toward KEMSA and build the agency's capacity.³¹

The Kenyan government, together with PEPFAR implementing partners and Global Fund financing, has achieved significant gains in HIV service delivery. Importantly, support from external donors is helping to build and strengthen government efforts to improve its national response.

DOMESTIC FINANCING

Funding from external donors, however, is not the sole source of support in Kenya's fight against AIDS. In 2012, government expenditures for health made up 4.7 percent of its total GDP.³² Though well below the Abuja Declaration target of 15 percent, the government, in particular the Ministry of Finance and the Ministry of Health, has expressed willingness to increase contributions for health.

Progress is already being made. Most notably, as part of the PEPFAR Partnership Framework,

the Government of Kenya agreed to increase its budget for health by 10 percent annually during the framework's four-year period for the procurement of ARVs.³³ In addition, the Ministry of Health plans to invest \$400 million in the Beyond Zero Campaign, an initiative launched in January 2014 by the First Lady of Kenya, Margaret Kenyatta, to improve maternal and child health and accelerate national efforts to eliminate new HIV infections among children.³⁴ This public-private partnership has also received support from other domestic donors, including Equity Bank in Kenya, which pledged \$580,000 during the launch event.³⁵

Kenya's increased domestic investments may be modest currently, but the government is actively working to address the anticipated future flat-lining of funding from external donors — funding that accounts for over 70 percent of all HIV spending in Kenya. Adding to this challenge is the escalating cost of the HIV response, which is projected to increase by 114 percent between 2010 and 2020. These factors will create an anticipated funding gap of approximately \$1.75 billion.³⁶

INNOVATIVE FINANCING MECHANISMS

To address these needs, Kenya's NACC has established a High Level Steering Committee for Sustainable Financing to explore and generate proposals for innovative and viable sources of revenue for the AIDS response. Key among these proposals is an AIDS and non-communicable diseases trust fund, which would pool additional public and private resources.

An innovative approach to sustainable financing, the AIDS and non-communicable diseases trust fund would draw 1 percent of government revenue each year. NACC projections indicate the trust fund would cover 74 percent of the HIV/AIDS financing gap up to 2019.³⁷ The committee submitted a cabinet memo to propose the establishment of this trust fund formally, which currently awaits approval by Kenya's Parliament.³⁸

Another viable source of domestic funding for health could come from the National Hospital Insurance Fund (NHIF), the primary provider of health insurance in Kenya. The NHIF is compulsory for all formal sector employees and optional for informal employees. Contributions are calculated on a graduated scale based on income. The NHIF does not exclude any disease and covers hospitalization of insured HIV, tuberculosis and malaria patients.

Several feasibility studies have indicated the NHIF could expand its coverage to include the cost of ARVs and treatment for outpatient opportunistic infections. These additional costs would be financed by increased premiums and reductions in management costs. This funding scheme would expand services and could substantially increase ARV treatment coverage for HIV/AIDS patients.³⁹ Recognizing the potential value in moving forward with this option, the NACC has prepared and submitted a memo to the cabinet proposing funding of ARV therapy by the NHIF.⁴⁰

WHAT'S NEXT

Just one year since the decentralization of the government, Kenya has achieved impressive economic growth. Its economy grew by 5.7 percent in 2013, and the government expects growth will be the same in 2014.⁴¹ With one of the highest GDP growth rates in Africa, Kenya is well-positioned to make greater investments in health — resources that will become increasingly vital as development assistance declines over the coming years.

Although there is much to be done before it can meet the Abuja Declaration target, Kenya is actively working toward that goal. The country's willingness to develop a trust fund for AIDS and non-communicable diseases and explore other innovative financing demonstrates its commitment to improving the quality of life for its citizens and growing its own contributions to their health. ■



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RWANDA

Efficiencies with aid management lead to broader improvements in health

INTRODUCTION

In the 20 years since civil war and genocide took its toll in Rwanda, the national government — in collaboration with public and private sector partners — has worked to prioritize health, focusing reconstruction efforts on reducing poverty and becoming a middle-income country. In support of these objectives, Rwanda has invested in improvements in its health sector, sought greater efficiencies in coordinating external aid and has set the stage for a sustainable fight against HIV/AIDS, tuberculosis and malaria. These efforts have also put the country on track to meeting each of the health-related Millennium Development Goals by 2015.

BACKGROUND AND HISTORY

Already among the poorest countries in the world, the genocide in 1994 further destabilized Rwanda, devastating its economy, claiming approximately 1 million lives and displacing millions more. During that time and for several years afterward, donors discontinued aid. Many health workers fled the country or were killed, leaving a shortage of skilled personnel, which resulted in the rapid spread of communicable diseases such as HIV/AIDS, tuberculosis and malaria.

As Rwanda worked to rebuild, it was clear to government leaders that improving and strengthening its health sector would be integral to achieving its broader development goals. This commitment to health was demonstrated in Vision 2020, the national government's long-term agenda for equitable and social development which was adopted in 2000.

Over the years, the government has worked toward fulfilling Vision 2020 and reaching the Millennium Development Goals (MDG) through strategies such as the Economic Development and Poverty Reduction Strategy and its Health Sector Strategic Plans. As a result, the country has made important

gains. Between 2001 and 2013, real gross domestic product growth averaged 8 percent per year which the World Bank deems remarkable development progress.⁴² In addition, the poverty rate dropped from 59 percent in 2001 to 45 percent in 2011 while inequality, measured by the Gini coefficient, reduced from 0.52 in 2005 to 0.49 in 2011.⁴³ The international community has recognized the country's impressive development progress, which is largely attributed to the government's effective use of aid.

This increased aid efficiency stems from the national government's commitment to the 2005 Paris Declaration on Aid Effectiveness, a roadmap to improve the quality of aid and its impact on development through ownership, alignment, harmonization, results, and mutual accountability. The government adopted these principles in 2006 with the development of the Rwanda Aid Policy, which recognizes the limits of vertical funding from donors and emphasizes the need to target aid in a way that achieves the greatest impact and value for money.

Rwanda's health sector has also been highlighted as a model of success for the gains it has achieved. Over the past decade, mortality associated with HIV fell by 78.4 percent and mortality from tuberculosis by 77.1 percent.⁴⁴ From 2005 to 2011, deaths from malaria dropped by 87.3 percent.⁴⁵

Although the country has made significant progress with respect to all three diseases, this case study focuses on the government's HIV/AIDS response and the positive impact it has had on its health systems at large.

THE HISTORY OF HIV/AIDS IN RWANDA

Rwanda was one of the first countries in Africa to report cases of AIDS in 1983. Thereafter, its early response to the epidemic was rapid and sustained. By 1986, the Ministry of Health, in collaboration with the Red Cross, established blood donor

screening and AIDS education programs.⁴⁶ In 1987, the National Program for HIV/AIDS Control was established in collaboration with the World Health Organization.⁴⁷ This program, which was charged with coordinating efforts to fight the epidemic, was subsequently restructured into two separate entities: the Treatment and Research AIDS Center (TRAC) and the National AIDS Control Commission (NACC), within the Ministry of Health. The TRAC emphasized HIV/AIDS surveillance, treatment of sexually transmitted infections, voluntary HIV counseling and testing, prevention of mother-to-child transmission of HIV, and clinical care and support, while the NACC was responsible for formulating the country's National Strategic HIV and AIDS Plan (NSP).

Several iterations of the NSP have guided the national response and coordinated government efforts across all sectors, institutions and partners. The NSP sets goals, timeframes for execution, and outlines performance targets and indicators. Until 2009, the NACC led the development of the NSP; ownership has subsequently transitioned to the Rwanda Biomedical Center, which developed the most recent iteration.

WHAT'S HAPPENING NOW

Since 2005, prevalence of HIV/AIDS in Rwanda among people ages 15-49 has remained stable at 3 percent⁴⁸ but is concentrated among key populations. Female sex workers, for example, were identified as one of the key drivers of the epidemic with a high prevalence of 51 percent nationally.⁴⁹ Prevalence is also higher in the city of Kigali (7.3 percent) than in other provinces (2.4 percent).⁵⁰

The Gender Assessment of Rwanda's National HIV Response shows that women and girls are disproportionately affected, representing nearly 60 percent of adults living with HIV.⁵¹ The 2010 Rwanda Demographic and Health Survey (DHS) likewise found that HIV prevalence is higher among women (3.7 percent) than men (2.2 percent). The



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government has worked to address this issue through the National Accelerated Plan for Women, Girls, Gender Equality and HIV (2010-2014) to reduce their increased vulnerability to, and risk of HIV.

Although Rwanda faces a mixed epidemic and challenges in reaching key populations, it has continued to further its progress. Transmission of HIV from mother to child has decreased from 6.9 percent in 2009 to 2.9 percent in 2013 for HIV-exposed infants at 18 months of age.⁵² In addition, the government is currently on track to meeting most of the targets set forth by the U.N. General Assembly 2011 Political Declaration on HIV and AIDS, including: halving sexual transmission of HIV; eliminating new HIV infections among children; increasing the number of people on treatment; and halving the number of tuberculosis-related deaths



Photo © The Global Fund / John Rae

among people living with HIV.⁵³ The Ministry of Health attributes the success of its AIDS response to the strengthening of its national health system.

