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THE UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

NATIONAL MULTISECTORAL HIV PREVENTION STRATEGY

2009-2012

'Towards achieving Tanzania without HIV'

November 2009

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NB: To include Foreword, Acknowledgement, Executive Summary before Introduction

List of Abbreviations

ART	Antiretroviral therapy
ARV	Antiretroviral drugs
CBOs	Community-based Organisations
CDC	Centres for Disease Control and Prevention (USA)
CHAC	Council HIV and AIDS Coordinator
CHMT	Council Health Management Team
CSOs	Civil Society Organisation
EGPAF	Elizabeth Glazier Paediatric AIDS Foundation
FBO	Faith-based organizations
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HCT	HIV Counselling and Testing
HCWs	Health Care workers
HSHSP	Health Sector HIV/AIDS Strategic Plan
HSV-2	Herpes Simplex virus type 2
IDUs	Injecting Drug Users
MARP	Most-at-risk Population Groups
MDA	Ministries, Departments and Agencies
MDG	Millennium development Goals
MLEYD	Ministry of Labour, Employment and Youth Development
MoCDGC	Ministry of Community Development, Gender and Children
MoEVT	Ministry of Education and Vocational Training
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MSM	Men who have sex with men
NACP	National AIDS Control Programme
NASA	National HIV/AIDS Spending Assessment
NBTS	National Blood Transfusion Service
NGOs	Non-governmental organizations
NHA	National Health Accounts
NMSF	National Multi-sectoral Strategic Framework
PEP	Post-exposure prophylaxis
PEPFAR	US Presidents Emergency Plan for AIDS Relief
PICT	Provider-initiated Counselling Testing
P-TWG	HIV Prevention Technical Working Group
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RMAC	Regional Multisectoral AIDS Coordinators
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic and Health Surveys
THIS	Tanzania HIV/AIDS Indicator Survey 2003-04
THMIS	Tanzania HIV/AIDS Malaria Indicator Survey 2007-08
TOMSHA	Tanzania Output Monitoring system for non-medical HIV and AIDS
TSPA	Tanzania service Provisions Assessment, 2007
UNCT	United Nations Country Team
UNGASS	United Nations General Assembly Special Session on AIDS
USG	United States Government
VCT	Voluntary HIV Counseling and Testing
VNRBD	Voluntary Non-remunerated blood donors
SGBV	Sexual and Gender-based Violence

Glossary of Terms and Concepts

Sex worker: This refers to individuals who receive money or goods in direct exchange for sexual services, either regularly or occasionally. In this document, this refers to people who self-identify themselves as sex workers. People who receive money or goods as part of a sexual act, but do not perceive themselves to be sex workers, are engaged in Transactional Sexual Relationships.

Cross-Generational Sex: This refers to relationships between older men and younger women, though some cross-generational relationships include older women and younger men. Some studies define age-mixing in sexual relationships as women aged 15-19 who report sex in the last 12 months with a man 10 years or more older than themselves and with whom they are not married or cohabiting.

Gender-Based Violence (GBV): This is defined as any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females

Locus of Control: Refers to the extent to which a person believes the current and anticipated circumstances, and its response to them (behavior), are within his or her control.

Most-At-Risk Populations (MARPs): These are populations most often considered to be at an elevated risk for HIV. These populations engage in illicit or socially stigmatized behaviors and are at disproportionately higher risk for HIV. HIV may spread rapidly in these populations, due to more frequent participation in high risk behaviors such as unprotected anal and vaginal sex, sharing of injection equipment, and the overlap of risk behaviors and sexual networks (such as sex workers who use drugs or MSM who sell sex). These populations include sex workers, clients of sex workers, drug-using populations, and men who have sex with men.

Risk: the probability that a person may acquire HIV infection

Risk Factor: Refers to an aspect of personal behaviour or life-style or an environmental exposure which on the basis of epidemiological evidence is known to be associated with HIV transmission or acquisition

Risk Perception: Refers to the subjective belief held by an individual, group, or society about the chance of occurrence of a risk or about the extent, magnitude, and timing of its effects.

Self-Efficacy: the belief a person has in him/herself that he or she has the skills and abilities necessary for performing a behavior under a number of circumstances.

Vulnerability: results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection

1. Introduction

The National HIV Prevention Strategy for Tanzania Mainland aims to guide comprehensive multi-sectoral HIV prevention efforts of all stakeholders during the expanded phase of HIV prevention in the country. Several national level programme reviews of Tanzania's HIV/AIDS response identified the need for a comprehensive HIV prevention strategy to guide accelerated HIV prevention efforts in the country. The recommendations concluded that it is critical for Tanzania to have comprehensive HIV prevention strategy that is based on current knowledge of what is driving the epidemic and targeting population groups where the majority of new infections are occurring. This was felt to be particularly vital in view of the fact that, despite 25 years of HIV prevention in the country, the rate and numbers of new infections (over 200,000 annually) is still very high. This situation means that the current prevention interventions are not having the desired impact and in the long run, will overwhelm efforts to provide care and treatment of people living with HIV.

The Government of Tanzania is committed to re-invigorated HIV prevention in order to drastically reduce the rate and numbers of new HIV infections. This commitment toward HIV prevention is reflected in the second National Multi-Sectoral HIV and AIDS Framework 2008-2013 (NMSF II), which was developed in 2007. This HIV prevention strategy is closely aligned to the NMSF II, and is designed to guide the implementation of the NMSF II's HIV prevention component. In turn, the NMSF II supports the National Health Policy (2007), The National HIV/AIDS Policy (2001), the National Strategy for Growth and Poverty Reduction (NSGPR – MKUKUTA 2005-10), and the Health Sector Strategic Plan (HSSP 2009-15).

The major emphasis of *The National HIV Prevention Strategy* is to bring to full scale proven and prioritized HIV prevention interventions that address the drivers of the epidemic, while ensuring that disproportionately affected population groups are provided with appropriate HIV prevention efforts. It is designed to provide stakeholders involved in a wide range of HIV prevention, care, treatment, and support programs with guided reference for the prevention of new HIV infections. These stakeholders are varied, and each plays a critical role in HIV prevention. They include policy makers, community leaders, government ministries, community based organizations, local governments, people living with HIV/AIDS, faith-based organizations, the private sector, and development partners. It is only by working together that we can stem the growth of the HIV epidemic.

The National HIV Prevention Strategy was based on a thorough review of HIV epidemiology in Tanzania (magnitude, trends and drivers) and current HIV prevention response (HIV prevention programmes and resources). The alignment of existing HIV prevention efforts and the prevailing drivers of the epidemic were assessed. The gaps identified formed the basis for recommendations that informed the design of the strategy. The latest data, especially that from the recently concluded 2007-08 Tanzania HIV/AIDS and Malaria indicator Survey (2007-08 THMIS) and the 2007 Tanzania Services Provision Assignment (2007- TSPA) was used to document the prevailing epidemiology and

coverage of HIV prevention in the country. A separate report of this review is available, entitled "*A Review of HIV Epidemiology and HIV Prevention Programmes and Resources in Tanzania Mainland*".

To ensure a comprehensive response, *The National HIV Prevention Strategy* addresses both biomedical and behavioural factors that facilitate HIV transmission, as well as their underlying socio-cultural, socio-economic and other structural factors that influence them. This document consists of five main sections. In section 2, we first highlight the mission, visions, and strategic objectives of HIV prevention in the NMSF II, followed by background information on the HIV epidemic in Tanzania including the factors currently driving the epidemic and most affected population groups in section 3. In section 4, the coverage and scope of existing HIV prevention in Tanzania is briefly summarized. In Section 5, the main outcomes of the HIV prevention strategy, the strategic priorities and priority actions for the first two years are elaborated. The cross cutting issues of strategic information for HIV prevention as well as coordination are also summarised. In Section 6, the implementation arrangements for HIV prevention are summarized with emphasis on coordination and monitoring and evaluation. The two year action plan, the design summary and HIV prevention monitoring indicators and targets are presented as annexes 1-2. The two year action plan 2009/10-2010/11 guides the implementation of prioritized activities during the immediate term. A separate annex 4 documents the costing of the 2-year action plan.

The Government of Tanzania calls upon all stakeholders to support this strategy, and make the reduction of new HIV infections a historic success, involving all Tanzanians, adults and youth, married and unmarried, HIV positive or HIV negative. The prevention of HIV infection concerns everyone, and together we can make a difference.

2. Mission, Vision, and Guiding Principles

The National HIV Prevention Strategy for Tanzania Mainland is based on the nine main strategic HIV prevention objectives stated in the National Multi-Sectoral HIV/AIDS Strategic Framework.

The National HIV Prevention Strategy's vision is consistent with that of the NMSF: ***a Tanzania with no new HIV infections***[1]**.** The goal is to serve as a resource to stakeholders to strengthen planning, implementation, and monitoring of their HIV prevention programs which will significantly reduce new infections by 25% by 2012.

The mission is to intensify and scale up high quality, evidence-based, and universally accessible HIV prevention initiatives within a multi-sectoral response that is led by the central government, anchored at local government councils, rooted in communities, and implemented with the participation of all Tanzanians.

The following principles of effective HIV prevention[2] have been taken into account during the development of this Strategy:

- The success of HIV prevention depends on good governance in the design and implementation of interventions
- Responsibility and accountability are key to achieving high quality, universally accessed HIV prevention interventions
- The promotion, protection, and respect for human rights is a basic right of the people of Tanzania
- The prevention of HIV infections needs the involvement and participation of the entire society
- The prevention of HIV infection is a national priority, and an integral part of the development policy of the country, supported by strong political and government commitment
- The human rights of PLHIV are respected and their active participation in HIV prevention policy development, programming and implementation of interventions is required
- Interventions are based on scientifically and ethically sound approaches ("best practices"), respecting the values and cultural diversity of the people while promoting gender equity
- Programmes and interventions are "people-centered", empowering communities, families and individuals to develop their own responses to challenges and threats of HIV/AIDS, and to learn from the experiences of other stakeholders in similar areas

The NMSF II's HIV Prevention Strategic Objectives

1): Empower young people with knowledge and skills to dialogue about sexuality; adopt attitudes and practices that protect against HIV infection.

2): Reduce risk of infection among those most vulnerable due to gender inequality, sexual abuse, and socio-cultural factors.

3): Increase the proportion of public, private, and informal sector enterprises developing and implementing comprehensive workplace interventions with attention to mobile workers.

4): Expand quality, gender responsive and youth friendly STI services including counseling and condom promotion to all health facilities and enhance utilization of services.

5): Increase the number of people who know their HIV status and who adopt appropriate measures to protect themselves and their partners from HIV.

6): Reduce the transmission of HIV from mothers to their children, during pregnancy, birth and/or breast-feeding and ensure entry into care and treatment for HIV-infected mothers and babies.

7): Increase the proportion of the sexually active adults especially in rural areas, who use condoms consistently and correctly and promote and expand the availability of female condoms as a female controlled and dual protection method.

8): Reduce the risk of HIV transmission through blood, non-observance of universal precautions, and through use of contaminated instruments.

9): Emerging prevention interventions are introduced based on international scientific evidence.

[1] The Prime Ministers Office: The Second National Multi-sectoral Strategic Framework on HIV and AIDS, 2008-2012:, October 2007
[2] UNAIDS: Intensifying HIV Prevention: UNAIDS Policy Position Paper. Geneva, Switzerland, August 2005

3. Background

A detailed description of Tanzania Mainland's HIV/AIDS epidemic can be found in the accompanying document "*Review of HIV Epidemiology and HIV Prevention Programmes and Resources in Tanzania Mainland*". Tanzania Mainland's HIV/AIDS epidemic is mature, generalized, and heterogeneous. The predominant mode of HIV transmission in the country is via heterosexual contact between HIV-infected and uninfected individuals, accounting for approximately 80% of infections. Vertical infections from mothers to newborns and medical transmission account for 18% and 1.8% of infections, respectively.

Within the generalized epidemic, there are socio-economic and demographic subgroups of the population with disproportionately higher risk, vulnerability, and HIV prevalence. For instance, women are more disproportionately affected across reproductive age-groups than men, and older adults aged over 30 years are more likely to be infected than younger age groups. Individuals that are either in marital union or were formerly married have higher HIV infection rates as do individuals living in more wealthy households. Most at risk populations (MARPs) include transactional sex workers, and their clients, men and women who work away from home (such as transportation workers or miners), men who have sex with men (MSM), and injecting drug users (IDUs) and other substance abusers.

Tanzania has had some recent decline in national HIV prevalence. Between 2003 -2008, the overall adult prevalence rate fell from 6.7% to 5.7% (from 6% -5% for men; 8%-7% for women)[3]. Declines in HIV prevalence were also observed among antenatal women and blood donors[4].

These HIV prevalence trends correlate with trends in some HIV transmission risk behaviors as well. For example, among adults aged 15-49 years, casual sex with non-marital, non-cohabiting partners declined from 46% to 29% among men, and from 23% to 16% among women.

A Snapshot of the HIV/AIDS Epidemic in Tanzania

- 4.6% of men and 6.6% of women ages 15-49 are infected
- ANC prevalence: 8.2%
- About 1.5 million Tanzanians are infected, of which approximately 10% are children
- Urban areas have a higher HIV prevalence than rural areas (9% versus 5%)
- The region with the lowest and highest HIV prevalence:
  - Kigoma: 1.2%

Nonetheless, many challenges still exist in Tanzania's effort to achieve reduction in new HIV infections. It is estimated that over 200,000 Tanzanians are infected with HIV each year. This can be attributed in part to widespread risky behaviors. For example, in 2008, 18% of men and 3% of women reported having had multiple sexual partners in the previous year[5], and 29% of married or cohabiting men, and 16% of such women, had had extramarital sex.