INTERNATIONAL FUNDING: MAXIMIZING INVESTMENTS FOR IMPACT

As the largest donors to Rwanda's HIV/AIDS response, the Global Fund and PEPFAR have played key roles in fighting the epidemic. The Global Fund provided 54.7 percent of all HIV spending in Rwanda in fiscal years 2012–2013, while PEPFAR and the U.S. government provided 34.6 percent of the total HIV spending during that period.⁵⁴

The Global Fund, in particular, has five active grants in the country, including one provided to the Ministry of Health to scale up the social support

for HIV orphans and vulnerable children and implement prevention platforms for most at-risk populations. Funding from the Global Fund has assisted in helping Rwanda place 130,000 people on antiretroviral therapy (ART).⁵⁵

Since 2004, PEPFAR has supported the government's efforts to plan, lead, manage and deliver health services across the country. Its fiscal year 2013 operational plan in Rwanda focused on maintaining gains in prevention of mother-to-child transmission, with an emphasis on scaling up pediatric care and treatment; expanding prevention care and treatment with key target populations; and ensuring the availability of commodities while strengthening the country's supply chain.⁵⁶ In addition, PEPFAR is working to support the gradual transition of direct government financing for clinical services and commodities to Rwanda.



Photo © The Global Fund / John Rae

The national government works with the Global Fund, PEPFAR and other donors to align strategies with the country's national strategic plans.⁵⁷ These efforts are consistent with the "Three Ones" principles, initiated by UNAIDS in cooperation with the World Bank and the Global Fund, to guide national authorities and their partners in coordinating the HIV/AIDS response through: one national coordinating body, one national strategy and one national monitoring and evaluation framework.⁵⁸

Investments in Rwanda's AIDS response have been a catalyst for broader health systems strengthening and capacity building in the health sector. Funds provided to scale up HIV/AIDS interventions have been used to strengthen primary care and expand health services across the country.⁵⁹ Health facilities originally built with funds earmarked for AIDS have expanded to provide integrated primary care.⁶⁰ In addition, national supply chains used for ART programming have been leveraged to deliver drugs for other ailments.⁶¹

DOMESTIC FINANCING

Although the country still relies heavily on external funding, Rwanda is well regarded for its proven success with national health programs and its own

investments in health. It has established a health care system that brings together partners under one national plan.⁶² In addition, it maximizes programs that address HIV/AIDS to benefit other health concerns. For example, its community-based health insurance program, which covers 85 percent of the general population, focuses on providing care to vulnerable populations and has more than halved out-of-pocket-health spending.⁶³ Plans under this program fully cover many treatment and prevention services for other diseases, in addition to HIV, exemplifying efficient and effective stewardship of resources.

The country is also recognized for making significant investments in its own health system. According to the World Health Organization and UNAIDS, Rwanda is one of six African Union member countries that have met or exceeded the Abuja target of allocating at least 15 percent of government expenditures for health.^{64 65}

That said, external aid will continue to play an important role in financing the national HIV/AIDS response for the foreseeable future. Total HIV spending in 2012-2013 was \$243.6 million, 8.2 percent of which was contributed by the Rwandan government while external donors contributed 91.8

percent.⁶⁶ It is important to bear in mind, however, that efforts toward sustainability are not synonymous with domestic financial takeover of programs. Changes such as innovative financing and incremental increases to domestic investments, both of which are occurring in Rwanda, are also indicators of progress.

RESULTS-BASED FINANCING

In March 2014, the Global Fund announced a new results-based financing (RBF) grant agreement with Rwanda, known as the National Strategy Financed Model (NSFM). This \$204 million grant agreement will be used to implement the country's national strategic plan for HIV (2013-2018) with sharply reduced oversight. The grant has been given as a block rather than disbursed as program-specific funds, which is a unique feature of this financing mechanism. This allows the government flexibility to spend funds on various programs within its NSP and allows for savings to be placed back in the response. In addition, the results-based model supports the Three Ones framework by providing for one operational plan taking all funding into account.⁶⁷

Continued funding under the NSFM will be contingent on improved health impacts (e.g., health outcomes) rather than inputs and outputs (e.g., the number of health products distributed).⁶⁸ Funding is based on progress as measured by six key indicators, specifically targets related to:

- Infants born to HIV-positive mothers who are infected by 18 months;
- Adults and children known to be on treatment 12 months after starting antiretroviral treatment;
- Adults and children currently receiving antiretroviral treatment;
- Men having sex with men reporting use of condoms;

- Female sex workers reporting condom use; and
- HIV/TB co-infected patients receiving both HIV and TB treatment.⁶⁹

The results of these indicators will be verified, using rigorous data quality audit methodology, by local fund agents within the country.

This results-based approach is designed to align with existing national systems and strategy, base future disbursements on outcome and impact indicators and lessen administrative burden and cost.

A number of mechanisms will enable the country to ensure the NSFM operates efficiently. These mechanisms are present at the strategic, operational and financial levels:⁷⁰

- A comprehensive NSP Operational Plan;
- Office of the Auditor General (auditing the financial aspects);
- Procurement and supply chain assessments; and
- Service availability and readiness assessment and procurement reviews.

WHAT'S NEXT?

Strong political will and government-led efforts, combined with good financial management and close collaboration with partners, have helped Rwanda achieve significant progress against its HIV/AIDS epidemic and in its national health system. Certainly, the country still has a number of challenges to overcome to achieve its Vision 2020 goals. But its post-genocide development efforts have proven that the government is well-organized, willing and has the policy and infrastructure in place to address them. Moreover, as its economy grows, Rwanda will be well-positioned to continue to reduce its reliance on aid in an incremental and sustainable way. ■



TANZANIA

Political Will and Partnership have Led to Steady Progress against HIV/AIDS

INTRODUCTION

The United Republic of Tanzania (URT) — comprising mainland Tanzania and Zanzibar — is a low-income and relatively young country formed in 1964. Despite these challenges, Tanzania has demonstrated strong political will in providing for the health of its citizens, as evidenced by its multi-sectoral approach to fighting communicable diseases such as HIV/AIDS.

BACKGROUND AND HISTORY

Today, Tanzania's primary objective is accelerating economic growth and fighting poverty. Its benchmark for success is, ultimately, achieving middle-income country status. To that end, the national government developed and is currently implementing a series of strategies and plans that began in 1999 with The Tanzania Development Vision 2025, which outlines goals to improve the quality of life for its citizens through good governance and a competitive economy.⁷¹ In 2005, the government subsequently adopted the National Strategy for Growth and Reduction of Poverty aligned with and based on the Millennium Development Goals.⁷²

From the outset, it was clear to government leaders that health was integral to the delivery of these strategies. As a means of reducing poverty and achieving the Millennium Development Goals the government developed a health policy with a focus on its response to communicable diseases, such as HIV/AIDS, tuberculosis and malaria.⁷³

These diseases continue to be of paramount concern for Tanzania. The country is among the 22 high-burden countries for tuberculosis. Its notification for new and retreatment cases for tuberculosis experienced a five-fold increase between 1983 and 2010, which is attributed to the HIV epidemic and population growth.⁷⁴ In addition, 93 percent of the population, including both the mainland and all of Zanzibar, live in areas where

malaria is transmitted. Ten percent of children under five in the country tested positive for the disease in a survey conducted between 2011 and 2012 and more than 40 percent of all outpatient visits are attributable to malaria. The National Malaria Control Program estimates that between 60,000 and 80,000 deaths result from the disease annually.^{75,76} Although the country struggles with not only HIV/AIDS but also tuberculosis and malaria — and has received significant international funding for all three — this case study focuses on the government's response to HIV/AIDS in mainland Tanzania as a way to illustrate its commitment to the health of its citizens.

THE HISTORY OF HIV/AIDS IN TANZANIA

The first AIDS cases in Tanzania were reported in the Kagera region in 1983. The disease spread rapidly throughout the 1980s, and by 1986 all regions of mainland Tanzania had reported AIDS cases to the Ministry of Health. The first comprehensive survey conducted on mainland Tanzania during this time period found that, as early as 1987, the HIV epidemic had already reached population groups considered to be at a low risk of infection.⁷⁷ In addition, and of great concern, it found that HIV prevalence among pregnant women was substantial.⁷⁸

Even before significant donor assistance arrived, the government of Tanzania demonstrated political leadership in dealing with the crisis. In 1985, the government, through the Ministry of Health, established the National AIDS Control Programme to coordinate prevention and control. Despite these efforts, the epidemic continued to grow and reached its peak in the 1990s. By the end of the decade, 118,713 cases were reported.⁷⁹ The rapid spread spurred then-President Benjamin William Mkapa to call attention to the epidemic in his New Year message on Dec. 31, 1999, calling it "an extraordinary crisis that requires extraordinary measures to deal with it."

President Mkapa's speech gave weight to the urgency of the AIDS epidemic and the need for a multi-sectoral approach to fight against it. One year later, he announced the formation of the Tanzania Commission for HIV/AIDS (TACAIDS), an organization within the Prime Minister's Office, to provide strategic leadership and facilitate the involvement of public and private stakeholders in developing and implementing a strategic framework to fight the epidemic.

In 2001, a bill establishing TACAIDS was passed by Parliament and enacted into law. That same year, 80 members of Tanzania's Parliament formed the Tanzania Parliamentarians AIDS Coalition (TAPAC) to increase understanding of HIV/AIDS issues, including the effects it has on society as it spreads. TAPAC was formed to help ensure greater awareness and understanding among both parliamentarians and the broader public.⁸⁰

Current President Jakaya Kikwete and his wife, First Lady Salma Kikwete, have continued this tradition of strong political leadership in improving health and are two of the country's biggest champions in the fight against HIV/AIDS. By way of example, both were tested publicly for HIV as part of a national testing campaign.

WHAT'S HAPPENING NOW

Today, Tanzania continues to face a generalized epidemic with 5 percent of people ages 15-49 testing positive for HIV. By the end of 2013, Tanzania had an estimated 1.4 million people living with HIV and 72,000 new HIV infections.⁸¹ This prevalence, however, is not distributed equally across genders, socioeconomic status or region. HIV prevalence is higher among women (6.2 percent) than men (3.8 percent) and is also higher in urban areas.⁸²

There is progress to report, however. Overall prevalence has dropped since 2002. This improvement is due in large part to early government-led efforts to coordinate public and

private sector activities to combat the disease as well as the arrival of significant donor funding.

INTERNATIONAL FUNDING: MAXIMIZING INVESTMENTS FOR IMPACT

Tanzania began receiving aid from the Global Fund in 2003 and from PEPFAR the following year. Active collaboration between the national government and these two donors became, and continues to be, the backbone of the country's HIV program scale-up. The Global Fund, which has approved more than \$1.5 billion in funding, \$ 772.2 million⁸³ of which is targeted to HIV/AIDS, and PEPFAR, which has contributed nearly \$2.2 billion,⁸⁴ provide almost 90 percent of the HIV/AIDS financing in Tanzania.⁸⁵ The successful partnership between the national government and the two organizations has been instrumental to the progress made against the epidemic in Tanzania.

Each partner on this three-part team plays a unique role. The Tanzanian government coordinates, manages, and operates the multi-sectoral national response — from health facilities, research centers, schools, and other institutions down to community interventions at the village and sub-village levels. The Global Fund provides financial support to the government and civil society organizations in their responses, with significant resources allocated to health commodities such as antiretroviral (ARV) drugs and HIV rapid diagnostic tests and other supporting interventions. In addition, the Global Fund makes significant investments in the health systems strengthening initiatives — building human resources, infrastructure, procurement and supply management and leadership skills.

PEPFAR, meanwhile, funds the work of a wide range of implementing partners and provides resources for the procurement of certain health commodities (e.g., emergency ARV procurement requests, second line adult and pediatric ARVs, lab supplies and equipment). Moreover, the U.S. bilateral program provides overall support for service delivery at



Photo. © The Global Fund / John Rae

health facilities, community sites and management teams at district, regional, and national levels.

The Tanzanian government, together with PEPFAR implementing partners and Global Fund financing, has achieved comprehensive national coverage in support of HIV service delivery. The Global Fund-financed activities are inter-related and complementary to government policies, strategic plans and to PEPFAR's work helping to build a response that can be sustained by the country over time.

DOMESTIC FINANCING

But it is not only external funding that is supporting the fight against HIV/AIDS in Tanzania. In an era where historically rapid growth in donor assistance for health is flattening, the national government is cognizant of the need to increase its own resources in order to defeat diseases, including HIV/AIDS. According to the World Health Organization (WHO), Tanzania's government expenditures for health in

2012 made up of 7 percent of the total GDP.⁸⁶ It is estimated the government allocates 5 percent of these funds for HIV/AIDS activities.⁸⁷ It has also committed to increasing its contribution to the national response program and recently finalized a health financing strategy, including a national insurance scheme, fiscal contributions and taxation models, and public private partnerships for health financing.⁸⁸

In addition, Tanzania enacted health reforms that decentralized the entire public sector.⁸⁹ As a result, local government authorities (LGAs) have become instrumental in the delivery of health care, including HIV/AIDS.⁹⁰ LGAs are highlighted in the Tanzania Third National Multi-Sectoral Strategic Framework (NMSF) for HIV and AIDS (2013/14 – 2017/18) for the important role they play in collecting resources for the national AIDS response. In particular, they are providing 20 percent of collected revenue — from various fees, charges, levies and taxes set locally — to be allocated to the HIV/AIDS response.⁹¹

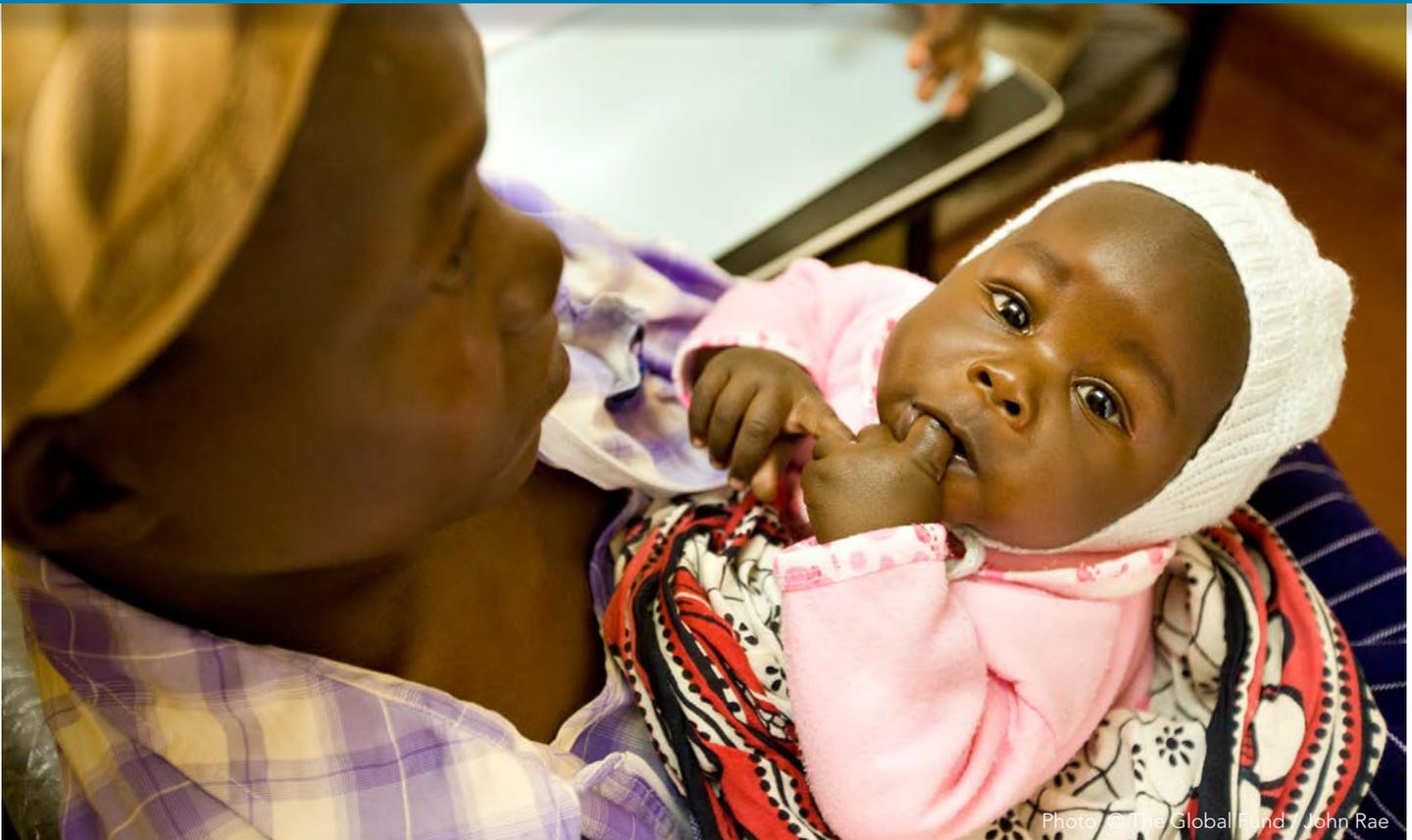


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INNOVATIVE FINANCING MECHANISMS

Understanding that national health funding alone will not be enough to bridge the resource gap, the national government is working to address the trend in decreasing donor aid for health in other innovative ways. For example, in an effort to proactively address the resource gap and ensure sustainable financing for its HIV/AIDS response, the Tanzanian government is working to establish an AIDS Trust Fund (ATF). The ATF will draw funds from a ring-fenced budget, which will be established by the government and other sources, such as foreign and local private donations and bequests as well as investment incomes (from ATF deposits and other treasury operations). There is initial support for the ATF from the private sector as well; the Public Expenditure Review (2012) indicated that 15 percent of the companies are willing to support and contribute to AIDS Trust Fund.⁹² Although this represents only 60 out of 400 companies,

it is progress on which further private sector engagement can be built.