[3] 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)
[4] NACP, MoHSW: HIV/AIDS STI Surveillance Report, Report Number 19, October 2005
[5] United Republic of Tanzania, UNGASS 2008 Report: Country Progress Report

Although condom use during casual sex increased from 38% to 43% among women and 50% to 53% among men aged 15-49 years during 2003-2008, less than half of the individuals who engaged in these risky sexual acts used condoms at their last encounter.

There is no data on the HIV transmission risk behaviors of HIV-infected individuals, however, 8% of married or cohabiting couples are in HIV-discordant relationships and 67% of HIV-infected individuals have HIV-negative partners. These HIV negative partners are at immediate risk of HIV infection.

There is a growing recognition that gender norms and gender-based violence are some of the most influential factors driving HIV transmission worldwide. Evidence shows that gender-based violence in the form of coerced sex or rape increases the risk of HIV infection for young girls and women; HIV positive women are more than twice as likely as HIV negative women to report physical and sexual violence. However, gender-based violence is widely considered to be an acceptable social norm even among women; for example, 41% of Tanzanian women in Dar es Salaam believe that male violence is justified when women are disobedient, unfaithful, or haven't completed the housework. 16.8% feel that fear of HIV infection is an inadequate justification for refusing sex. Nonetheless, the fear of violence prevents women from reporting acts of violence to authorities, or in negotiating protective measures against HIV infection. For similar reasons, many women, especially married ones, do not disclose their HIV status to partners, family members, and communities due to fear of being physically and emotional abused. At the same time, a gender-sensitive approach to HIV prevention must be careful not to further enhance risk of infection; for example, some evidence suggests that the empowerment of women can actually lead to more multiple partnerships.

4. HIV Prevention in Tanzania Mainland

In support of the NMSF II's strategic objectives, Tanzania's current HIV prevention approach is based on multiple HIV prevention approaches, comprising of behavioural and biomedical initiatives for both the general population and for specific vulnerable groups. Woven into these interventions are programs that address the underlying social values and norms that drive the epidemic, including gender norms, gender based violence, and stigma.

Behavioral initiatives include communications programs designed to reduce risky behaviors, including multiple partnering, low condom use, and mixed-aged relationships. The biomedical services include the prevention of mother to child transmission (PMTCT), HIV counseling and testing, management of sexually transmitted infections (STIs), blood transfusion and injection safety, and post-exposure prophylaxis (PEP) for post-rape and occupational exposure. New initiatives being added to the national HIV prevention repertoire include prevention with positives[6] (PwP), adult male circumcision, and IDU services. Some programmes implement a number of initiatives to address structural and underlying factors, such as gender norms, harmful socio-cultural practices, and gender based violence.

There has been recent increase in the coverage of most biomedical interventions. For instance, the proportion of individuals who have ever tested for HIV and know their status recently increased from 15% of men and women in 2003 to 37% of women and 27% of men in 2008. In fact, about half of individuals who have ever tested for HIV in the country did so in the previous 12 months; a testimony to Tanzania's focus on promoting counseling and testing. The proportion of antenatal mothers accessing PMTCT services increased from virtually none, nine years ago to 61% in 2008. Services for STI management are available in 61% of public and private facilities, and the numbers of male condoms procured and distributed in the country increased from 50 million in 2003 to 150 million in 2006.

HIV prevention in Tanzania is implemented by a wide range of stakeholders, including line Ministries and their networks at regional, district and sub-district levels, international and national NGOs, CBOs, the private sector, PLHIV networks, research institutions, and international development partners.

In addition to distinct HIV prevention programs, there are efforts at varying levels of coverage to integrate HIV prevention into other ongoing health services and other development programs. Such linkages include integration of HIV prevention into sexual and reproductive health services, life skills education, primary health care, and HIV/AIDS care, treatment and support, although coverage is still suboptimal.

Resources for HIV/AIDS have increased tremendously in recent years, from TShs 226 billion in 2005/06 to TShs. 595.7 billion in 2007/08. Most of this funding comes from external multilateral and bilateral sources. The National AIDS Spending Assessment (NASA; 2005/06) indicated that funding for HIV prevention accounted for approximately 31% of total HIV/AIDS resources, though the National Health Accounts (NHA) for the same period reported approximately 42% of HIV/AIDS resources were used for

[6] It has been suggested that the term "Prevention with positives (PwP)" be replaced by " Positive, Health, Dignity and Prevention (PHDP)". However, in this document, the old term has been retained.

HIV prevention. Overall, there has been an absolute increase in HIV prevention resources as well as increase in relative share of HIV prevention.

Nonetheless, despite the recent decline of HIV prevalence on a national level, there are still many issues and challenges for Tanzania's HIV prevention efforts. ***The most important issue is the inconsistent alignment of HIV prevention programmes to the drivers of the epidemic, including intervention content as well as geographic and audience targeting.*** This means that many initiatives are achieving only a fraction of their potential.

Although HIV prevention efforts have resulted in high levels of awareness of HIV/AIDS, prevention, and availability of services, many interventions still focus on building knowledge levels. Although knowledge is a pre-determining factor in HIV prevention, there is no statistical association between high knowledge levels and behavior change. This is demonstrated in the data showing that educated, wealthy, and urban residents are more likely to be knowledgeable about HIV prevention, but have higher rates of risk-taking behaviour and HIV infection. The challenge continues to be implementing workable interventions that translate knowledge into factors that influence behavior change, such as risk perception and self-efficacy (the belief that an individual has in himself/herself the ability to perform a specific behavior).

The coverage of biomedical services remains uneven and is not yet universal. Notwithstanding the current success in HIV testing, more than 60% of Tanzanians ages 15-49 do not know their HIV sero-status, much less test continuously. More than 40% of antenatal mothers do not have access to PMTCT services, and the uptake of ARV prophylaxis by HIV-exposed infants and HIV-infected antenatal mothers is less than 50%. About one-one third of STI clients are not appropriately managed according to national guidelines, nor are they provided with preventive counseling on condom use and partner notification, and less than half receive counseling and testing. Less than half of blood transfused in the country is channeled through the national quality assured system, while only 5% of facilities met the minimum requirement for infection control in health facilities in 2007.

Another challenge is the inconsistency of implementing behavioral interventions to a defined standard of technical approach and quality. Most of the biomedical service interventions are based on national policies and technical guidelines that are evidence-based and regularly updated. This includes the technical guidelines for HCT, PMTCT, STI management and guidelines for blood transfusion. However, condom promotion and many behavioral interventions are not based on up-to-date national technical policies, guidelines, or communication strategies. These policies and guidelines do not exist on a national level, and state of the art direction from normative agencies is often not followed. Although many partners do align their messages to epidemic drivers and target audiences in an appropriate manner, this best practice is applied inconsistently across initiatives, and coverage is limited.

Another challenge is the availability of funding for HIV prevention. Although Tanzania experienced a dramatic increase in funding levels during the past few years, on a global level funding for HIV prevention is expected to remain constant or decrease. Donors and national governments have

promised treatment for life for people on ART, which adds further pressure on HIV prevention resources[7].

Other challenges include:

- The lack of prioritized strategies to address HIV prevention within Tanzania Mainland
- Incomplete geographic coverage of HIV prevention initiatives and services, including programs that target underlying drivers such as social and gender norms
- The inconsistent definition of and provision of minimum packages of HIV prevention services targeted to specific audiences, ensuring that individuals have access to a comprehensive, high quality range of appropriate services
- The lack of standards, guidelines, or communications strategies for behavioral interventions, including those targeting MAPRs
- The need for data, disaggregated by age and sex, on HIV incidence in order to understand the evolving nature of the HIV epidemic and track programme outcomes
- The uneven use of behaviorally-sound interventions to translate high knowledge levels into actual positive behavior change
- The lack of human capacity in behavioral interventions for HIV prevention, including behavior change communications
- Achieving the appropriate mix and utilization of interpersonal and mass media communications approaches, with incorporated interactive elements
- The lack of a thorough integration of HIV prevention services into existing facility- and community-based facilities and programs
- The inconsistent use of data for program design, tracking/monitoring, and evaluation, including the evaluation of HIV prevention interventions to understand impact
- Insufficient coordination between public, private, and civil society partners at the national, regional, district, and community levels
- The need for sustainable public, private, and community partnerships in all HIV prevention efforts

[7] The World Bank: The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact. Conference Paper, July 8, 2009

5. HIV Prevention Strategies and Priority Actions

Tanzania is within a generalized epidemic, but with geographic hotspots typical of a concentrated epidemic, as well as MARPs with risk behaviors that make them more vulnerable than the general population. *The National HIV Prevention Strategy* provides guidance on how to target efforts in line with the drivers of the epidemic in Tanzania Mainland. The specific focus of the strategy is on behavioural, biomedical and structural drivers of the epidemic as well as cross cutting issues such as coordination and strategic information for HIV prevention. This strategy will lead to the attainment of the following outcomes that are consistent with the NMSF II's HIV prevention strategic objectives:

i. Increased adoption of safer sexual behaviors and reduction in risk taking behaviors.
ii. A strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic.
iii. Increased coverage, quality and utilization of HIV prevention services
iv. Risk reduction among other most-at-risk populations that have a potential for increased HIV transmission
v. Strengthened information systems for planning, monitoring, and evaluation of HIV prevention.
vi. Strengthened coordination of HIV prevention programmes

Priorities for HIV Prevention

One of the first priorities for HIV prevention in Tanzania is to align HIV prevention programmes to the drivers of the epidemic. Right now, in Tanzania Mainland, approximately 80% of HIV infections arise from sexual contact between HIV-infected and uninfected individuals. Vertical infections from mothers to newborns represent 18% of HIV infections, and medical transmission for 1.8%. Less than 1% of infections might be due to IDU, homosexual, or anal transmissions, although there are no data on these forms of transmission. In line with this, the priority for Tanzania is to adequately address the key driver of the Epidemic which is HIV transmission through unprotected sex. The priority interventions are reducing multiple and concurrent sexual partnerships in order to reduce "unsafe sex" (i.e. multiple partnerships, early debut especially for young girls, cross-generational sex and transactional sex.) In addition, making "unsafe sex" safer through condom promotion/distribution and increased male circumcision should be accorded priority. Furthermore, gender/socio-cultural/structural constructs that facilitate sexual transmission of HIV in Tanzania should be concurrently addressed. Other priority interventions incude scaling up high quality HIV prevention services comprising of PMTCT, medical infection control, HCT, blood transfusion safety and STI control. Finally, specific behaviors within populations that are not well understood, such as MSM or IDUs, might play an increasingly important role in driving the epidemic, thus the need for more research and monitoring.

It is appreciated that epidemic patterns evolve, and it is possible that factors that drive today's epidemic will change in the future. Therefore, monitoring the dynamics of the epidemic should be paramount

The National HIV Prevention Strategy **is a living document,** and stakeholders will provide further prioritization based on emerging data, results, best practices, and lessons learned. The strategy should evolve as HIV prevention initiatives themselves evolve. The Immediate priorities include:

Drivers of epidemic and target audiences:

Multiple sexual partners	▪ At risk adults and youth who have more than one sexual partner ▪ Youth/partners in cross generational sexual relationships ▪ Men and women engaged in commercial sex ▪ Men and women who work away from home (transportation workers, migrant workers, the uniformed services)
Vertical transmission	▪ Parents who plan to have children, or who are pregnant
Geographic areas:	
High prevalence areas	▪ Regions with high HIV prevalence such as Iringa, ▪ Epidemic hotspots: transport corridors, borders crossing points ▪ Urban areas
Structural drivers:	
Societal norms	▪ Gender norms that promote values of masculinity & femininity ▪ Gender-based violence ▪ Widespread acceptance of multiple sexual partnerships
Individual factors	Including, but no exclusive to: ▪ Inaccurate risk perception ▪ Low self efficacy ▪ Low locus of control
Substance abuse	▪ Alcohol and other substance abuse ▪ Injecting drug users

The Minimum Package of HIV Prevention Services

A minimum package of HIV prevention services is designed to offer individuals a priority evidence-informed set of services. Since it is not expected that one organization or partner will provide all services in the package to a target audiences, it is critical to establish and maintain functioning coordination and referral systems at the national, district, and community levels within and between sectors.

For a generalized epidemic, the HIV prevention interventions must be woven into existing systems and structures, and comprises a comprehensive service package supported by widespread mass media. The minimum package of HIV prevention services include behavior change communication (BCC) integrated into structural responses (workplace, schools, community groups, FBOs) and outreach, supported by mass media campaigns, HIV counseling and testing (HCT), condom distribution, STI screening and treatment, male circumcision, prevention for HIV-positives, prevention of medical transmission, PEP, PMTCT, and supporting policy, advocacy, and community mobilization.

For MARPs and populations in geographic hotspots, the HIV prevention programmes should be mainly **out-reach based**. The minimum package of HIV prevention services for this

The Minimum Package of Prevention Services for At-Risk Adults

- Behavior change communication integrated into existing structures (religious institutions, work places, school, etc)
- Messages and social norms promoted through mass media
- HIV counseling and testing
- Condom promotion
- STI screening and treatment
- Male circumcision
- HIV care and treatment
- PMTCT
- Blood, injection, and bio-safety
- Supporting policy and advocacy

group should comprise of BCC focused on outreach services to MARPs, HCT, targeted media, condom distribution, STI screening and treatment, and referrals to HIV prevention, care and treatment services.

Based on the prioritization of strategies and approaches, stakeholders must review and codify minimum packages of services for specific target audiences. This includes service packages for:

- Most at risk adults engaged in multiple partnerships
- Sexually active youth, with a focus on those engaged in cross-generational and transactional sex
- MARPs, including sex workers, military, transport workers, MSM, and IDUs

Expanding the quality and coverage of Behaviour Change Communication:

Whether or not partners implement behavioral modification initiatives or work in HIV prevention service delivery, behavior change communications are a fundamental programme element. However, many BCC programmes are not implemented to international standards, thus realizing only a fraction of their potential. Many BCC interventions in Tanzania focus on building HIV/AIDS knowledge levels, including knowledge of the availability of HIV prevention, care, and treatment services. Although an important first step, high knowledge levels are not enough to foster behavior change.

Programmes often focus more on implementation of BCC (such as drama, or life skills and workplace programs) than on the ***content*** to be disseminated through these channels. Programmes must translate the prevailing high knowledge levels into factors that influence behavior change, including accurate risk perception and self-efficacy, and design interventions that incorporate these elements. Formative research is required to help identify and find solutions for barriers to behavior change.

It is also vital to develop an appropriate mix of communications channels, balancing mass media and interpersonal communication. Mass media is effective in influencing social norms, and transmitting brief but powerful messages. Interpersonal communication is critical for thorough processing of culturally-adapted messages and activities designed to influence risk perception, self-efficacy, and skills at community and individual levels. This requires coordination and systems to align messages to target audience and drivers of the epidemic, coordinate the mix of communication messages, build capacity in the design and implementation of behaviorally-sound programs, and manage quality assurance systems.

The following outlines the strategies and priority actions for HIV prevention in Tanzania Mainland

5.1 Increased adoption of safer sexual behaviors and reduction in risk taking behaviors:

Increased adoption of safer sexual behaviour and reduction of risk taking behaviour will be realized through expanding the coverage and scope of the existing behavioural interventions, with specific focus on multiple partnerships, transactional sex, early sexual debut, cross generational sex, and condom use.

Reducing Multiple partnerships:

Multiple concurrent sexual partnerships are perhaps the leading driver of the HIV epidemic in Tanzania. Multiple concurrent partnerships occur in several forms, including extramarital and casual sexual relationships. Cross-generational and transactional sex can also be forms of multiple concurrent partnerships, and are addressed separately below. Multiple concurrent partnerships in Tanzania are

driven by complex socio-cultural male and female gender norms, but are also influenced by other factors, including frequent travel, working away from home and peer pressure.

Current sexual behavioral modification programmes in Tanzania do not sufficiently focus on this leading driver of the HIV epidemic in the country. For example, there are no standardized or adapted guidelines and tools, or reinforcing messages, to support behavioural interventions addressing partner reduction or mutual fidelity. There are also no annualized national-level targets and benchmarks, or well-coordinated and clearly defined priorities and strategies in this area. Messages around partner reduction are not often clear or not tailored to specific target audiences or partner type within cultural contexts. Often they do not address the root causes of these behaviors or the underlying social norms. In addition, Tanzanians may not thoroughly appreciate the risk of being connected to sexual networks.

Therefore, one of the main priorities for *The National HIV Prevention Strategy* is to promote reduction in the number of sexual partners, and increase mutual fidelity in both marriage and other types of relationships. This is a complex behavioral goal, requiring changes in sexual behaviors, and social values and norms that support and reinforce this sort of behavior.

Multiple Concurrent Partnerships

According to the 2007/8 THMIS:

3% of women and 27% men reported having more than one sexual partner in the previous 12 months

HIV prevalence increases with the number of sexual partners over a lifetime:

- HIV prevalence of 1.4% / 3% among men/ women with ONE life-time sexual partner
- HIV prevalence of 11.4% / 21.5% among men/ women with 10 or more life-time sexual partners

A results-oriented approach toward long term partner reduction and mutual fidelity require coordination at the national, regional, district, and community levels. Initiatives addressing this issue must include the following elements:

- Be based on a rapid but rigorous review of the social context and range of existing behaviors, as well as the root causes that drive these behaviors
- Construct messages that modify existing social norms and address factors that influence personal choices, such as risk perception and behavioral determinants including alcohol use and wealth
- Embed approaches within an appropriate package of HIV prevention services targeted to the specific audience, such as at-risk adults, youth, or MARPS
- Reinforce messages though many channels (such as mass media, community-level, person-to-person, in-school, etc) including all available clinical arenas (such as VCT, PMTCT, CT, and MC).
- Integrate partner reduction messages into as many existing multi-sectoral programs as possible in order to achieve widespread breadth and depth
- Engage national, indigenous, and local leadership within a mutually-reinforcing focus, reinforcing social change at the family, community, and social normative levels

Partner reduction and mutual fidelity programs must be tailored to the local cultural context and address beliefs, values, and desired behaviors accordingly[8]. Any HIV prevention initiative must undertake formative research to thoroughly understand the beliefs and values associated with different

[8] UNAIDS: Strategic Considerations for Communication on Multiple Concurrent Partnerships within Broader HIV Prevention in Southern Africa: UNAIDS, Geneva, Switzerland, 2009

forms of behaviour within specific cultural contexts. Programs must respond to the widespread social acceptance of certain forms of transactional sex, such as long term non-marital partners or cross-generational sexual relationships. Approaches and messages must be realistic and respectful of local cultures. For example, one desired behavior might be mutual fidelity within polygamous relationships. Other considerations include raising awareness among the general population of the risk associated with multiple partnerships, and to promote social norms whereby these sorts of relationships are increasingly undesirable. In doing so, it is important not to stigmatize individuals engaged in multiple relationships, rather, offer opportunities for change or help build protective behaviors, such as condom use.

Reducing the proportion of youth that engage in cross generational sex

Tanzanian youth experience different situations regarding their choice - or lack thereof - to engage or not engage in sexual relationships, and these differences should be reflected in HIV prevention strategies. This includes approaches for youth who are not yet sexually active, in order to delay sexual debut, as well as for sexually active youth to promote fidelity with one uninfected partner and correct and consistent condom use.

Youth and Sexual Relationships

According to the 2007/8 THMIS:

8% of young women had sexual relationships with men 10 years older or more

38% / 47% male/female of unmarried youth 15-24 years are sexually active

11% of youth under the age of 15 have had sex

Many youth, particularly females, engage in cross-generational sexual relationships, often, motivated by money, gifts or an aspirational social standing. Maganja et al (2007) found that youth exchanged sex for money and other materials in all types of sexual relationships, casual and long term[9]. Another study in Mwanza that among students, the main reason for having a sexual relationship was to receive presents or money (Luke and Kurz, 2002))[10].

Not all youth can control whether or not they have sexual relationships. HIV prevention strategies must consider the lack of control that youth; particularly girls might have over their choices. Some female youth, are required by their families to engage in sexual relationships for monetary gain. Females are vulnerable to sexual and gender-based violence (SGBV), including sexual abuse and rape. There are particular groups of young people, for example adolescent OVCs, who are vulnerable to HIV infection, but for whom little data exists. Initiatives that address cross-generational sex must be firmly rooted in formative research with a sound understanding of the context and relationship dynamics. For example, some young women exploit older men in these relationships for money or gifts, with strong perceptions of self-efficacy and locus of control.

Initiatives that address cross-generational relationships need to be rooted in communities and with a wide range of opinion leaders in order to influence underlying societal norms which require strong advocacy. These approaches should simultaneously address modification of older peoples' behaviors, the empowerment of younger people to make choices or build negotiation skills, and widespread issues

[9] Maganja et al: Skinning the goat and pulling the load: transactional sex among youth in Dar es Salaam, Tanzania
[10] Luke and Kurz. Cross-Generational and Transactional Sexual Relations in Sub-Saharan Africa" International Centre for Research on Women (ICRW), 2002

of coercion and violence. Youth should be involved in the design and implementation of initiatives. Communities should play a key role in identifying and reaching older partners who engage in cross-generational relationships, and most-at-risk youth, including out of school youth and OVCs. However, they should also target youth who might be seen to be better off than their peers, since one of the main motivations for cross generational relationships is social standing and not just a transactional gift. Targeted outreach programs should engage youth with age appropriate risk reduction messages.

Sexually active youth and older partners should receive condoms and referrals for HCT. Initiatives for cross generational sex should include mitigation for those who have had negative consequences, such as HIV infection, pregnancy, abortion, or STIs. HIV positive youth and older partners should be referred for comprehensive prevention, care, and treatment. HIV prevention strategies should incorporate empowerment and gender elements into programming, and include strong social norms and gatekeeper components to create safer and more enabling environments for youth, particularly young women and girls. Youth who have experienced gender-based violence should be referred to specific youth-friendly counseling services and services for PEP.

Youth and Sexual Relationships

According to the 2007/8 THMIS:

38% unmarried male and 47% of unmarried female youth 15-24 years are sexually active

11% of youth under the age of 15 have had sex

Delay of Sexual Debut for Youth

Evidence-based targeting of youth with age- and context-specific messages is key towards promoting delay of sexual debut. Scarce resources must be appropriately targeted to support youth who in fact can exercise this choice, as well as toward strengthening an enabling environment that supports and respects youths' decisions not to have sex.

Messages for delaying of sexual debut must be integrated into wider IEC/BCC communication including information on HCT prior to engaging in sexual relationships and information on life skills, condom use, STIs and pregnancy. These messages should be incorporated into existing programs, such as school curricula and after school and faith-based programs. Communities must take a key role in identifying and supporting youth who are at risk of engaging in risky sexual relationships, as well as reinforcing the decision of those who have the ability and choice to delay. Mass media should reinforce these messages, and help create conducive social norms. There are segments among youth who are vulnerable, but for which little data exist. For example, there is scanty information on the vulnerability of OVC in regards to their ability to delay sexual debut, or to engage in coercive or cross-generational sexual relationships.

The Minimum Package of Prevention Services for MARPs

- Community-based peer education and outreach
- Risk reduction counseling (delivered through peer outreach or in clinic settings)
- Condom promotion and distribution
- HIV counseling and testing
- STI screening and treatment
- Family planning and reproductive health services
- PEP
- HIV care and treatment
- Access to health/social services
- Structural issues (both community mobilization initiatives and policy level initiatives, including those which address stigma and discrimination)

Reducing transactional sex and sex work

People who receive money or goods as part of sex are engaged in transactional sexual relationships. Transactional sex, which

can be either a form of multiple concurrent partnerships or serial relationships, presents in several ways in Tanzania. One form of transactional sex is sex work, which is discussed below. In this strategy, it distinguished from other forms of transactional sex because of its overt nature in which sex workers directly solicit for money in exchange for sex. Cross generational sexual relationships are often another form of transactional sex.

One challenge facing partners who work in HIV prevention is the full understanding of the nature and range of other transactional relationship manifestations. Transactional sex, not necessarily seen culturally as commercial sex, has long been in existence in the country and is still common. Some forms of transactional sex are with short term casual partners. Other forms are with longer-term partners, and might be condoned within the practice of polygamy.

Studies in Tanzania indicate a social acceptance of receiving something in exchange for sex, usually from the male to the female partner. One study showed that men equated this practice to buying meat from a butcher: "it is never free and should never be free". In fact, in some cases the lack of some form of remuneration would be considered socially unacceptable.

As with other forms of multiple partnering, there are health risks to transactional sex. One study in Tanzania has found that women were at higher risk of acquiring HIV if they had engaged in paid sex within the previous three months. Recent case studies confirmed that often, whenever sex is part of an economic exchange, women's ability to protect themselves from STIs and HIV is limited.

Due to the widespread acceptance and practice of transactional sex, initiatives must be embedded within existing structures and programs, such as school and work place programs, or interpersonal communication. In addition, it is important for programs to stress that fidelity within marital or other relationships is not necessarily protective, since one partner could have been infected before the start of the relationship. Therefore, HIV prevention programs should promote couple communication and joint counseling and testing within ethical principles, such as the right for privacy and choice.

Reducing Risk of HIV transmission through Sex work

Sex workers are often females who receive money or goods in exchange for sex, either regularly or occasionally and directly solicit for sex in exchange for money. This form of transactional sex is of particularly importance in regards to HIV transmission owing to the complex set of sexual networks and the number of multiple concurrent partnerships involved. In Tanzania are particularly common in urban areas and other hot spots such as fish landing sites, truck stops on highways, around mining towns, and border crossings. Many sex workers are self-employed and find their clients through independent means. Some sex workers do so full time, but others do so part time. The main motivation for engaging in sex work is money, although some individuals are trafficked or coerced into selling sex.

Sex workers are often stigmatized by laws that prohibit the practice, or social attitudes, and do not receive services from health facilities,

Commercial Sex

According to the 2007/8 THMIS:

8% of men aged 15-49 paid for sex in the past 12 month, of which 60% used a condom

This practice is significantly more common among men who were divorced, separated, or widowed (at 23%)

law enforcement, or leaders in their communities. Some sex workers are further stigmatized by their associations with IDUs and MSM.

The magnitude of commercial sex in Tanzania is likely to be grossly underestimated, and there are many gaps in understanding the full range of related motivations, correlations, behaviors, and the role of coercion and gender-based violence. HIV prevention strategies in Tanzania targeted to sex workers and their clients should include a specific minimum package of HIV prevention services (UNAIDS, 2009)[11]. This includes risk reduction counseling, condom distribution, highly targeted media, HCT services, STI screening and treatment, and referrals to HIV prevention, care and treatment services. HIV positive individuals engaging in sex work should have access to non-stigmatizing risk reduction services, and well as prevention, care, and treatment.

Initiatives targeting sex work should facilitate universal access to HIV prevention, care, and treatment. This includes referrals to a minimum package of HIV prevention services for both HIV-positive and HIV-negative sex workers and access to information, male and female condoms, and contraceptives for sex workers and their clients. Initiatives should also build supportive environments and address structural issues for sex workers, including policies, legislation, and practices that limit access to comprehensive HIV/AIDS services or condone violence and abuse. Supporting programs include legal support and skill building for sex workers who might choose to quit the practice, and initiatives should also target social norms and practices that punish sex workers, but ignore the widespread demand for paid sex.