This funding mechanism will provide an enabling environment for the private sector to contribute more to the HIV/AIDS response. Legislation to develop the trust fund is currently moving through the Parliament and is estimated to be operational by July 2015. Over time, the ATF is expected to decrease donor dependence more than 36 percent. The funding mechanism will begin with an initial investment from the Government of Tanzania and will then open up to the private sector.⁹³

PRIVATE SECTOR ENGAGEMENT

The private sector and civil society organizations play an important role in fighting the epidemic, including contributing about 2 percent of the funding used for the national response per year (in 2012).⁹⁴ Though private sector funding is modest at

the moment, the national government is developing a number of mechanisms to support increased engagement.

The government recognizes the role of the private sector in bringing about socioeconomic development through investments.⁹⁵ To that end, they have passed a number of public private partner policies to regulate and attract investments. Health, in addition to a few other select sectors, has been successful in this effort. For example, the Abbott Fund, the philanthropic arm of the global health care company, Abbott, and the Government of Tanzania formed a public-private partnership to strengthen the country's health care system and address critical areas of need. To date, the Abbott Fund has invested more than \$100 million in this partnership effort, which has lasted more than 10 years. In addition, the Abbott Corporation has made more than \$5 million in corporate donations.⁹⁶

The Tanzanian government is also engaging the private sector through other means of resource mobilization. For instance, Geita Gold Mine (GGM), a mine in Tanzania owned by the AngloGold Ashanti company, works with TACAIDS to cosponsor the Kilimanjaro Challenge, an annual event to raise awareness of HIV/AIDS and generate funds for civil society organizations' efforts to combat the epidemic. GGM and TACAIDS held its 13th Kilimanjaro Challenge in 2014; the event raises approximately \$500,000 per year.⁹⁷

The private sector is also helping to support capacity building efforts. Project Last Mile, for example, is a successful collaboration that demonstrates the powerful partnership between the Global Fund, Coca-Cola and the Government of Tanzania. Established in 2010 to help Tanzania's government-run medicine distribution network, the Medical Stores Department, build a more efficient supply chain, Coca-Cola's proven logistics and beverage delivery model was used to deliver critical medicines to remote communities.

As a result, Tanzania has been able to implement practices that have elevated its planning, distribution and performance management processes, improving its capability to deliver critical medical supplies in a consistent manner throughout the country. It also has been able to increase the availability of medicines in clinics by 20 to 30 percent in regions where Project Last Mile has been implemented.⁹⁸

WHAT'S NEXT

Strong political will and partnership has led to consistent incremental progress against HIV/AIDS in Tanzania. This is exemplified by not only the establishment of a national strategy and governance structures but, more recently, the development of innovative financing mechanisms.

Maximizing investments to achieve the greatest impact coupled with mobilizing an increased level of domestic funding will be critical going forward, given decreasing funding from external donors. In addition, the government is working to address key challenges that remain in defeating the HIV/AIDS epidemic: lack of human resources, treatment integration for HIV/TB co-infection and a lack of integrated databases for HIV programs.

The efforts above, though, are only part of the solution to creating a more sustainable HIV/AIDS response. Innovative financing, such as the AIDS Trust Fund, combined with robust engagement with the private sector will be important components in the long term fight to defeat the epidemic in Tanzania. ■



ZIMBABWE

Laying the Groundwork for a Sustainable Future

INTRODUCTION

Despite facing both economic and political obstacles — including large-scale unemployment and issues related to land reform⁹⁹ — Zimbabwe has continued to cultivate a skilled health workforce, a commitment to the development and refinement of innovative financing, and a determination to enhance its health programs. These efforts are contributing to noteworthy progress and laying the groundwork for a more sustainable future.

BACKGROUND AND HISTORY

Epidemiological gains have been made, but communicable diseases such as HIV/AIDS, tuberculosis and malaria continue to pose serious risks in the country. As of 2010, Zimbabwe ranked 17th in the world for tuberculosis burden and fourth for incidence per capita, presenting a rate of infection of 782 per 100,000.¹⁰⁰ Since then, the incidence rate has dropped to 552 per 100,000 with a mortality rate — excluding those co-infected by HIV/tuberculosis — of 40 per 100,000.¹⁰¹

In 2013, 422,633 cases of malaria — and 352 deaths — were reported in Zimbabwe. This represents progress; in 2012, 98 percent of all confirmed malaria cases from African countries were from Zimbabwe and the country accounted for 80 percent of all malaria-related deaths in the sub-region.¹⁰² In reaction to such a high burden of malaria, ownership of insecticide-treated nets (ITN) increased significantly. According to the 2014 World Malaria Report, as much as 67 percent of the country's population is estimated to now be protected by ITNs. Overall, Zimbabwe is now listed as a low-transmission Southern African country and it is on track to show a 50-75 percent decrease in incidence between 2000 and 2015.¹⁰³

Although the country faces substantial challenges and has received significant international funding for all three diseases, this case study focuses on Zimbabwe's response to HIV/AIDS, which best

exemplifies the country's commitment to the use of innovative financing mechanisms in improving the health of its citizens.

The first cases of AIDS were detected in Zimbabwe in 1985, only five years after the country officially gained its independence. As the epidemic spread rapidly, peaking in the late 1990s, the national government took proactive efforts to address the crisis. Prior to the founding of the Global Fund and PEPFAR and the provision of external donor resources in the early 2000s, the Zimbabwean government began demonstrating strong political will to fight the epidemic. In 1999, the country established the National Policy on HIV and AIDS, the National AIDS Council and an innovatively-funded National AIDS Trust Fund.¹⁰⁴

THE HISTORY OF HIV/AIDS IN TANZANIA

Zimbabwe's domestic efforts — combined with significant contributions from the Global Fund, PEPFAR and other funders — have led to dramatic gains in the country's fight against HIV/AIDS over the past 20 years. As of December 2014, the Global Fund has contributed nearly \$616.2 million to Zimbabwe's HIV/AIDS response.¹⁰⁵ As testing, preventative measures and treatment have been implemented and expanded throughout the country, both the rates of prevalence and incidence of infection have steadily declined.¹⁰⁶

Today, the country is home to approximately 1.4 million people living with HIV (PLHIV).¹⁰⁷ Among those most impacted are sex workers; current estimates for HIV prevalence among this key affected population in the country range between 40 and 60 percent.¹⁰⁸ While similar data is not available for men who have sex with men (MSM) in Zimbabwe,¹⁰⁹ it is anecdotally believed that this population is also disproportionately affected.

Despite these challenges, the rate of HIV incidence dropped sharply from 5.5 percent in adults in 1992 to about .98 percent in 2013.¹¹⁰ The implementation

of prevention of mother to child transmission (PMTCT), a prophylactic treatment, now covers 93 percent of HIV-positive pregnant women,¹¹¹ and ART coverage is at approximately 77 percent for eligible adults and 46 percent for children, with more than 9,000 PLHIV initiating treatment each month.¹¹² In addition, the Zimbabwe National Behaviour Change Programme, which targets sexually active populations ages 15 to 49, is operational in all of the country's 65 districts and is well integrated into different sectors, including prisons.¹¹³

In Zimbabwe, external resources from the Global Fund, PEPFAR and other donors augment a substantial national response. In 1999, the government adopted the aforementioned National Policy on HIV and AIDS. That same year, Parliament established both the National AIDS Council (NAC),

which leads efforts to manage and coordinate the overall HIV/AIDS response within Zimbabwe,¹¹⁵ and the National AIDS Trust Fund, a domestic HIV/AIDS financing initiative that is funded through an "AIDS Levy" tax. The innovative levy concept, in particular, was conceived in response to the worsening HIV/AIDS situation and a lack of funding. External support for Zimbabwe at the time was the lowest in the region (US \$4 per person living with HIV compared to between \$23 and \$400 in other countries).¹¹⁶

WHAT'S HAPPENING NOW: ZIMBABWE'S AIDS LEVY

Zimbabwe's biggest challenge in fighting HIV/AIDS continues to be financing. The country had a