Increasing Availability and Consistent use of Condoms

Condom use among adults is still low in Tanzania. Among adults who engage in "higher risk sex" i.e. sex with a non-marital, non-cohabiting partner, less than half used a condom in 2007 at their last casual sex encounter. Condom use is even lower among couples in long standing relationships including HIV-sero-discordant couples. There is little data on the consistency of condom use, especially among at risk adults and MARPs, such MSM, people who engage in transactional or commercial sex, and men and women who work away from home.

In Tanzania, condoms are provided through several channels. Free, public sector condoms are provided through health facilities, subsidized branded condoms are distributed through several venues targeted to the general population and MARPs, and private sector brands are sold in pharmacies and stores. There are several partners that work with the MoHSW to design and implement condom communications and marketing campaigns, which address condom availability, barriers to use, and negotiation skills. The number of male and female condoms procured and distributed in the public health system and social marketing channels increased from 50

Condom Use

According to the 2007/8 THMIS:

Among women who reported having higher risk sex in the past 12 months, 43% used a condom during the last act

Among men who reported having higher risk sex in the past 12 months, 53% used a condom during the last act

These levels were higher among younger respondents

Of the men ages 15-49 who paid for sex in the past 12 month, 60% used a condom

[11] UNAIDS: UNAIDS Guidance Note on HIV and Sex Work: Geneva Switzerland, March 2009

million in 2003 to 150 million in 2006. However, availability is still limited; there is a constant shortage of free condoms, especially in rural areas. Tanzania lacks specific guidelines for condom distribution.

Condom use is a sensitive issue within most communities in Tanzania and reticence about condom use hampers open discussion about their use. Many people are uneasy with promoting condom use among youth, even if they are sexually active. Gender issues also undermine condom use, such as the ability of women to negotiate use with male partners. Outlet owners often do not feel comfortable selling condoms to people for whom they think condom use is inappropriate, such as youth or women. MARPs, such as MSM and sex workers may feel stigmatized by owners if they purchase condoms in an outlet, and sexually active youth are often reluctant to buy and are stigmatized when they do so. Married couples might feel the same, particularly if they are discordant or both are HIV positive. Community leaders may either neglect to promote condoms, or actively bar usage, due to misconceptions.

HIV prevention initiatives targeted to the general population and MARPs must integrate condom distribution, promotion, and related skill building as a core element within a comprehensive package of HIV prevention services. It is critical that all individuals who are at risk of HIV infection, or who themselves are infected, have access to condoms within their own communities. Public, private, and socially-marketed condoms must be clearly differentiated and targeted to specific audiences. For example, Tanzania's *Salama* condom brand is targeted to youth agesd15-30, *Dume* is targeted to MARPs, and *Familia* is targeted to committed couples.

Accessibility has many dimensions: price, physical availability, and one's perception of the acceptability of use as well as having a product that "suits their needs" or "reflects their status". Condoms should be widely available in various outlet, including pharmacies, clinics, bars, and hotels. Outlet workers and owners, including barmaids and pharmacy staff, should be engaged as agents for condom education and promotion. It is vital to move condom availability to a level whereby they are readily accessible during times of need. Current availability gaps include rural areas and MARPs.

Condom promotion should address the causes of low condom use by type of target audience. For instance, partner type influences perceptions of risk and protective behaviors; for example, individuals in long standing relationships are less likely to think about HIV risk and condom use with a stable partner. HIV prevention initiatives should dispel misperceptions around partner type and condom use. Other barriers that should be addressed include stigma, socio-cultural, and gender issues. Communities should provide youth-friendly information on condom use as well as youth-friendly distribution points.

It is critical to advocate with key gatekeepers, including religious leaders, teachers, and government officials, to accept condom use, particularly within discordant relationships and among at-risk youth. This is vital to reduce the stigma associated with condom use. Public, NGO, and private partners should increase the number of youth- and MARPs- friendly distribution points. Outlet owners should be included as key gatekeepers and strengthen their capacity to provide high quality information on HIV prevention to their clients. The MoHSW should develop condom distribution and promotion guidelines in order to address the distribution bottlenecks and shortage of condoms especially in rural areas.

The female condom is an important female-controlled product within a market niche. International best practices for female condoms include product positioning and supporting promotional activities to specific target audiences, e.g. women engaged in transactional sex, or female IDUs. Programmes targeting these audiences should integrate the promotion of female condoms. Female condom availability in non-traditional outlets such as hair salons, VCT centers, or peer networks have been successful especially when supported by interpersonal communication.

Introduction and Targeted roll-out of Medical Male Circumcision:

Male circumcision has been demonstrated in three clinical trials in Sub-Saharan Africa to significantly reduce the risk of HIV acquisition by about 50-60% among men[12]. It is estimated that if safe medical male circumcision was widely available, it could lead to reduction of at least six million new HIV infections and three million deaths in Sub-Saharan Africa (SADC, 2006)[13,14]. However, circumcision has not yet been adopted as one of the interventions for HIV prevention in Tanzania. However, a technical working group in the MoHSW is developing relevant policies and guidelines and feasibility and local acceptability studies are going on.

Currently, male circumcision is mainly conducted as a cultural or religious practice in Tanzania. In regions like Mara, Arusha, Manyara, Singida, and Dodoma where male circumcision is done for cultural reasons, about 75% of males are circumcised. The remaining regions in the mainland have very low prevalence of male circumcision.

The MoHSW and partners are piloting male circumcision in a demonstration project in two regions (Kagera and Mbeya) to assess the feasibility and acceptability of male circumcision. These sites were selected to enable examination of male circumcision in a range of cultural, demographic, and epidemiological contexts. The demonstration project will guide the drafting of operational guidelines, training materials, and quality standards. Partners within the catchment areas will initiate a comprehensive male circumcision service package including the provision of counseling and testing services, STI treatment, infection control, risk reduction counseling, condoms, and referrals to other social support services. Patient follow up will include an assessment of counseling effectiveness, monitoring of adverse effects, and possibly sero-conversion. Service provision will be complemented by demand creation and partner education.

The demonstration project will provide critical direction on the national scale up of male circumcision that balance general

Male Circumcision

According to the 20071007/8 THMIS:

- In Tanzania, 70% of males between the ages of 15-49 are circumcised
- MC rates vary greatly between regions, from 26% to 97%
- In regions where MC is done for cultural reasons (Mara, Arusha, Manyara, Dodoma, etc), MC rates are above 75%
- Men who are circumcised have lower HIV infection rates than those uncircumcised (4% v. 6%)

[12] Gray RH, et al. Lancet 2007, Bailey RC, et al.Lancet 2007, Auvert B, Plos Med 2005.
[13] Wilson D, de Beyer J. Male Circumcision, Evidence and Implications. Washington, Wold bank, 2006
[14] SADC: Report of the Expert Think Tank on HIV Prevention

access to high quality, comprehensive services with the need to reach high risk males. The findings will also inform policies and protocols for a regulatory environment. Other key issues to explore are the potential roll of neonatal MC, and of involvement of traditional male circumcisers. It is expected that male circumcision will be rolled out in a phased manner, starting with regions with high HIV prevalence.

Strategic priorities for promotion of safer sexual behaviors and reduction in risk taking behaviors

The following are the specific cross-cutting priority strategies for promotion of safer sexual behaviour and reduction of risk taking behaviour:

1.1 Scale up improved communication on safer sexual behaviors to decrease transmission of HIV while addressing underlying factors that hinder or encourage such behaviors

The priority actions for the immediate term under this strategy are:

- Development of standardized, culturally and age appropriate HIV prevention messages and tools for specific target audiences. The messages should be aligned to the drivers of the epidemic, e.g. multiple concurrent partnerships, delay of sexual debut, partner reduction, cross-generational and transactional sex, harmful gender norms and alcohol/substance abuse, and the risk associated with sexual networks. Target audiences should include the general population, adults, especially in urban areas, in and out of school youth, those with multiple partners, OVC, IDUs, transport workers and uniformed services. Standardized or adapted tools should include guides for conducting community-level discussions, sermons, or radio call-in shows.
- Updating and or developing communication strategies/guidelines on safer sexual behaviour, with effective mix of interactive mass media and interpersonal channels.
- Update the quality and comprehensive context of existing materials and approaches based on the appropriate minimum package of HIV prevention services. This includes workplace programs, school-based programs (e.g. life skills education and training of teachers and school counselors), peer education programmes in schools and vocational training institutions, curricula for youth centers and for out-of-school youths, programmes for sex workers, youth-friendly and gender responsive services, CBO condom programmes for vulnerable groups, skill training particularly for girls, young women, and MARPs
- Conducting countrywide dissemination of messages and behavioural interventions through mass media, interpersonal communication, and a mix, and expand programmatic focus to include partner reduction, transactional sex, socio-economic factors, gender norms, CT with a focus on couple testing, partner disclosure, gender norms, and GBV; PwPs, HIV discordancy; PMTCT and roles of families and men, substance abuse, and stigma and discrimination.
- Provision of a comprehensive minimum package of services for MARPS and roll out targeted educational programmes for high HIV prevalence populations and regions and hot-spot venues
- Expanding HIV prevention for out-of-school youth through training of youth counselors as well as rehabilitation and establishment of out-of-school youth centres
- Expanding HIV/AIDS training in primary schools, higher learning vocational training institutions to fight cross-generational, early sex and transactional sex. This should be through training of teachers and school counselors, school clubs and involvement of parents.

- Refine youth programmes to address the low age of sexual debut and preparing youth to transition to safer sexual behaviors, through targeting decision-makers and gatekeepers.

1.2 Empower national, regional, and community leaders to engage communities in high quality behavioural HIV prevention activities

The priority actions for the immediate term under this strategy are to:

- Promote dialogue with community and cultural leaders and sensitise communities countrywide on socio-cultural and gender norms that contribute to HIV transmission. In particular, the dialogues should address sensitive or uncomfortable issues around HIV prevention, such as condom promotion, multiple concurrent partnerships and substance abuse.
- Roll out a standardized participatory approach to bolster community participation in HIV prevention. This will assist communities to identify their roles, e.g. i) identification of MARPs and most at risk youth, ii) formulation of culturally appropriate IEC/BCC messages, ii) Social support initiatives designed to strengthen positive behavior change and, iv) integration of activities into existing community-based programs, such as peer education, life skills and faith-based programs.
- Strengthen the role of community leaders in the oversight of HIV prevention initiatives using Village Health Team, VMACs and WMACs.
- Support communities to review and enforce laws and by laws that discourage cross-generational and early sex, SGBV and provide safe spaces for vulnerable youth
- Development of communication "kits" to guide community leaders in their activities

1.3 Strengthen the quality, implementation and monitoring of behavioural HIV prevention initiatives

The priority actions for the immediate term under this strategy are:

- Strengthen the capacity of NGOs, CBOs, CSOs, PLHIV networks etc to design, implement, and monitor HIV prevention initiatives as well as functioning of referral systems.
- Implement standard quality assurance approaches to monitor the quality of messages, appropriateness of targeting, provision of minimum package, and functioning of referral systems.
- Ensure that communication channels (mass media and interpersonal) mutually reinforce messages for breadth and depth of impact, preferably with interactive components.

1.4 Strengthen multi-sectoral coordination forums at the national, regional, and community levels to ensure high quality behavioral HIV prevention initiatives

The priority actions for the immediate term under this strategy are:

- Establish decentralized structures and train youth officers and district development officers, social welfare officers etc, to roll out programmes for out-of-school youth
- Conduct an analysis of the strengths, weaknesses, and opportunities for outcome-focused HIV prevention, working via existing structures, such as the National HIV Prevention Technical Working Group, Council HIV and AIDS Committees at district & community levels.
- Identify specific roles for each coordinating entity- these roles might include: i) Facilitation of interactive and interpersonal communication, ii) Oversight of referral systems, iii) Monitoring

service coverage, alignment to epidemic drivers and gaps, iv) promotion of innovative HIV prevention programs e.g. peer group networks, parent-youth communication, v) advocacy to enforce laws and by laws that discourage risky behaviors and protecting vulnerable youth, vi) identification and leveraging of resources during planning processes

1.5 Promote increased participation of PLHIV in behavioural HIV prevention initiatives

The priority actions for the immediate term under this strategy are:

- Facilitate and build the capacity of PLHIV networks to participate in the design, implementation, monitoring, and evaluation of HIV prevention initiatives
- Advocate for active participation of PLHIV and organizations in district- and community-level education, advocacy, and oversight activities
- Support NACOPHA's organizational development and its role in coordination, including the development of clusters at the regional level
- Support PLHIV to conduct public education activities including public testimonies

1.6 Expanding Condom availability especially in rural communities, through:

- Setting up a condom distribution desk for coordination of public sector condoms and developing guidelines for condom distribution and promotion through a public-private partnership and community/workplace outlets
- Increasing accessibility of affordable male and female condoms, particularly in rural areas by unblocking the existing distribution bottlenecks.
- Developing and rollout an initiative to engage distribution outlet owners in HIV prevention education and skills building with clients
- Expanding the availability of condoms in PwP/ discordant couple/ youth/ MARP – friendly outlets. This should include hot-spot areas, urban slums, hotels and lodges, bars etc
- Promotional campaigns for condom use including condom use in long-standing relationships
- Targeting condom promotion efforts to high-risk venues and populations, including discordant couples and HIV-positive individuals through expanded PwP programming.
- Continued support of male and female condom social marketing and public/private sector condom distribution and programming (demand creation).

1.7 Introduction and targeted scale up male circumcision through:

- Development and dissemination of policies and guidelines for male circumcision
- Undertake additional studies on policy, cultural, and operational aspects of medical circumcision in selected regions with low prevalence of circumcision and high HIV prevalence
- Finalisation and dissemination of national plan for male circumcision, prioritizing regions with low male circumcision and high HIV prevalence.
- Phased introduction of adult and neonatal male circumcision services in public health facilities in the eight regions with the highest HIV prevalence through appropriate capacity building (skills, infrastructure, and equipment)
- Increased collaboration and referrals between HCT and male circumcision services

- Determine the appropriate role of traditional male circumcisers
- Public education on male circumcision with emphasis on guarding against behavioural disinhibition, norms and dynamics as well as gender concerns.

5.2 Strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic

Successful HIV prevention programs cannot address risk behaviors at the individual level in isolation of the socio-economic conditions or norms and values in society. In many communities, risk behaviors are tacitly accepted. Often, there is reticence to modify risky behaviors if it is seen to undermine traditional or cultural values. A fundamental element in a national HIV prevention approach is a sustainable environment for positive societal norms while mitigating factors that drive HIV infection. These factors include gender norms and inequities, SGBV, harmful socio-cultural norms and stigma and discrimination.

Gender norms and inequities, and gender-based violence

There is a growing recognition that gender norms and gender-based violence are some of the most influential factors driving HIV transmission worldwide. The epidemiology of HIV/AIDS in Tanzania shows that adult women and young girls are more vulnerable to HIV than their male counterparts. These differences stem from sexual behaviors and socially constructed 'gender' differences between men and women in roles and responsibilities, access to resources, and decision making power.

Women are exposed to increased risk by multiple social and cultural factors that prevail in our patriarchal societies. These factors include customary norms that prevent women and young girls from discussing sexuality, a tacit acceptance of male partner infidelity, and limited decision making power. As for men, certain cultures encourage the notion of masculinity which encourages multiple sexual partnerships, violence, and substance abuse to prove their manhood.

Physiological differences between men and women also enhance women's risk. For example, semen remains in the vagina for hours after intercourse, which extends the risk window in women. Mucus membranes in the vagina can tear during dry sex, loss of virginity, or coerced sex, also increase infection risk. A widespread understanding of why women contract the virus more easily than men may help decrease the stigma associated with HIV in women.

There is evidence that gender-based violence in the form of coerced sex or rape increases the risk of HIV infection for girls and women; HIV positive women are more than twice as likely as HIV negative women to report physical and sexual violence. However, gender-based violence is widely considered to be an acceptable social norm even among women; for example, 41% of Tanzanian women in Dar es Salaam believe that male violence is justified when women are disobedient, unfaithful, or haven't completed the housework. Only 16.8% feel that fear of HIV infection is an inadequate justification for refusing sex. The fear of violence prevents women from reporting the acts to authorities, accessing PEP and HCT services, or in negotiating protective measures against HIV infection. For similar reasons, many women, especially married ones, don't disclose their HIV status to partners and family members.

The Tanzanian Government has shown support for the reduction of gender-based violence. President Kikwete publicly stated that gender based violence should be included as a Millennium Development

Goal. Tanzania's Poverty Reduction Strategy Paper (PRSP) lists violence against women as one of its indicators of poverty (a feature that is rare among PRSPs in other countries). The Sexual Offense Special Provisions Act of 1998 prescribes severe penalties for perpetrators of sexual violence, and each GoT Ministry has a gender focal point. The Police created gender desks to respond to GBV.

Nonetheless, there are gaps. There is no specific law on domestic violence and it is only vaguely addressed in the Law of Marriage Act. Police and health service providers have had little training, and there are no protocols for working with survivors of SGBV. PEP is not widely available throughout the country, legal aid services are limited, and there are only two known shelters for GBV survivors, and both are in the capital. Many women who have experienced gender based violence do not feel that they can access services due to shame and societal pressure. Perpetrators are rarely prosecuted.

This complex set of visible and invisible gender factors that fuel the HIV/AIDS epidemic in the country should be incorporated into the design and execution of strategies and initiatives for HIV prevention. Partners should support the MoCDGC to advocate for budgets to implement gender-based violence plans of action, and roll out initiatives within the law enforcement and health sectors, with strong participation from civil society and the private sector. Services should include clear protocols, integration into a range of health services, and widespread availability of PEP. Aggressive sensitization via mass media and interactive dialogues at national, regional and community levels should take place. Initiatives at the community and interpersonal levels should also focus on improving relationships, communication, and positive male norms such as an acceptance of partner reduction.

Individual Factors

There are individual factors that play important roles in increasing or decreasing individuals' risk of acquiring or transmitting HIV. These include, risk perception, self-efficacy, and locus of control. Risk perception is the belief that an individual, group, or society has about the chance of a risk happening, and the magnitude of its effects. Self-efficacy is the belief that a person has in him / herself that she or he has the skills and abilities to perform a specific behavior. Locus of control is the extent to which a person believes a circumstance and behavior are within his or her control.

It is key to note that it is an individual's ***perception*** of these factors that influences his or her behaviors or choices; simply put, perception is their reality. For example, if a young man doesn't think he can successfully negotiate condom use with a partner, then it is unlikely that he will even try to do so. Young women who feel they can successfully manage a relationship with an older man might be more willing to engage in cross generational relationships. If an older married man doesn't think that there is any risk of acquiring HIV through a long term non-marital relationship such as a mistress, then it is unlikely he will use condoms, go for CT with that partner, or even stop having sex with her. These individual factors, and many others, often strongly influence people's behaviors, and must be integrated into all HIV prevention programming. This requires solid formative research, and messages, tools, and approaches that are well grounded in behavioral theory and models.

Harmful Socio-cultural norms

In Tanzania, there are some cultural practices that increase the risk of HIV infection. They include polygamy and inheritance rights, whereby male relatives are compelled to marry the wife of a male relative, and it is possible that the relative might have died of AIDS. Other practices include early marriages for girls and the practice of dry sex. In some cultures, there are widespread beliefs that condone multiple sexual partnerships. Other practices are traditional circumcision and excision, scarring and tattooing, and brotherhood rites which can lead to HIV infection.

Socio-cultural practices are often deeply-rooted within communities, and advocacy efforts should be very sensitive and respectful when addressing harmful practices with communities. Community leaders should be engaged from the onset in promoting any sort of social change. Several programs have demonstrated success in the modification rather than the eradication of a harmful practice, such as HIV testing before widow inheritance or substituting a ritual for female circumcision. Programs should explore such options with community leaders. In addition, communities should be supported to enact bye-laws that counteract harmful socio-cultural practices.

Socio-economic factors

Socio-economic factors have a complex relationship with HIV infection risk. Many people associate HIV vulnerability with poverty, however, recent data indicate that HIV prevalence for people in the highest wealth quintile is three times greater than for the lowest quintile. This is in part attributed to risk behaviors such as multiple partnerships among wealthy individuals. The effects of poverty, economic inequalities between men and women, and inadequate or non-existent social security systems drive behavioral risk taking, and often these individuals do not have the ability to take protective measures.

It is important to analyze the current mix of targeting of HIV prevention initiatives to Tanzania's socio-economic groups, and adjust the national response accordingly. It is unclear if these socio-economic groups understand their relative risk, or the behaviors that expose them to HIV infection (risk perception). Further research might be necessary to thoroughly understand the exact risk behaviors and factors by sex and socio-economic status, particularly among wealthy Tanzanians. Socio-economic status and issues should be integrated into the design and implementation of all HIV prevention initiatives. These initiatives should include programs that assist with barriers to protective measures, particularly among the less wealthy, such as infant replacement feeding.

Stigma and discrimination

The negative effect stigma and discrimination have on HIV prevention initiatives is several fold. Fear and concern inhibit people's risk reduction behaviors and willingness to know their HIV status. HIV positive people do not access critical services or reduce unsafe behaviors for fear of raising suspicion about their HIV status. Ramifications at the family and community levels are real; individuals hesitate to disclose their status to their family for fear of rejection and discrimination. Stigma associated with HIV often leads to discrimination and human rights violations against PLHIV and their families.

It is important to understand the roots of stigma. There will always be an element of fear and stigma with HIV/AIDS until we develop a cure or vaccine. However, the increasing accessibility of high quality AIDS treatment services should help to mitigate the perception that HIV infection is "a death sentence".

Also, HIV/AIDS is associated with taboos or uncomfortable behaviors, such as multiple partnerships. This inhibits communities from addressing risk behaviors. People often feel justified in their discriminatory treatment of HIV infected individuals, often based on misperception.

One of the first steps in reducing stigma and discrimination is creating "an open dialogue" about HIV and AIDS. In this, Tanzania has made great strides in the past few years. For example, President Kikwete's open support and promotion of HIV testing resulted in the greatest number of Tanzanians getting tested in the country's history. HIV prevention initiatives should continue this "open dialogue", by enabling community leaders and others to discuss these issues. Efforts should continue to address stigma and discrimination against PLHIV. Tanzania has created an enabling legislative and policy environment for addressing HIV stigma and discrimination through the HIV and AIDS bill. Non-existent or weak enforcement may contribute to stigma and discrimination. Specific programs for addressing HIV-related discrimination are integral to ensuring the success of HIV prevention efforts and must be prioritised in every setting, particularly in workplaces and educational institutions. Provider training for all cadres should include modules on stigma and discrimination within service provision.

Strategic priorities for a strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic

Ensuring a sustainable environment that mitigates underlying factors that drive HIV in Tanzania will be the focus of all education and service provision actions highlighted above. In addition, the following are additional strategic priorities and actions that *cut across* specific types of interventions for an enabling environment for uptake of HIV prevention services and safer sexual behaviour:

2.1 Empowering communities to address harmful gender and socio-cultural norms and gender based violence as well as stigma and discrimination, through:

- Supporting the MoCGDC to develop a multi-sectoral GBV network and a specific GBV budget
- Supporting local governments to translate GBV action plans into concrete community by-laws
- Building the capacity of traditional, religious and opinion leaders to speak against harmful cultural practices, beliefs, norms, stigma and discrimination while reinforcing positive practices
- Training workers on existing laws, regulations, standing orders and code of conduct on sexual relationship at work place and supporting their enforcement
- Supporting the police to expand gender desks and training of police staff
- Advocacy for a specific law on domestic violence as well as stigma and discrimination
- Expanding safe environments for vulnerable girls and women and safe spaces for GBV victims.
- Linking with other socio-economic development and support services

2.2 Mainstreaming gender considerations in all HIV and AIDS services through

- Incorporating gender based violence and gender equity in all HIV and health policies and plans and tracking their implementation
- Piloting a one-stop service center for GBV survivors and codify a minimum package of services for survivors of gender based violence
- Incorporating GBV screening and referrals into all health and HIV services and clinics

- Linking GBV and HIV in BCC mass media and interpersonal communication campaigns
- Expanding efforts to effect normative social and cultural change, addressing gender and social norms that underlie key behavioral drivers.

2.3 Increased coverage, quality and utilization of HIV prevention services

This component will support the scaling up of quality HIV prevention services and increasing demand and uptake of health services to achieve universal access to PMTCT, HCT, condoms, safe blood transfusion, medical infection control including PEP, positive prevention and medical circumcision.

Expanding the Coverage, Scope and Quality of HIV Counseling and Testing Services

HIV counseling and testing is a cornerstone for HIV/AIDS services, and is the door to the continuum of HIV prevention, care, and treatment for those who test HIV positive, and to other HIV prevention services for those who test HIV negative. It is particularly important to target counseling and testing services to couples: In the 2007-08 THMIS, 6.3% of married or cohabiting couples were in HIV-discordant relationships, 2.5% were concordant HIV-positive and in 91%, both partners were uninfected. Currently, most discordant couples do not know about their sero-discordant status. This is a major concern since condom use in marital and other long standing relationships is low.

In Tanzania, although 63% of women and 73% of men aged 15-49 years have never been tested for HIV and don't know their HIV sero-status. However, HIV testing levels have dramatically increased since the 2007/08 THMIS. This is in part due to Tanzania's national HIV testing campaign, which was launched by President Kikwete in 2007. More people were tested in the nine month period of this campaign than during the previous 15 years. This testing campaign was a historic step in Tanzania's efforts to increase individuals' knowledge of HIV status. Advances in HIV rapid testing methodologies, counseling approaches, and service delivery platforms have made learning one's HIV status easier. Counseling and testing delivery methods include client initiated voluntary counseling and testing (VCT), provider initiated testing and counseling (PITC), home based counseling and testing and community outreaches through mobile counseling and testing.

Counseling and Testing

According to the 2007/8 THMIS:

- 27% of men and 37% of women aged 15-49 have been tested for HIV and received their results
- However, HIV testing has dramatically increased since the 2007/08 THMIS. 19% of men and women aged 15-49 were tested and received their results within the 12 months prior to being interviewed
- 6.3% of married or cohabitating partners are in HIV discordant relationships. Of these:
    - 3.5% the male is HIV positive
    - 2.8% the female is HIV positive
- 2.5% of married or cohabitating partners are in concordant HIV positive

A balanced and strategic scale-up of CT services with based on different modalities for different groups or areas is required in Tanzania. For examples, appropriate delivery platforms in high HIV prevalence areas include PITC and home-based HCT. In geographic "hot spots", such as transport corridors, and for population with higher risk behaviors, mobile HCT and local campaigns are effective approaches. Scale up of HCT should build on initial service expansion efforts: HCT services are expanding to target MARPs and hard to reach groups along transport

corridors, in the work place, and through outreach-based and mobile services. The MoHSW recently approved home-based testing as a component of existing home-based care activities.

There are several challenges to increasing coverage of HCT. Overall, case identification, strong referral systems, and networks for those who test HIV positive or negative must be strengthened throughout the country. Couple testing and disclosure of HIV test results to partners is still limited, and therefore knowledge of partners' HIV sero-status is probably very low. In addition, there are opportunities to expand CT platforms to include other prevention initiatives. For example, counselors could screen for SGBV, STIs, FP and RH needs, and substance abuse during sessions, and refer to services. It is also important to expand pediatric counseling and testing, and screen for vulnerable children, including OVC, and refer them to appropriate services. Community and faith based leaders should become more involved in promoting couple counseling and testing, especially before marriage. PLHIV can assist with community sensitization as well as appropriate levels of counseling as a form of task-shifting. Post-test clubs can assist with further prevention programs for those who test HIV negative, as well as with support and referrals for those who test HIV positive.