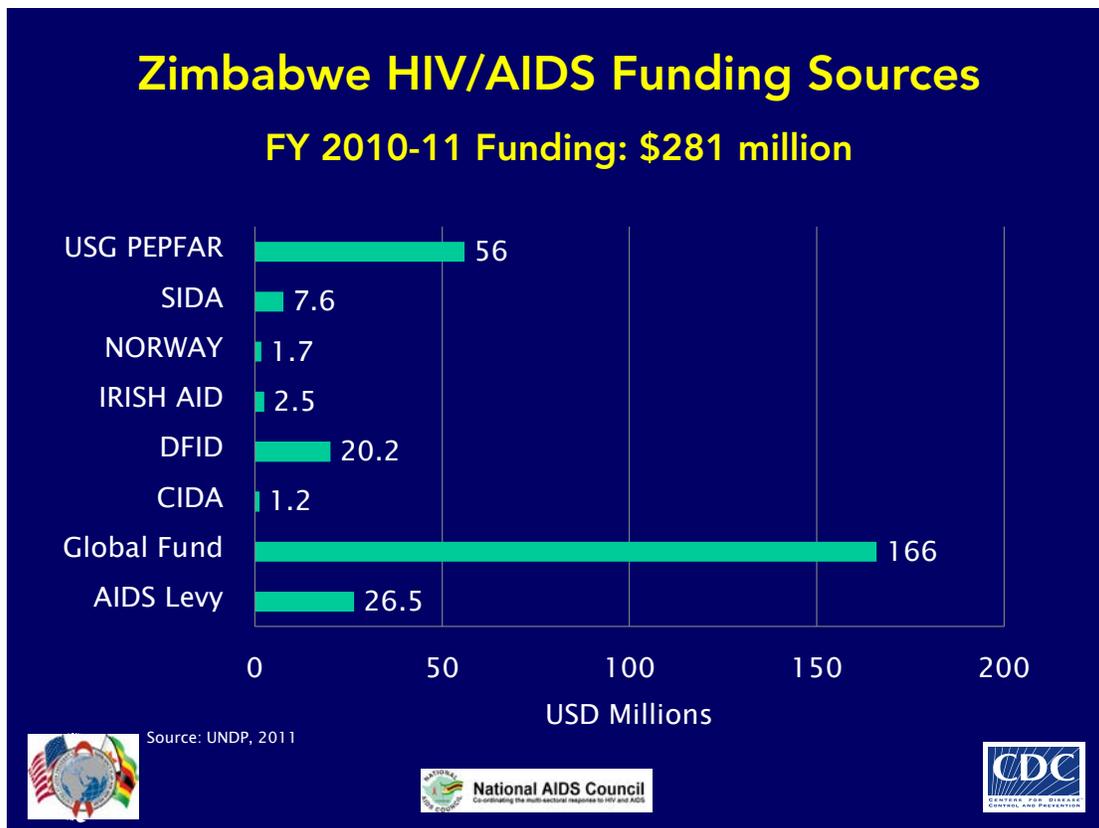


Figure 1: HIV/AIDS Funding Sources in Zimbabwe. Zimbabwe's National AIDS Trust Fund (AIDS Levy): A Case Study.¹¹⁴

devastating economic collapse between 2000 and 2008, from which it has not completely recovered. However, there is a strong focus at the highest levels of the national government on mobilizing domestic resources and sharing the burden of cost for the health care of its citizens. One of the ways the Zimbabwean government has demonstrated domestic ownership is through the development of the AIDS Levy.

The AIDS Levy, in effect since 2000, is a 3 percent tax on the income of Zimbabwe’s formally-employed individuals and companies. The funds from the levy support every aspect of the HIV/AIDS response in Zimbabwe; however, the government has mandated since 2006 that at least 50 percent of these resources go toward drug procurement.¹¹⁷

The tax has dramatically raised domestic resources to fight AIDS. In 2009, when the country officially began accepting foreign currencies, \$5 million was collected from the AIDS Levy. A year later, levy funding grew to \$20 million. By 2012, it reached \$32 million, singlehandedly supporting 23 percent of Zimbabwe’s population on ARV treatment — 100,000 people.¹¹⁸

Zimbabwe’s AIDS Levy represents a significant financial innovation; this funding mechanism not only is the first of its kind in Africa, but also has served as an inspiration for other nations, including Uganda and Zambia, to explore the creation of similar schemes.¹¹⁹

Although this funding mechanism represents remarkable progress, there are challenges with its

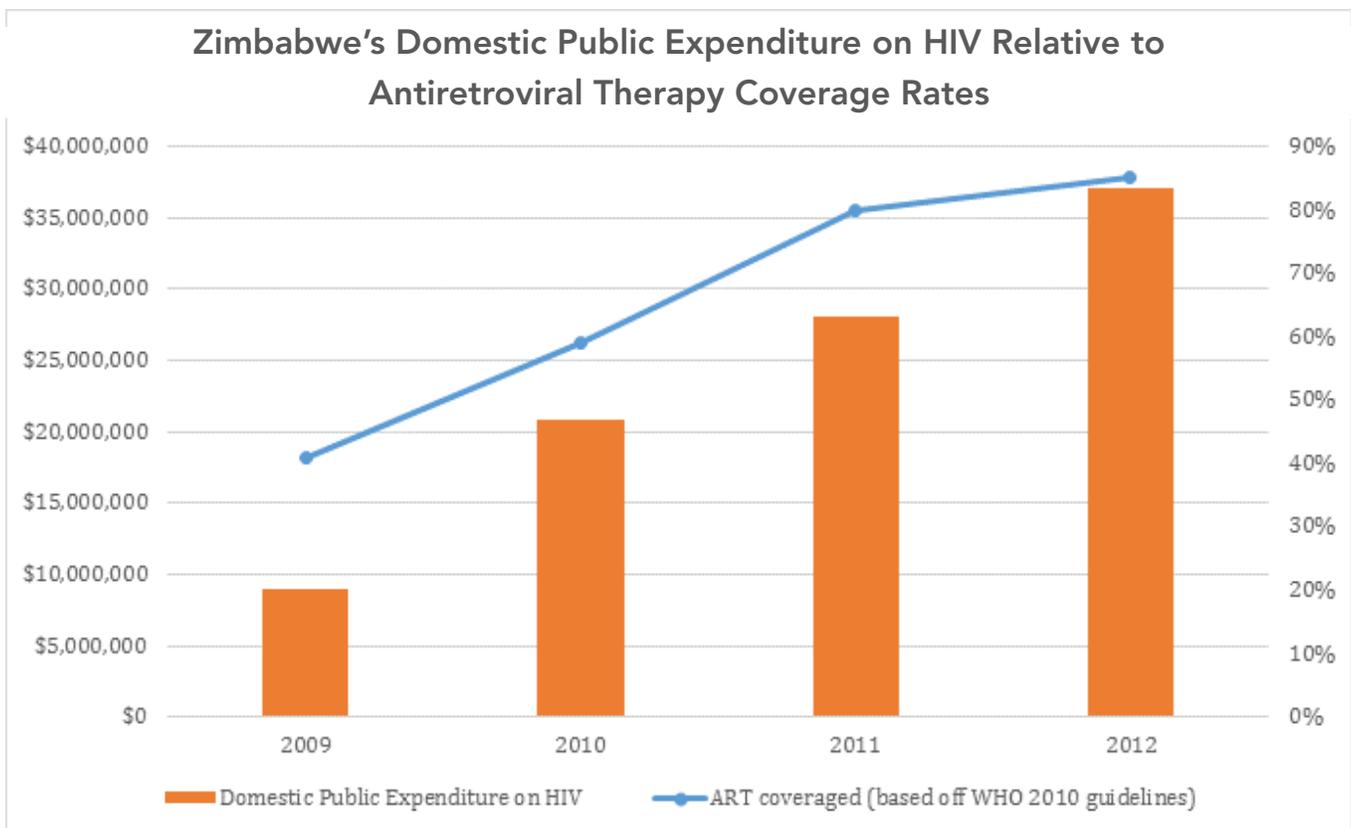


Figure 2: Zimbabwe’s Domestic Public Expenditure on HIV Relative to Antiretroviral Therapy Coverage Rates.

implementation. Mining companies, a prominent industry in Zimbabwe, are exempt from the tax, as are individuals who are informally employed. With 70 percent of the productive population of Zimbabwe considered to be employed by the informal sector,¹²⁰ this is a source of concern. The NAC is currently exploring possible ways to address these issues.

BUILDING CAPACITY: ZIMBABWE'S HEALTH CARE WORKER RETENTION SCHEME

Beyond the AIDS Levy, Zimbabwe has shown leadership in a variety of other ways intended to drive sustainable progress. Its worker retention scheme, for example, was initiated in 2008 and is an important step toward strengthening the country's health sector.¹²¹ With a history as a nation with strong services, Zimbabwe has a large workforce of health care technicians. In fact, many health care workers who have gone on to work throughout sub-Saharan Africa were trained in Zimbabwe.¹²² The country's hyperinflation period from 2007 to 2009, however, caused many health workers to migrate in search of employment in neighboring regions.

The retention scheme, largely supported by the Global Fund since 2009,¹²³ subsidizes health care workers' compensation in an effort to reverse this outward migration and to ensure that the number of new trainees entering Zimbabwe's health system exceed those leaving the sector.¹²⁴ The scheme has succeeded in helping draw technicians back to the country, with the number of health care workers in Zimbabwe increasing from 13,000 in 2010 to about 30,000 in 2014.¹²⁵

WHAT'S NEXT

Zimbabwe continues to face economic and political challenges that will impact its ability to meet budgetary needs in health as well as other sectors.¹²⁶ In 2014, the country's overall budget

declined 9.9 percent from the prior year and the budget for health decreased 11.6 percent.¹²⁷ This fragile economic environment means that, in the short term, it will be difficult for the Zimbabwean government to increase its own investments in health.