There is also a need to improve effective social support and referral systems for HIV-infected individuals, including increased access to psychosocial, socio-economic, care and treatment services. All HCT clients should be referred to prevention programs that reinforce risk reduction. Programmes should develop innovative strategies to improve risk reduction counseling, and condom promotion.

Expanding Coverage and Scope of Services for Prevention of Mother-to-Child Transmission of HIV

With more than 1.5 million births annually and HIV prevalence among antenatal women of 8.2%, approximately 123,000 HIV-positive women deliver exposed infants annually in Tanzania. Assuming a 35% transmission rate without intervention, about 43,050 children would become infected with HIV each year. Ninety-eight percent of pregnant women attend ANC at least once during pregnancy (DHS 2004-05) and this provides an excellent opportunity to prevent paediatric HIV infections as well as extend care and treatment to HIV-infected women and their families. The MoHSW has expanded the availability and reach of PMTCT services. By end 2008, 61% of all antenatal women in Tanzania had received HCT, and 55% of all HIV positive pregnant women received ARV prophylaxis for PMTC. The uptake of HCT by mothers attending ANC in facilities providing PMTCT services increased from 86% to 98% as routine CT became more widely implemented. The percentage of RCH facilities providing PMTCT services has increased from 53% in 2007 to 65% in 2008. In 2008, the MoHSW initiated early infant diagnosis (EID) based on DNA PCR tests aimed at identifying HIV-infected infants and providing them with ART and other interventions. EID is gradually being rolled out country-wide.

Despite this considerable expansion of PMTCT services, only 55% of all HIV positive women in Tanzania receive ARV prophylaxis. Key steps to expand PMTCT services include strengthening each of the four prongs of PMTCT i.e. i) primary prevention of HIV among reproductive-age women and their partners, ii) provision of family planning services for HIV-infected women and their partners to prevent unintended pregnancies, iii) HCT for antenatal mothers and ARV prophylaxis for prevention of HIV transmission from mothers to infants, and iv) clinical and CD4 count assessment to determine eligibility

of mothers for ART and provision of treatment, care and support to HIV-infected women, their partners, infants and families.

The program will also strengthen referral and linkages from PMTCT to several related services such as: adult/pediatric care and ART, home based care, immunization and EID, and network of mother support groups at the community level. Comprehensive PMTCT services should include other child health services, cotrimoxizole prophylaxis, TB screening, family planning to prevent unwanted pregnancies, referrals, and mosquito bed nets.

PMTCT-related behavior change communications should stress *parent* to child transmission, and promote responsibility within the family. This includes both partners' responsibility for prevention of HIV transmission and the entire family's responsibility for ensuring that women participate in PMTCT. Other messages should include men's role in PMTCT, family planning, couple counseling and testing, risk reduction, and post-delivery risk reduction for infants. Others include growth monitoring, nutritional assessment, counseling and support, cotrimoxizole prophylaxis to the mother and HIV-exposed infants, TB screening, referrals, prevention and treatment of STI and partner testing.

Expanding Coverage and quality of Sexually Transmitted Infections Management Services

In 2007-08 THMIS, 6% of sexually active men and 7% of women indicated that they had recently had STI symptoms, of whom, only 56% obtained treatment from qualified health care providers[15]. Prevention and treatment of STIs for HIV prevention in Tanzania is integrated into routine health service delivery and is available in about 60% of public hospitals, health centres and dispensaries, but some FBOs and private health facilities also provide STI services[16]. The challenges for STI case management include the prevailing low health care seeking behaviour, the limited coverage of antenatal screening for syphilis in RCH facilities, and lack of targeted STI services for high-risk groups such as CSWs, truck drivers and fishermen. In health facilities, the supply chain management of STI commodities is weak, characterized by frequent interruption of service delivery. In addition, although herpes simplex type 2 virus (HSV-2) is perhaps the most prevalent STI, it is not covered under the current STI syndromic management guidelines. There is also weak monitoring of antimicrobial susceptibility of STI causative organisms to inform the formulation of STI treatment algorithms. In health facilities, preventive counseling including partner notification, provision of condoms and referral for STI services for this high risk group is generally weak[17].

Although the land mark trial that established the role of STI management in HIV prevention was conducted in Tanzania, subsequent studies didn't confirmed this finding[18]. Furthermore, although HSV-2 is a leading driver of the HIV epidemic in several sub-Saharan African countries, randomized trials of HSV-2 management did not reduce HIV incidence[19]. For these reasons, donor support for STI

[15] 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)
[16] 2007 Tanzania Services Provision Assessment TSPA
[17] NACP, MoHSW: Report of the Evaluation of Sexually Transmitted Infections Services in Tanzania Mainland, 2005
[18] Grosskurth H, Gray R, Hayes R, Mabey D, Wawer M. Control of sexually transmitted diseases for HIV-1 prevention: understanding the implications of the Mwanza and Rakai trials. Lancet 2000 Jun 3;355(9219):1981-7.
[19] Watson-Jones D, Weiss HA, Rusizoka M, Changalucha J, Baisley K, Mugeye K, et al,: Effect of herpes simplex suppression on incidence of HIV among women in Tanzania. N Engl J Med. 2008 Apr 10;358(15):1560-71.

management for HIV prevention has declined substantially in recent years. However, STI management targeted at MARPs is a cost effective intervention for HIV prevention. Control and management of STIs is an important public health intervention in its own right and also vital for maternal and child health.

In this HIV Prevention Strategy, it is recommended that the Government of Tanzania and stakeholders expand coverage and quality of STI services in public and private facilities. Efforts should be made to provide targeted STI services to MARPs, and residents of hotspot areas through various approaches. The national STI treatment guidelines should be updated to include HSV-2 infection that is among the main drivers of the epidemic in the country, and syndromic aetiologies should be routinely validated. All partners including the Medical Stores Department (MSD) should Endeavour improve logistics management of all commodities including medical and pharmaceutical supplies for STI management.

Expanding Coverage and Scope of Medical Infection Control

The World Health Organization estimates that at least 5% of new HIV infections globally are attributed to unsafe injection practices. The 2007-TSPA found that only 5% of health facilities in the country had all the basic requirements for infection control such as water, soap, gloves, disposal boxes for sharps etc. About one third of health units had facilities for adequate disposal of sharps and other biohazard materials while only 15% had guidelines for infection control. Furthermore, only 4% of facilities had access to PEP services for their staff. A recent study in Tanzania by Watson-Jones et al, 2009 suggested that HIV acquisition was associated with having received injections during the previous three months. Factors contributing to unsafe practices include lack of safe disposal containers, improper disposal procedures, and disposal of hazardous wastes in open, unguarded rubbish areas. Post-exposure prophylaxis is neither widely used nor consistently available.

The MoHSW's accomplishments to date in injection control and biosafety include the development of policy guidelines on medical infection control, decentralized training of health workers through zonal training centers and educational programmes to reduce provision and demand for unnecessary injections. Disposable syringes and biosafety boxes are now included in the national essential drug list.

The MoHSW and its partners should continue to expand capacity building for universal precautions to reduce the risk of medical transmission of HIV. This includes injection safety training, needle stick surveillance, and advocating for a complete roll out of PEP and hepatitis B vaccination for health care workers. Other activities include referrals for staff reporting work accidents for HIV counseling and testing and PEP. Medical infection control and biosafety capacity building and related procurement should be included in council health plans. Health infrastructure for safe disposal of medical waste should be strengthened. Communities should play a supportive role in decreasing demand for unnecessary injections, as well as house-hold level safe disposal procedures, particularly for home based care. Communities should be sensitized about community infection control practices.

Expanding Coverage and Scope of Blood Transfusion Safety

Prevention of HIV transmission through the transfusion of contaminated blood is a key component in the GoT's HIV/AIDS policy. Women and children are at greater risk than men because of the frequent transfusion of blood and blood products due to pregnancy and delivery and the aneamia among young

children due to malaria. The National Blood Transfusion Service (NBTS) in the MoHSW is responsible for ensuring that all blood and blood products transfused through the health care system is screened for infectious disease markers. The strategy involves increasing blood collection from voluntary non-remunerated blood donors (VNRBD).

All blood collected and distributed by NBTS is screened for HIV, HBV, HCV, and syphilis prior to distribution, using ELISA testing in line with WHO guidelines. However, challenges and constraints for blood transfusion safety include the limited coverage of quality assured services; there are only eight blood transfusion centres that do not provide adequate geographical coverage. Furthermore, the number of repeat VNRBD mobilized is still limited and therefore do not provide enough blood to meet the country's requirements. For instance, only 33% of the annual demand of blood units were collected, screened and distributed through the quality assured system in 2008. In addition, the geographical distribution is still uneven, and the existing blood transfusion services do not have adequate storage, testing and distribution capacity at regional and district levels.

Blood Transfusion Safety

- Tanzania's annual blood transfusion requirement: 500,000 units; NBTS's FY10 collection target: 200,000 units
- 80% of donors are voluntary non-remunerated blood donors (VNRBD); 20% are recurrent
- Collection from VNRBD has reduced HIV prevalence in donations from 7% in 2005 to 2.8% in 2008
- 80% of blood is collected by mobile teams

One key NBTS goal is to identify and sustain the number of HIV-negative voluntary non remunerated recurrent blood donors throughout the country. One strategy is through blood donor clubs, which consist of individuals counseled, tested, and committed to remaining HIV free. Communities and other HIV prevention programs should support NBTS in the recruitment and retention of HIV-negative blood donors by collaborating on identification of potential volunteers, and with the maintenance of blood donor clubs. A database of these donors has been developed and is maintained. Collaborative efforts should link blood donation efforts to HCT services, whereby HIV-negative individuals are referred as potential volunteers. The private sector should support donor recruitment by sponsoring non-remunerative blood donation and provision of IEC materials as well as implementation of acceptable donor motivational strategies. Mass media messages should complement the community mobilization.

Reduction of unnecessary transfusion through malaria prevention and rational use of blood and blood products is another important strategy. The MoHSW should ensure that health care workers involved in blood donation and blood transfusion services are trained on PEP and proper waste disposal.

Expanding HIV prevention among HIV-infected individuals

Initiatives for "Positive Prevention" aim to facilitate HIV-infected individuals to avoid onward transmission of HIV infection to others, and to help them avoid re-infection with other strains. The delivery of comprehensive HIV prevention, care, and treatment services to HIV-positive individuals is a proven effective prevention initiative in itself. HIV positive individuals decrease the risk of infecting others or re-infecting themselves with HIV through safer sexual practices. In addition, ART also suppresses viral load and perhaps infectivity. Prevention with positives (PwP) delivery platforms are

facility and community based, and requires a well coordinated provision of a minimum package of HIV prevention services. PwP core messages must emphasize the importance of risk reduction and prevention, and the limitations of ART.

In the 2007-08 THMIS about two-thirds (67%) of HIV-infected individuals had HIV-negative (or sero-discordant) partners. This situation puts the uninfected partners at extremely high risk of HIV infection and represents a high unmet need for HIV prevention. It has been shown that the per-act risk of HIV transmission among discordant couples is more than ten times that of the general population.[20] With most discordant couples unaware of their sero-discordant HIV status, in an environment where condom use in marital and other long standing relationships is low, it makes a compelling case for increasing knowledge of HIV sero-status of partners and tailored HIV prevention interventions for HIV sero-discordant partners.

Currently, some ART centres are integrating HIV positive prevention, but the coverage is still inadequate. Many HCT programmes, particularly those implementing provider initiated HCT are increasingly identifying HIV discordant couples and providing risk reduction counseling, although their coverage is also still sub-optimal. Furthermore, there are no guidelines on PwP and the HIV-transmission sexual behaviour of HIV-infected individuals in Tanzania has not been characterised to inform these programmes

Tanzania is currently rolling out its basic service package for adult PLHIV in public and faith based facilities. As PwP services expand, it is critical to include community components, including integration of services into home based care as well as psychosocial services. Successful PwP programs require well functioning, multi-directional referral systems, as well as close follow up and support. Community and partner organizations should consider designing task-shifting strategies to lower level health care workers, counselors, and trained PLHIV.

The nature of PwP services makes it an excellent platform to further strengthen community-facility coordination and dialogue. Communities can play an increasingly stronger role in identifying most at risk individuals and couples, and facilitate invitations to counseling and testing services paying attention to avoidance of stigma and discrimination. Additionally, PLHIV can be trained and empowered to provide high quality HIV prevention services; as community members participating in mobilization, as well as community sensitizers, peer educators, and expert patients.

Prevention with Positives Services

The minimum package of Positive Prevention services include:

- Risk reduction counseling, including skill building in safe sex negotiation and practices, and partner disclosure
- CT, particularly with partners
- PMTCT services
- STI screening and management services
- Condom distribution
- Care and treatment services, including screening for SGBV and substance abuse
- Other health services: reproductive health and family planning, TB, safe water and sanitation, malaria, nutrition, etc.
- Facility and community based psychosocial and spiritual support

[20] Gray RH, Wawer MJ, Brookmeyer R, Sewankambo NK, Serwadda D, Wabwire-Mangen F, et al. Probability of HIV-1 transmission per coital act in monogamous, heterosexual, HIV-1-discordant couples in Rakai, Uganda. Lancet 2001 Apr 14;357:1149-53

Strategic priorities for increasing coverage, quality and utilization of HIV Prevention Services

The following are the strategic priorities and priority actions that *cut across* specific types of biomedical HIV prevention services:

3.1 Promotion of health seeking behavior to increase utilization of HIV prevention services, while addressing barriers to their use. The priority actions for the immediate term under this component are to:

- Develop appropriate messages promoting health-care seeking behaviors to increase use of specific HIV prevention, care and treatment services. The messages should address risk perception, motivation and self-efficacy, covering HCT (including couple testing and partner disclosure), PwP, discordant couples, PMTCT (and the role of families and men and infant feeding), STI management with a focus on MARPs, biosafety and unnecessary injections and male circumcision. These messages must be tailored to specific target audiences.
- Design and roll out communication activities to increase demand for and use of services, through a mix of mass media, promotional, and interpersonal communication.
- Develop communications "kits" to integrate messages on health-seeking behaviour into on-going interpersonal and other community level IEC activities

3.2 Build the capacity of national, regional, and community leaders to engage in the coordination of high quality HIV prevention services. The priority actions for the immediate term under this component are to:

- Roll out a participatory approach to bolster community participation in service delivery in collaboration with health facilities. This will assist communities to identify their roles which include promotion of services and participation in IEC/BCC initiatives to strengthen service uptake e.g. couple counseling, male circumcision, PwP and integration into existing community-based programs such as premarital HCT into faith-based programs
- Strengthen the role of community leaders in the oversight of facility-level service delivery and targeted services for specific groups. This might involve for instance, including them in facility management committees.

3.3 Strengthening the supply chain management of medical and pharmaceutical supplies for HIV prevention. The priority actions for the immediate term under this component are to:

- Assess the procurement and supply chain management system, and act upon recommendations for improving them.
- Forecast, procure and distribute commodities, supplies and equipment for HIV prevention. These include HIV test kits, drugs for STI treatment, condoms, protective clinical equipment, biohazard and sharps-disposal boxes, single use syringes with auto-destruct features, disinfectants, medical circumcision surgical kits etc.
- Advocate for inclusion of appropriate commodities and supplies into local council health plans

3.4 Promote increased participation of PLHIV in HIV prevention service delivery through:

- Advocating for the participation of PLHIV in task-shifted activities, such roles as expert patients, lay counselors and peer and community educators
- Building the capacity of networks of PLHIV to participate in the design, implementation, monitoring, and evaluation of HIV prevention services and communications initiatives
- Advocating for the active participation of PLHIV and organizations in district- and community-level education, advocacy, and oversight activities

3.5 Integration of HIV prevention services within clinical and community settings to maximize access to high quality HIV prevention services, through:

- Reviewing the status of integration of HIV prevention services such as risk reduction counseling and condom distribution within clinical and community settings. The settings where integration should occur include:
  - at the facility level, within STI, RCH, FP, TB, PMTCT, and substance abuse clinics,
  - within treatment settings, ART, treatment education, and adherence clinics,
  - within other settings, home-base care, VCT, PLHIV support groups, OVC programs
- Reviewing the comprehensiveness of current policies, standards and guidelines on integration of HIV services in clinical and community settings and revise or update as required
- Providing technical assistance and training to facilities and community organizations to scale up integration of HIV prevention services and referrals. Initial integration focus should include:
  - Provision of FP services to HIV-positive women as part of SRH/PMTCT integration
  - Strengthened linkages between HCT with STI and substance abuse screening, care and treatment, and SRH including FP
  - Referrals between OVC programs to pediatric counseling and testing services

3.6 Provision of appropriate biomedical services as part of the minimum package of HIV prevention services for specific target audiences.

The priority actions for the immediate term under this component are to:

- Defining the minimum package of services for the general population and specific population groups including MARPs
- Inventory and mapping of all HIV prevention, care and treatment resources and establish appropriate referral networks.
- Using the minimum packages of prevention services defined for each target audience strengthen coordination and referral systems at the district level.
- Roll out provision of specific services based on the minimum package to specific groups including the general population, MARPS such as sex workers, fisher folk, transport workers, migrant workers, residents of specific hot spot areas etc.

3.6.1 Expanding coverage, quality and scope of HIV counseling and testing through:

- Expanding access to gender sensitive, couples-oriented, adolescent, and youth friendly counseling and testing services, with a focus on high prevalence areas and population groups

- Expanding mobile counseling and testing targeted to MARPs, difficult to reach populations, and rural areas.
- Expanding PITC within home-based and facility settings in high HIV prevalence regions
- Expanding paediatric HCT services, with an initial focus on OVC

- Reviewing and update national HCT technical policies and guidelines so as:
  - To allow for task-shifting and lay-counselors in HCT delivery including trained PLHIV
  - To incorporate risk reduction counseling, positive prevention, and couple counseling, testing and disclosure
  - To provide for pediatric HCT guidance
  - Allow the addition of other services to the counseling and testing platform, e.g. screening for gender-based violence, STIs, and substance abuse
- BCC and promotional campaigns focusing on testing literacy and opinion leader endorsements
- Building the capacity of community and faith based groups to assist with counseling and testing, especially premarital couple counseling and testing, disclosure, and post-test clubs
- Recruiting and training health care workers, social workers, and lay counselors
- Improving effective social support and referral systems:
  - For HIV-infected individuals - increased access to psychosocial, socio-economic, care and treatment services
  - For all CT clients - prevention programmes that reinforce risk reduction.
- Develop innovative strategies to improve risk reduction counseling, and condom promotion and distribution through CT services.

3.7.2 Expanding coverage, quality and scope of PMTCT through:

- Expanding gender-sensitive counseling and testing services to reach 80% of pregnant women through RCH clinics and outreach.
- Strengthening of EID services
- Rolling out the revised PMTCT ARV prophylaxis involving use of more efficacious ARV regimens to all PMTCT outlets
- Strengthening facility- and community-based post natal follow up
- Reviewing and addressing gaps in provision of a basic preventive-care package to mothers and infants
- The provision of safe alternative infant feeding options to HIV-negative exposed children or making breast milk of HIV-infected women safer through provision of HAART to mothers during breast feeding period (this is still pending policy discussions)
- Expanding provision of family planning and RH services to HIV-positive women and their partners
- Expanding communication activities around PMTCT to enhance HIV prevention among women of reproductive age group, service uptake and male and community involvement and support

3.7.4 Expand coverage, quality and scope of STI management through:

- Scaling up the provision of and referrals to youth-friendly STI clinics, especially targeted to MARPs and urban hotspots
- Scaling up targeted STI management services to hotspot areas and groups e.g. fishermen, truck drivers and sex workers
- Reviewing and strengthening the quality and gender-sensitivity of STI services
- Reviewing STI syndromic management guidelines and incorporating management of HSV-2
- Conducting STI syndrome aetiology validation and antimicrobial susceptibility studies to inform the formulation of national STI syndromic management guidelines

3.7.5 Expanding coverage and quality of medical infection control and biosafety through:

- Production and dissemination of guidelines for infection control, PEP and occupational exposure to all public and private health facilities as well as communities
- Rolling out Hepatitis B virus vaccines for all health workers, and increasing access to PEP for all people exposed to contamination of blood, blood products, including care-givers, victims of rape and sexual assault and medical staff
- Training all health care workers in infection control through decentralized training at zonal level as well as integration of medical infection control in the pre-service training curricular
- Establishing and supporting functional infection control committees in all heath facilities
- Strengthen health infrastructure to manage medical waste through provision of incinerators, autoclaving and sterilizing equipment.

3.7.6 Expanding the coverage of the blood transfusion safety programme through:

- Ensuring all blood supply is accurately screened for HIV according to national standards and increase coverage of safe blood distribution from NBTS to at least 80% of health facilities
- Increasing the number of blood transfusion centers from zonal level to all regions
- Strengthening HIV prevention among blood donors through linkages with HCT
- Distribution of the national blood transfusion policy and the blood donor recruitment and retention guidelines to all care givers
- Increasing recruitment of VNRBD through establishment of more blood donor clubs, mobilisation campaigns in schools, and strengthening the data-base of voluntary donors.
- Expanding the overage of the quality assurance scheme for the NBTS at distribution points and in private hospitals and strengthening storage, testing and distribution capacity.

3.7.7 Expanding coverage of HIV prevention with positives and HIV-discordant couples through:

- Developing appropriate guidelines for integration of HIV prevention into AIDS care and treatment programmes
- Defining and rolling out to all HIV/AIDS prevention, care, and treatment programs in the country a HIV prevention package for HIV discordant couples and PwPs at the facility and community level, with a focus on risk reduction counseling and condom use.
- Training and supporting PLHIV to provide appropriate PwP services to peers

- Scaling up provision of condoms to HIV-infected individuals as part of their ongoing care and promote condom use among discordant couples and individuals in longstanding relationships
- Promoting premarital HCT, and the development of messages and materials addressing the prevention of HIV transmission such as consistent condom use and partner reduction.

5.4. Risk reduction among other most-at-risk populations that have a potential for increased HIV transmission:

There are many gaps in understanding the full complexity of what drives Tanzania Mainland's HIV/AIDS epidemic. Current data suggest that the majority of HIV infections are attributed to multiple sexual partnering among heterosexual adults, and vertical HIV transmission. However, it is possible that there other populations that are at risk now, or in the near future, but for which we lack data. These include other MARPs, such as MSMs, IDUs, uniformed services, OVC, incarcerated adults, and people who abuse alcohol. In addition, there are other harmful practices, such as gender-based violence, socio-economic factors, and cultural norms,that exacerbate the drivers of the HIV/AIDS epidemic, although more is required to fully understand these dynamics.

Stakeholders should coordinate and fund research in order to better understand these populations and the behaviors that drive, or have the potential to drive, Tanzania's epidemic. This includes population size estimates for MARPs, behavioral surveillance for specific at risk populations, incidence testing to understand what is causing new HIV infections among who, and in depth formative research.

Nascent research indicates that the following groups might be at significant risk for HIV infection:

Substance abusers who engage in risky behaviors

HIV transmission is influenced by abuse of substances such as alcohol and injected drugs. There is little data on the breadth and depth of substance abuse in Tanzania. It seems that the number of injecting drug users (IDUs) are increasing in urban areas on the coast of mainland Tanzania, although they could be increasing in-land as well. There is also little data on excessive alcohol consumption, or on risk behaviors and HIV vulnerability when under the influence of alcohol or drugs.

Nonetheless, alcohol and drug use and their roles in HIV/AIDS is gaining recognition throughout East and Southern Africa. Individuals who consume alcohol have less successful outcomes on ART, and alcohol consumption seems to speed up individuals' progression to full-blown AIDS. In addition, both alcohol and drug consumption are associated with risky behaviors which increase vulnerability to HIV infection. Sharing of needles,

Substance Abuse

Men who drink alcohol have an HIV prevalence rate 3 times higher than those who do not drink (20% vs 7%)

Women who drink alcohol have an HIV prevalence rate 2 times higher than those who do not drink (14% vs 7%)

27% / 58% of male/ female IDUs in Tanzania are HIV positive

Of IDUs in Dar es Salaam:

- 18%/ 6% of men/women reported injecting themselves with used needles
- 23%/ 6% of men/women shared needles
- 21%/ 11% of men/women loaded used needles Of female IDUs in Dar es Salaam and Zanzibar:
- 84% traded sex for money
- 23% traded sex for drugs

drawing blood from one another, multiple concurrent partnerships including transactional sex, and unprotected sex are practiced among IDUs. Of IDUs surveyed in Dar es Salaam and Zanzibar, during the last sexual encounter, 69% of women reported condom use, compared to 28% of men. These women also reported having over 12 times the number of sexual partners than men.

HIV prevention strategies targeted to substance abusers should undertake appropriate studies on magnitude, distribution, and dynamics of IDUs and individuals who abuse alcohol or other drugs. Programs should pilot behavioral and structural interventions, analyzing risk reduction and addicting treatment in a variety of low-resource settings (urban/rural, community and clinic based, etc.). HIV prevention strategies should incorporate outreach-based components including risk reduction counseling, referrals to CT, STI screening and treatment, condom distribution and HIV prevention, care, and treatment for HIV positive individuals. There should be particular efforts to make such services appropriate, accessible, and "friendly" to this population. Addiction treatment strategies should include facility-based detoxification services, drug substitution programs, community-based follow up and support, prevention counseling, and referral to HIV prevention, CT, and STI services.

Substance abuse issues and behaviors are widely controversial, and these programs should include an aggressive sensitization and advocacy component to foster a greater understanding in Tanzania. Partners should provide forums for discussing opportunities, gaps, challenges, and strategies for HIV prevention efforts with IDU and alcohol abuse populations. These issues should be included in the Drug Control Commission's HIV prevention strategy.

Men who have sex with men and heterosexuals who practice anal sex

The extent of MSM and anal sex behaviour among hetero-sexual behaviour in Tanzania is not well known. However, a few studies indicate that in some parts of the country, practice of anal sexual intercourse (heterosexual or among men who have sex with men) occurs and may have an important role in driving HIV transmission. There is anecdotal evidence that this practice might be more common in Zanzibar and Pemba islands. On the mainland, the practice might be increasing along the costal regions. Makwagile et al (2001) and Hoffman et al (2004) also documented anal sex behaviour among young people on the mainland and the practice might be common among sex workers and their clients. It is also acknowledged that many men who have sex with men also engage in sexual intercourse with women. From these reasons, it is necessary for the HIV prevention strategy to quantify the magnitude of these practices and recommend appropriate strategies.

4.1 Strengthen Tanzania's response to substance abuse and addiction treatment, with a focus on IDU and alcohol abuse

The priority actions for the immediate term under this strategy are to:

- Undertake appropriate studies on magnitude, distribution, and dynamics of IDUs, individuals who abuse alcohol and MSMs
- Pilot behavioral and structural interventions involving a minimum package of HIV prevention services, analyzing risk reduction and addicting treatment in a variety of low-resource settings.