The NAC, for its part, is cognizant of these constraints and is actively looking to develop new, innovative means of increasing revenue and supplying a larger portion of the country's overall AIDS spending.¹²⁸ The NAC is currently conducting two studies that are due to be completed in shortly.¹²⁹ The first will examine the feasibility of expanding the AIDS Trust Fund to include the informal sector of the workforce, allowing it to reach a much larger portion of Zimbabwe's population; the second explores options for expanding the base of the AIDS Trust Fund to include sectors that currently are exempt from contributing. Also being considered is the possibility of a value-added tax, a sin tax and a tax on the growing mobile phone industry.¹³⁰

Health funding for Zimbabwe likely will remain largely dependent upon donor support for the foreseeable future. However, the country's strengthened health workforce, demonstrated commitment to the advancement of innovative financing, and dedicated leadership illustrate important steps in building a sustainable approach toward HIV/AIDS and health care at large. ■

METHODOLOGY & ACKNOWLEDGEMENTS

METHODOLOGY

To develop this report, Friends gathered information via phone and email exchanges with Global Fund Portfolio Managers, officials at U.S. bilateral aid organizations such as PEPFAR and USAID, individuals within a particular country's Ministry of Health and/or representatives from a Country Coordinating Mechanism. In all, more than 20 subject matter experts were consulted.

The Fund Portfolio Managers, in particular, were asked to describe the health situation in the countries prior to the arrival of international aid. In addition, they were asked about Global Fund (or joint Global Fund/U.S. bilateral) support that contributed to any major scale-up of health services or coverage. Finally, they were asked how the country is implementing or exploring innovative financing approaches to address resource gaps, continue building capacity and striving for sustainability. Questions were open-ended to ensure comprehensive and frank answers.

Global Fund experts also reviewed this paper and offered input to ensure that characterizations of the relationship and various activities were accurate. To support the qualitative information, Friends utilized available open-source data.

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END NOTES

1. UNAIDS. 2014. "The Gap Report." Accessed February 2, 2015. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf.
2. WHO. 2014. "Global Tuberculosis Report." Accessed February 2, 2015. http://apps.who.int/iris/bitstream/10665/137094/1/9789241564809_eng.pdf.
3. WHO. 2014. "World Malaria Report." xii. Accessed February 2, 2015. http://apps.who.int/iris/bitstream/10665/144852/2/9789241564830_eng.pdf?ua=1.
4. Whiteside, Alan, Robert Greener, Samantha Bradshaw, Collins Mucheuki, and Gavin Surgey. December 2013. "Responding to Health Challenges: The Role of Domestic Resource Mobilisation." HEARD. Accessed February 2, 2015. <http://hesp-news.org/2013/12/06/responding-to-health-challenges-the-role-of-domestic-resource-mobilisation/>.
5. Ernst, Houston. Email to Colleagues on behalf of Friends of the Global Fight Against AIDS, Tuberculosis and Malaria. November 25, 2014. "Update on the Global Fund's 32nd Board Meeting."
6. Results for Development Institute. October 2013. "Financing National AIDS Responses for Impact, Fairness, and Sustainability: A Review of 12 PEPFAR Countries in Africa."
7. Whiteside, Alan, Robert Greener, Samantha Bradshaw, Collins Mucheuki, and Gavin Surgey. December 2013. "Responding to Health Challenges: The Role of Domestic Resource Mobilisation." HEARD. Accessed February 2, 2015. <http://hesp-news.org/2013/12/06/responding-to-health-challenges-the-role-of-domestic-resource-mobilisation/>.
8. The World Bank. September 2014. "Kenya: A Bigger, Better Economy." Accessed February 2, 2015. <http://www.worldbank.org/en/news/feature/2014/09/30/kenya-a-bigger-better-economy>.
9. The Kenya Vision 2030. "The Vision." Accessed February 2, 2015. <http://www.vision2030.go.ke/index.php/vision>.
10. Jamison, Dean T., and Summers, Lawrence H. 2013. "The Lancet Commissions, Global Health 2035: a world converging within a generation". The Lancet 382, no. 9908 (December 3): 1898–1955, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62105-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext).
11. World Health Organization. "Kenya: Cooperation Strategy at a glance." Accessed February 2, 2015. http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_ken_en.pdf?ua=1.
12. UNAIDS. 2014. "The Gap Report." Accessed February 2, 2015. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf.
13. UNAIDS. July 2013. "Kenya and the Global Fund and UNAIDS Signal Partnership." Press Release. Accessed February 2, 2015. <http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2013/july/20130701prkenyauaidsqf>.
14. The Global Fund to Fight AIDS, Tuberculosis and Malaria. March 2014. "Kenya Aims to Reduce Malaria Mortality by Two Thirds by 2017." Accessed February 2, 2015. http://www.theglobalfund.org/en/mediacenter/newsreleases/2014-03-31_Kenya_Aims_to_Reduce_Malaria_Mortality_by_Two_Thirds_by_2017/.
15. National AIDS Control Council. March 2014. "Kenya AIDS Response Progress Report: Progress towards Zero," 3. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/KEN_narrative_report_2014.pdf.
16. National AIDS Control Council. March 2014. "Kenya AIDS Response Progress Report: Progress towards Zero." Accessed February 2, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/KEN_narrative_report_2014.pdf.
17. AVERT. 2012. "HIV & AIDS in Kenya." Accessed February 2, 2015. <http://www.avert.org/hiv-aids-kenya.htm>.
18. Ibid.
19. National AIDS Control Council, Kenya Ministry of Health. "About NACC." Accessed February 2, 2015. http://www.nacc.or.ke/index.php?option=com_content&view=article&id=53&Itemid=126#.
20. Office of the President National AIDS Control Council, National AIDS and STI Control Programme and MAISHA. 2012. "The Kenya AIDS Epidemic: Update 2012."
21. National AIDS Control Council. March 2014. "Kenya AIDS Response Progress Report: Progress towards Zero," 2. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/KEN_narrative_report_2014.pdf.
22. UNAIDS. 2014. "The Gap Report," A9. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf.
23. National Coordinating Agency for Population and Development. "Kenya Service Provision Assessment Survey 2010." Accessed February 2, 2015. <http://dhsprogram.com/pubs/pdf/SR182/SR182.pdf>.
24. Kenya Ministry of Health. June 2014. "Kenya HIV Estimates," 4.
25. National AIDS Control Council. March 2014. "Kenya AIDS Response Progress Report: Progress towards Zero," 23. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/KEN_narrative_report_2014.pdf.
26. National AIDS Control Council. March 2014. "Kenya AIDS Response Progress Report: Progress towards Zero," 3. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/KEN_narrative_report_2014.pdf.
27. National AIDS Control Council. March 2014. "Kenya AIDS Response Progress Report: Progress towards Zero," 15. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/KEN_narrative_report_2014.pdf.
28. Office of the President National AIDS Control Council, National AIDS and STI Control Programme and MAISHA. 2012. "The Kenya AIDS Epidemic: Update 2012," Executive Summary, xi."
29. AVERT. 2012. "HIV & AIDS in Kenya." Accessed February 2, 2015. <http://www.avert.org/hiv-aids-kenya.htm>.
30. The Global Fund to Fight AIDS, Tuberculosis and Malaria. "Grant Portfolio: Kenya." Accessed February 2, 2015. <http://portfolio.theglobalfund.org/en/Country/Index/KEN>.
31. Ochero, John, Kenya Fund Portfolio Manager for the Global Fund to Fight AIDS, Tuberculosis and Malaria. Phone

- interview with Friends of the Global Fight Against AIDS, Tuberculosis and Malaria, July 22, 2014.
32. World Health Organization. 2013. "Countries: Kenya." Accessed February 2, 2015. <http://www.who.int/countries/ken/en/>.
33. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR). "Partnership Framework Between the Government of the Republic of Kenya and the Government of the United States of America to Support the Implementation of the Kenya National AIDS Response as Articulated in the Kenya National AIDS Strategic Plan III 2009/10-2012/13," 8. Accessed February 2, 2015. <http://www.pepfar.gov/documents/organization/135213.pdf>.
34. UNAIDS. January 2014. "New 'Beyond Zero Campaign' to improve maternal and child health outcomes in Kenya." Accessed February 2, 2015. <http://www.unaids.org/en/resources/presscentre/featurestories/2014/january20140130beyondzerocampaign/>.
35. Ibid.
36. AVERT. 2012. "HIV & AIDS in Kenya." Accessed February 2, 2015. <http://www.avert.org/hiv-aids-kenya.htm>.
37. The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2013. "Sustainability Review of Global Fund Supported HIV, Tuberculosis and Malaria Programmes, Final Report," 63.
38. Ibid.
39. Ibid.
40. The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2013. "Sustainability Review of Global Fund Supported HIV, Tuberculosis and Malaria Programmes, Final Report," 51.
41. The World Bank. October 2014. "Kenya Overview." Accessed February 2, 2015. <http://www.worldbank.org/en/country/kenya/overview>.
42. The World Bank. October 2014. "Rwanda Overview." Accessed February 2, 2015. <http://www.worldbank.org/en/country/rwanda/overview>.
43. Ibid.
44. Farmer, Paul E, Cameron T. Nutt, Claire M. Wagner, Claude Sekabaraga, Jonathan L. Weigel, Didi Bertrand-Farmer, Antoinette Habinshuti, Soline Mugeni Dusabeyesu, Jean-Claude Karasi, and Peter C. Drobac. 2013. "Reduced Premature Mortality in Rwanda: Lessons from Success." *BMJ* 346: f65, doi: 10.1136/bmj.f65. <http://www.bmj.com/content/346/bmj.f65>.
45. Farmer, Paul E, Cameron T. Nutt, Claire M. Wagner, Claude Sekabaraga, Jonathan L. Weigel, Didi Bertrand-Farmer, Antoinette Habinshuti, Soline Mugeni Dusabeyesu, Jean-Claude Karasi, and Peter C. Drobac. 2013. "Reduced Premature Mortality in Rwanda: Lessons from Success." *BMJ* 346: f65, doi: 10.1136/bmj.f65. <http://www.bmj.com/content/346/bmj.f65>.
46. Kayirangwa, E., J. Hanson, L. Munyakazi, and A. Kabeja. 2006. "Current trends in Rwanda's HIV/AIDS epidemic." *Sexually Transmitted Infections* 82, doi: 10.1136/sti.2006.019588. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2593071/>.
47. Ibid.
48. Ministry of Health, Republic of Rwanda. 2013. "Rwanda HIV and AIDS National Strategic Plan July 2013-June 2018," 3. Rwanda Biomedical Center. Accessed February 2, 2015. http://www.nationalplanningcycles.org/sites/default/files/country_docs/Rwanda/final_nsp_2013-2018.pdf.
49. Ministry of Health, Republic of Rwanda. 2014. "Rwanda: Global AIDS Response Progress Report (GARPR)," 22. Rwanda Biomedical Center. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/country/documents/RWA_narrative_report_2014.pdf.
50. National Institute of Statistics of Rwanda and Macro International Inc. 2012. "Rwanda Demographic and Health Survey 2010," xxv. Accessed February 2, 2015. <http://dhsprogram.com/pubs/pdf/FR259/FR259.pdf>.
51. Ministry of Health, Republic of Rwanda. 2014. "Rwanda: Global AIDS Response Progress Report (GARPR)," 51. Rwanda Biomedical Center. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/country/documents/RWA_narrative_report_2014.pdf.
52. Ministry of Health, Republic of Rwanda. 2013. "Rwanda HIV and AIDS National Strategic Plan July 2013-June 2018," 74. Rwanda Biomedical Center. Accessed February 2, 2015. http://www.nationalplanningcycles.org/sites/default/files/country_docs/Rwanda/final_nsp_2013-2018.pdf.
53. Ministry of Health, Republic of Rwanda. 2014. "Rwanda: Global AIDS Response Progress Report (GARPR)," 9-10. Rwanda Biomedical Center. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/country/documents/RWA_narrative_report_2014.pdf.
54. Ministry of Health, Republic of Rwanda. 2014. "Rwanda: Global AIDS Response Progress Report (GARPR)," 51. Rwanda Biomedical Center. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/country/documents/RWA_narrative_report_2014.pdf.
55. The Global Fund to Fight AIDS, Tuberculosis and Malaria. "Grant Portfolio: Rwanda." Accessed February 2, 2015. <http://portfolio.theglobalfund.org/en/Country/Index/RWA>.
56. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR). 2014. "Rwanda Operational Plan Report FY 2013," 3. Accessed February 2, 2015. <http://www.pepfar.gov/documents/organization/222179.pdf>.
57. Ministry of Health, Republic of Rwanda. 2014. "Rwanda: Global AIDS Response Progress Report (GARPR)," 53. Rwanda Biomedical Center. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/country/documents/RWA_narrative_report_2014.pdf.
58. Ibid.
59. Binagwaho, Agnes, Paul Farmer et al. 2014. "Rwanda 20 years on: investing in life." *The Lancet* 384, no. 9940 (July 26): 371-375. <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2814%2960574-2/abstract..>
60. Ibid.
61. Ibid.
62. Silborn, Patrik, Rwanda Fund Portfolio Manager for the Global Fund to Fight AIDS, Tuberculosis and Malaria. Phone interview with Friends of the Global Fight Against AIDS, Tuberculosis and Malaria, June 20, 2014.
63. Emery, Neal. 2013. "Rwanda's Historic Health Recovery: What the U.S. Might Learn." *The Atlantic*, February 20. <http://www.theatlantic.com/health/archive/2013/02/rwandas-historic-health-recovery-what-the-us-might-learn/273226/2/>.
64. World Health Organization. 2011. "The Abuja Declaration: 10 Years On." Accessed February 2, 2015. http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1.

65. UNAIDS. 2013. "Abuja+12: Shaping the Future of Health in Africa." http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2524_Abuja_report_en.pdf.
66. Ministry of Health, Republic of Rwanda. 2014. "Rwanda: Global AIDS Response Progress Report (GARPR)," 51. Rwanda Biomedical Center. Accessed February 2, 2015. http://www.unaids.org/sites/default/files/country/documents/RWA_narrative_report_2014.pdf.
67. The Global Fund to Fight AIDS, Tuberculosis and Malaria. February 2014. "Rwanda Pilots Innovative Financing Mechanism." Press Release. Accessed February 2, 2015. http://www.theglobalfund.org/en/mediacenter/newsreleases/2014-02-10_Rwanda_Pilots_Innovative_Financing_Mechanism/.
68. Fan, Victoria, Denizhan Duran, Rachel Silverman, and Amanda Glassman. August 2013. "Grant Performance and Payments at the Global Fund." Center for Global Development. Accessed February 2, 2015. http://www.cgdev.org/sites/default/files/Global-Fund-PBF-layout_0.pdf.
69. von Rege, Daniel. February 2014. "Rwanda and Global Fund sign a pilot results-based financing model." Aidspace. Accessed February 2, 2015. http://www.aidspace.org/gfo_article/rwanda-and-global-fund-sign-pilot-results-based-financing-mode.
70. Nyemazi, Jean Pierre. April 2014. "Summary – Rwanda: Results-Based Financing. Global Fund document." Rwanda Biomedical Center.
71. World Health Organization. 2009. "WHO Country Cooperation Strategy 2010-2015: Tanzania," 2. Accessed February 2, 2015. http://www.who.int/countryfocus/cooperation_strategy/ccs_tza_en.pdf.
72. The World Bank. October 2014. "Tanzania Overview." Accessed February 2, 2015. www.worldbank.org/en/country/tanzania/overview.
73. Ministry of Health and Social Welfare, The United Republic of Tanzania. "Health Sector Strategic Plan III (July 29 – June 2015)," 12. Accessed February 2, 2015. <http://tanzania.um.dk/en/~media/Tanzania/Documents/Health/Health%20Sector%20Strategic%20Plan%20III%20FINAL%20090408.pdf>.
74. The Global Fund to Fight AIDS, Tuberculosis and Malaria. "Grant Portfolio: Tanzania (United Republic)." Accessed February 2, 2015. <http://portfolio.theglobalfund.org/en/Country/Index/TZA>.
75. President's Malaria Initiative. "Tanzania: Malaria Operational Plan FY 2014." Accessed February 2, 2015. http://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy14/tanzania_mop_fy14.pdf?sfvrsn=10.
76. President's Malaria Initiative. "Tanzania: Malaria Operational Plan FY 2015." Accessed February 2, 2015. <http://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy-15/fy-2015-tanzania-malaria-operational-plan.pdf?sfvrsn=3>.
77. National AIDS Control Program, The Ministry of Health and Social Welfare, The United Republic of Tanzania. "HIV/AIDS in Tanzania." Accessed February 2, 2015. <http://www.nacp.go.tz/site/about/hiv-aids-in-tanzania>.
78. Ibid.
79. Tanzania Commission for AIDS, The Prime Minister's Office, The United Republic of Tanzania. "About TACAIDS." Accessed February 2, 2015. http://www.tacaids.go.tz/index.php?option=com_content&view=category&layout=blog&id=40&Itemid=52.
80. IRIN. August 2001. "Tanzania: MPs Form Anti-AIDS Advocacy Group." Accessed February 2, 2015. www.irinnews.org/report/25595/tanzania-mps-form-anti-aids-advocacy-group.
81. UNAIDS. "AIDSinfo: Tanzania." Accessed February 2, 2015. <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>.
82. Prime Minister's Office, The United Republic of Tanzania. November 2013. "Tanzania Third National Multi-Sectoral Strategic Framework (NMSF) for HIV and AIDS (2013/14 – 2017/18)," 18. Accessed February 2, 2015. http://tacaids.go.tz/index.php?option=com_docman&task=doc_download&gid=81&Itemid=142.
83. The Global Fund to Fight AIDS, Tuberculosis and Malaria. "Grant Portfolio: Tanzania (United Republic)." Accessed February 2, 2015. <http://portfolio.theglobalfund.org/en/Country/Index/TZA>.
84. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR). "Partnership to Fight HIV/AIDS in Tanzania." Accessed February 3, 2015. <http://www.pepfar.gov/documents/organization/199593.pdf>.
85. Peterson, Tatjana, Tanzania Fund Portfolio Manager at the Global Fund to Fight AIDS, Tuberculosis and Malaria. Email to Juliet Glassroth. October 15, 2013.
86. World Health Organization. "WHO African Region: Tanzania." Accessed February 3, 2015. <http://www.who.int/countries/tza/en/>.
87. Prime Minister's Office, The United Republic of Tanzania. November 2013. "Tanzania Third National Multi-Sectoral Strategic Framework (NMSF) for HIV and AIDS (2013/14 – 2017/18)," 32. Accessed February 2, 2015. http://tacaids.go.tz/index.php?option=com_docman&task=doc_download&gid=81&Itemid=142.
88. The United Republic of Tanzania. March 2014. "Global AIDS Response Country Progress Report," 30. http://www.unaids.org/sites/default/files/country/documents/TZA_narrative_report_2014.pdf.
89. World Health Organization. 2009. "WHO Country Cooperation Strategy 2010-2015: Tanzania," 2. Accessed February 3, 2015. http://www.who.int/countryfocus/cooperation_strategy/ccs_tza_en.pdf.
90. Ministry of Health and Social Welfare, The United Republic of Tanzania. "Health Sector Strategic Plan III (July 29 – June 2015)," 12. Accessed February 2, 2015. <http://tanzania.um.dk/en/~media/Tanzania/Documents/Health/Health%20Sector%20Strategic%20Plan%20III%20FINAL%20090408.pdf>.
91. Prime Minister's Office, The United Republic of Tanzania. November 2013. "Tanzania Third National Multi-Sectoral Strategic Framework (NMSF) for HIV and AIDS (2013/14 – 2017/18)," 32. Accessed February 2, 2015. http://tacaids.go.tz/index.php?option=com_docman&task=doc_download&gid=81&Itemid=142.
92. Prime Minister's Office, The United Republic of Tanzania. November 2013. "Tanzania Third National Multi-Sectoral Strategic Framework (NMSF) for HIV and AIDS (2013/14 – 2017/18)," 31-37. Accessed February 2, 2015. http://tacaids.go.tz/index.php?option=com_docman&task=doc_download&gid=81&Itemid=142.
93. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR). February 2013. "USG PEPFAR Mission Presentation, TACAIDS Conference."
94. Prime Minister's Office, The United Republic of Tanzania. November 2013. "Tanzania Third National Multi-Sectoral Strategic Framework (NMSF) for HIV and AIDS (2013/14 – 2017/18)," 31-37. Accessed February 2, 2015. http://tacaids.go.tz/index.php?option=com_docman&task=doc_download&gid=81&Itemid=142.
95. The World Bank. October

2014. "Tanzania Overview." Accessed February 3, 2015. <http://www.worldbank.org/en/country/tanzania/overview>.
96. Abbot Fund. December 2013. "Public Private Partnership for Health Care in Tanzania: Improving Muhimbili National Hospital." Accessed February 3, 2015. <http://www.abbottfund.org/project/17/68/Modernizing-Muhimbili-National-Hospital-in-Tanzania>.
97. Mburu, Shawn. 2014. "The Kilimanjaro Challenge Against HIV and AIDS 2014." 24 Tanzania. May 2. <http://24tanzania.com/the-kilimanjaro-challenge-against-hiv-and-aids-2014/>.
98. The Global Fund to Fight AIDS, Tuberculosis and Malaria. June 2014. "Project Last Mile Expands to Improve Availability of Medicines." Press Release. Accessed February 3, 2015. http://www.theglobalfund.org/en/mediacenter/announcements/2014-06-23_Project_Last_Mile_Expands_to_Improve_Availability_of_Medicines/.
99. Population Reference Bureau. April 2004. "Zimbabwe's Political and Economic Problems Hinder Effective Response to AIDS." Accessed February 3, 2015. <http://www.prb.org/Publication/s/Articles/2004/ZimbabwesPoliticalandEconomicProblemsHinderEffectiveResponseToAIDS.aspx>.
100. World Health Organization. "National Guidelines for TB/HIV Co-Management." Accessed February 3, 2015. <http://www.who.int/hiv/pub/guidelines/zimbabwe.pdf>.
101. World Health Organization. "Global Tuberculosis Report 2014: Annex 2," 146. Accessed February 3, 2015. http://www.who.int/tb/publications/global_report/gtbr14_annex2_country_profiles.pdf?ua=1.
102. World Health Organization. "World Malaria Report 2014." Accessed February 3, 2015. http://www.who.int/malaria/publications/world_malaria_report_2014/wmr-2014-profiles.pdf?ua=1.
103. Ibid.
104. UNAIDS. "Global AIDS Response Country Progress Report: Zimbabwe 2014." Accessed February 3, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/ZWE_narrative_report_2014.pdf.
105. The Global Fund to Fight AIDS, Tuberculosis and Malaria. "Grant Portfolio: Zimbabwe." Accessed February 3, 2015. <http://portfolio.theglobalfund.org/en/Country/Index/ZWE>.
106. UNAIDS. "Global AIDS Response Country Progress Report: Zimbabwe 2014." Accessed February 3, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/ZWE_narrative_report_2014.pdf.
107. UNAIDS. "Zimbabwe: HIV and AIDS estimates (2012)." Accessed February 3, 2015. <http://www.unaids.org/en/regionscountries/countries/zimbabwe/>.
108. Key Population Challenge Fund. "Summary of USG Key Population Challenge Fund in Zimbabwe." The U.S. President's Emergency Plan for AIDS Relief (PEPFAR).
109. Key Population Challenge Fund. "Summary of USG Key Population Challenge Fund in Zimbabwe." The U.S. President's Emergency Plan for AIDS Relief (PEPFAR).
110. UNAIDS. "Global AIDS Response Country Progress Report: Zimbabwe 2014." Accessed February 3, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/ZWE_narrative_report_2014.pdf.
111. Ibid.
112. Ibid.
113. Ibid.
114. Bhat, Nisha, Peter Kilmarx, Tapuwa Magure, Freeman Dube, Albert Manenji, and Medelina Dube. June 2013. "Zimbabwe's National AIDS Trust Fund (AIDS Levy): A Case Study." PowerPoint Presentation. National AIDS Council of Zimbabwe.
115. UNAIDS. "Global AIDS Response Country Progress Report: Zimbabwe 2014." Accessed February 3, 2015. http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/ZWE_narrative_report_2014.pdf.
116. Manenji, A. "Legal Provision Governing Earmarked Public Funds in Zimbabwe." PowerPoint Presentation. National AIDS Council of Zimbabwe.
117. Bhat, Nisha, Peter Kilmarx, Tapuwa Magure, Freeman Dube, Albert Manenji, and Medelina Dube. June 2013. "Zimbabwe's National AIDS Trust Fund (AIDS Levy): A Case Study." PowerPoint Presentation. National AIDS Council of Zimbabwe.
118. Ibid.
119. Hanene, Thuleti Tikili. August 2012. "Zimbabwe's AIDS Levy blue print for future HIV funding." HIV/AIDS/Zimbabwe Charity, INC. Accessed February 3, 2015. <http://www.hivaidszimbabwe.org/zimbabwes-aids-levy-blue-print-for-future-hiv-funding/>.
120. National AIDS Council of Zimbabwe. "Zimbabwe National AIDS Trust Fund (AIDS Levy), HIV and AIDS Domestic funding of the national response to HIV and AIDS: A success initiative in a constrained economic environment." Accessed February 3, 2015. <http://www.nac.org.zw/sites/default/files/The%20Story%20So%20Far%20.pdf>.
121. Ministry of Health and Child Welfare. "Rebuilding Health Services after a Health Workforce Crisis in Zimbabwe." Global Health Workforce Alliance. Accessed February 3, 2015. <http://www.who.int/workforcealliance/forum/2011/hrhawardscs18/en/>.
122. Kilmarx, Peter, Director of CDC Zimbabwe. Phone interview with Friends of the Global Fight Against AIDS, Tuberculosis and Malaria, July 8, 2014.
123. The Global Fund to Fight AIDS, Tuberculosis and Malaria, Office of the Inspector General. May 2013. "Audit of Global Fund Grants to the Republic of Zimbabwe." Accessed February 3, 2015. http://www.theglobalfund.org/documents/oig/OIG_GFOIG13012AuditZimbabwe_Report_en/.
124. United Nations Development Programme. "Global Fund Increases Support to Zimbabwe." Accessed February 3, 2015. http://www.zw.undp.org/content/dam/zimbabwe/docs/hivaids/UNDP_ZW_HIVAIDS_Global%20Fund%20Support%20Zw.pdf.
125. Mwangala, Perry, Zimbabwe Fund Portfolio Manager for the Global Fund to Fight AIDS, Tuberculosis and Malaria. Phone interview with Friends of the Global Fight Against AIDS, Tuberculosis and Malaria, June, 24, 2014.
126. Kilmarx, Peter, Director of CDC Zimbabwe. Phone interview with Friends of the Global Fight Against AIDS, Tuberculosis and Malaria, July 8, 2014.
127. Chinamasa, Patrick. December 2013. "The 2014 National Budget Statement: Towards an Empowered Society and a Growing Economy." Ministry of Finance and Economic Development. Accessed February 3, 2015. <https://www.newsday.co.zw/2013/12/19/2014-zimbabwe-national-budget-full-document/>.
128. Yekeye, Raymond, Programme Director at National AIDS Council of Zimbabwe. Phone interview with Friends of the Global Fight Against AIDS, Tuberculosis and Malaria, July 10, 2014.
129. Ibid.
130. Ibid.

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