- Conduct sensitization and advocacy campaign with national, district, and community leaders to foster a greater understanding of substance abuse and solutions in Tanzania.
- Rehabilitate mental health facilities or establish rehabilitation centres to accommodate IDUs for rehabilitation services

5.5 Strengthened Information Systems for HIV prevention

Current Situation and Context:

A strengthened information system for strategic planning and evaluation of HIV prevention programmes will involve enhanced HIV/AIDS and behavioural surveillance, improved tracking of programme outcomes, outputs, quality and coverage as well as HIV prevention resources and inputs. Operational research particularly evaluation of various interventions is necessary to provide an improved evidence base for HIV prevention programmes. Detailed discussion of strategic information for HIV/AIDS programmes is beyond the scope of this *National HIV Prevention strategy for Tanzania*.

Impact and outcome evaluation of HIV Prevention Programmes

Currently, tracking the impact of HIV prevention programs in Tanzania is based on HIV prevalence. This data in Tanzania is available from the HIV surveillance system conducted among antenatal women and blood donors, and periodic national population-based HIV-serological surveys.

This HIV prevalence-based surveillance system in Tanzania will increasingly be confounded by the roll out of antiretroviral therapy and improved AIDS care. Tanzania requires systems to triangulate data from various sources to obtain estimates and trends of new infections. In addition, the MoHSW should strengthen the national HIV/AIDS surveillance system and population based surveys and surveys among MARPs. Furthermore, surveillance reports should be more regular and widely disseminated.

National HIV prevention programme outcome evaluation is based on HIV/AIDS knowledge, practices and attitudes of the general population and quality of health services obtained from periodic population-based and facility-based surveys, respectively. There is need to improve the comprehensiveness of these information systems and expand their scope to capture information on MARPs and other sub-national population groups. Deeper analysis and dissemination of this information should also be enhanced. Impact and outcome evaluation of individual programmes and specific interventions and programmes, should also be strengthened to provide evidence base on best practices for HIV prevention in the country.

Tracking coverage and quality of HIV prevention programmes

Tracking of outputs and quality of HIV / AIDS services based on routine reporting systems is vital for monitoring coverage and progress of HIV programmes. However, there is lack of adequate up-to-date strategic information on coverage and quality of most HIV prevention services at all levels in the country. There is currently no integrated system to comprehensively track this information and consolidate it into one report for regular dissemination. Consequently, information about coverage of HIV services is scanty and not always provided to implementers at all levels.

The Health Management information system is the main source of coverage data for biomedical interventions from health facilities, complemented by vertical data collection on some output indicators conducted by NACP and other implementing partners. The Tanzania Output Monitoring System for non-medical HIV/AIDS (TOMSHA) that has recently been formulated is being rolled out by TACAIDS and aims to capture data from community level activities. The regular collection and compilation of data on output and coverage as well as quality of HIV prevention services through these systems is currently incomplete, irregular, not timely and should be the focus of intensified efforts. In addition, regular data quality assessment and assurance should be instituted.

Tracking of resources for HIV prevention

Tracking resources for HIV prevention should be considered an essential element of the expanded HIV prevention in the country. Currently, more than 95% of financing for HIV/AIDS in Tanzania comes from external sources, and more than 80% of it expended off-budget, making tacking, very challenging.

There are various mechanisms for flow of funds for HIV/AIDS in Tanzania. They include general budget support (GBS), basket funding, and direct funding to local organizations. Under the Joint Assistance Strategy for Tanzania, GBS is seen as the most appropriate mechanism with funds flowing through the Government financial system. However, in the interim, GoT will continue to use a mix of funding arrangements with attention to reducing transaction costs associated with project approach.

Currently, there is no financial tracking system that routinely captures and tracks all financial resources for HIV and AIDS. Also, disaggregated data on HIV prevention expenditure is currently not documented including the Public Expenditure Reviews for Health Sector and HIV/AIDS, National Health Accounts, and National AIDS Spending Assessment. The only attempt to disaggregate HIV prevention spending was done for Tanzania 2008 UNGASS report, but about 73% of HIV prevention spending was not categorised. Without disaggregated HIV prevention expenditure data, it is difficult to link the allocation of resources to the drivers of the epidemic and assess alignment. The GoT should expand the coverage of the existing financial tracking processes, particularly the HIV/AIDS Public Expenditure Review, to include disaggregated data on HIV prevention. In addition, the GOT should strengthen coordination and reporting systems at all levels and regularly assess alignment of expenditure and HIV transmission dynamics.

Operational Research

Operational research including public health evaluation is a vital addition to routine data collection, necessary to provide comprehensive strategic information for programmes. There are a several operational and basic science studies that have been carried out in the country by various stakeholders and findings disseminated, often internationally. However, these studies are not based on a national research strategy. There is no national research agenda with clearly defined priority areas of focus. Furthermore, dissemination of study results is limited and therefore utilization of studies has been suboptimal. Furthermore, funding for research is also inadequate.

In light of this, there is need to streamline the conduct of priority research to better understand the complex factors around HIV transmission and effective HIV prevention approaches. For instance,

research to track the dynamics of HIV transmission among MARPs and to establish the size of at-risk populations is among the priorities for HIV prevention research. Research on the sexual behaviour of HIV infected individuals is also a priority. Funding for operational research based on national priorities should be strengthened. Finally, efforts should ensure that findings are readily accessible locally in Tanzania is widely disseminated and their utilization should be enhanced.

Management of Strategic Information:

It is essential that strategic information arising from programme monitoring and evaluation, surveillance, population surveys as well as operational research is routinely consolidated and packaged for dissemination to programme stakeholders. This information should be readily accessible to all stakeholders in the country. Unfortunately, there is currently no one stop centre where this information is well catalogued and where it can be readily accessed. As part of this strategy, a one stop information centre is to be established and supported to carry out this vital role. A system for regular reporting and dissemination should also be supported.

Strategic Priorities for strengthened information systems for HIV prevention

The priorities under this component are as follows:

5.1 Strengthening outcome and Impact monitoring through:

- Regular triangulation of data from various sources to obtain estimates of HIV incidence
- Research on HIV incidence determination with a view to obtaining practical ways of ascertaining HIV incidence estimates in future
- Regular national HIV and AIDS surveillance system and population based surveys as well as surveys among MARPs, including their size estimation and mapping
- Secondary analysis of existing behavioural and biological data to obtain more in-depth understanding of HIV/AIDS dynamics in the country
- Conducting a UNAIDS “modes of HIV transmission study”, for modeling the modes of HIV transmission to better guide alignment HIV transmission dynamics and response.
- Conducting a service availability and quality assessment servey

5.2 Strengthening tracking of coverage, outputs and quality of HIV prevention programmes, through:

- Operationalising TOMSHA and streamlining collection and flow of HIV/AIDS programme data from village, ward, district, regional and national levels.
- Strengthening the HMIS to collect and report more comprehensive and timely output data necessary to comprehensively track coverage of HIV prevention programmes. This will involve a review of indicators and HIV prevention data reported through the HMIS and strengthening the overall HMIS in the health sector.
- Strengthen the capacity of Ward multisectoral AIDS Committees (WMACs) and village multi-sectoral AIDS Committees (VMACs) to utilize M&E data and report it to higher levels.
- Training for Trainers to RACs and CHAC on collection and reporting of strategic information and how to use the data for their own programme planning

5.3 Strengthen the management, dissemination and utilisation of data for programme planning as well as documentation of best practices

This will be conducted jointly with all other HIV and AIDS programming. The priority actions under this component for the immediate term are:

- Establish national HIV/AIDS information centre for maintaining and dissemination of strategic information for HIV prevention (e.g. establishing web-based data sharing)
- Undertake appropriate studies on magnitude, distribution and dynamics of not-well understood behaviors or MAPRs, such as IUDs, alcohol abuse and risk behavior, and OVC.
- Strengthening the use of results of HIV and AIDS surveillance and surveys in program planning and evaluation

5.4 Strengthening the tracking of HIV prevention Resources.

Tracking of HIV prevention resources will be conducted as part of the tracking of all other HIV and AIDS resources. The priority actions for the short term are as follows:

- Expanding the coverage of the existing financial tracking processes, particularly the HIV/AIDS Public Expenditure Review to include disaggregated data on HIV prevention
- Strengthen reporting systems at national, regional, district and community levels in order to establish the link between financial resources and prevention interventions.
- Commission a thorough 'expenditure tracking' study during the first year
- Develop and disseminate a standard reporting template (guidelines) for tracking HIV resources

5.6 Strengthened coordination of HIV prevention resources and program

Current Situation and Context:
A well coordinated response is vital to a harmonized programme that avoids duplication, conflicts and gaps in programme activities. However, currently, coordination and accountability of HIV prevention in Tanzania is weak at all levels. TACAIDS according to its mandate is responsible for provision of overall multisectoral coordination, but has only recently established a HIV prevention desk that is not yet adequately resourced. The MoHSW provides effective coordination of the public health response. However, the coordination of non-biomedical intervention is particularly weak, with inexistent or weak horizontal and vertical linkages between stakeholders.

There is need for more efforts directed to coordination of activities by different donors, and partners. This should include efforts to track and harmonise the activities of NGOs, CSOs, CBOs and FBOs involved in HIV prevention at all levels. This should be conducted alongside strengthening reporting systems. Coordination of HIV prevention resources and programs should include strengthening the RAC, WMACs, CHACs and linking them to the health sector response for HIV/AIDS.

More discussion of coordination of HIV prevention will be found in the next section. However, detailed discussion of coordination of all HIV and AIDS control activities in the country is beyond the scope of this *HIV Prevention Strategy for Tanzania Mainland*.

5 Implementation Arrangements for HIV Prevention:

6.1 Coordination mechanisms for HIV Prevention

Effective implementation of the HIV Prevention Strategy will require a harmonized implementation framework. The coordination of HIV prevention will facilitate the translation of the HIV prevention strategy into operational plans of various entities including line ministries, regional and district governments, communities, NGOs, CBOs and development partners. In view of the multisectoral nature of HIV prevention, the Prime Minister's office is best placed to provide oversight of all HIV prevention activities. In line with the principle of the "three ones", and to ensure full accountability of HIV prevention, TACAIDS that is under the Office of the Prime Minister, in line with its core mandates of coordination, planning, resource mobilisation and advocacy will provide overall coordination of all HIV prevention activities. However, TACAIDS will have to be restructured and strengthened to fulfill this mandate. It will be necessary for TACAIDS to establish sufficient and formalized horizontal and vertical linkages with regions, districts and communities, development partners, CBOs, NGOs, FBOs and the private sector. It is necessary for the Government of Tanzania to strengthen the human, technical and infrastructural capacity of TACAIDS to enable it to effectively execute this role. The recently established HIV prevention unit in TACAIDS should be strengthened as part of this effort.

Currently, at technical strategies for coordination of HIV prevention activities through different fora e.g. the National HIV Prevention Technical Working Group (P-TWG) and technical working groups for specific interventions already exists. However, these mechanisms need to be formalized and strengthened. Under this coordination framework mechanism to coordinate the various sub-committees or TWGs for specific program areas e.g. male circumcision, MARPs, HCT, PMTCT will be established. It is presumed that under this framework, the existing technical committees / working groups will be subsumed and continue to serve as sub-committees of the National HIV Prevention Technical Working Group.

The HIV Prevention Technical Working Group:

Under this coordination framework, the HIV Prevention Technical Working Group (P-TWG) that is already in place will continue with its role as a technical reference for TACAIDS in analyzing scientific evidence, making appropriate recommendations to TACAIDS and monitoring the implementation of the HIV prevention strategy. The technical committees of the specific programme areas will be transformed to become technical sub-committees of the P-TWG. The roles of the P-TWG will be reviewed and its membership expanded / revised to represent all technical constituencies.

Coordination of Line Ministries

The implementation of the various components of the strategy will continue to be based in respective line ministries. HIV prevention activities in the respective ministries will be coordinated by the respective focal persons. All Ministries, Departments and Agencies (MDAs) will continue to develop, implement and monitor HIV prevention activities in their respective sectors line with their constitutional mandate and comparative advantages. The MoHSW through the NACP has a significant role in implementing and providing technical leadership of substantial areas of HIV prevention, especially

coordination of all biomedical interventions. The NACP will continue to provide this leadership in coordination with TACAIDS. Coordination of HIV prevention efforts will require institutional restructuring of TACAIDS and NACP to fulfill this mandate and establish sufficient linkages at lower levels. The NACP might also wish to re-examine where HIV prevention efforts will be coordinated/led within the programme.

Coordination of HIV Prevention at Regional and District Level

Coordination of HIV prevention programmes and resources should include strengthening regional and district level structures and establishment of vertical and horizontal linkages among stakeholders. The Regional AIDS Coordinator (RAC) under the RAS, will provide oversight to all activities of public and private sectors involved in HIV prevention at regional level and provide technical support to the respective district coordinators. The Council HIV and AIDS Coordinator (CHAC) and the health sectors District AIDS Coordinator (DAC) will coordinate HIV prevention at district level and support CMACs. The DACs and CHACs will provide oversight to CBOs and local NGOs implementing HIV prevention in the district. Currently the CHACs/CMACs are weak and their coordination role at LGAs level is sub-optimal. Strategies should be adopted to strengthen these structures at the regional and district and LGA level. In particular, the CHACs and DACCs should be strengthened to facilitate planning, implementation and monitoring of multi-sectoral HIV prevention. As part of this effort, vertical and horizontal linkages should also be strengthened.

Coordination of HIV Prevention at Community level

The village multisectoral AIDS committees (VMACs) and ward multisectoral AIDS committees (WMACs) are vital structures for the grassroots implementation and monitoring of HIV prevention. However, they are currently constrained by inadequate financial and human resources including lack of technical skills and most of them are currently not functional. For the HIV prevention strategy to be owned by communities, the VMACs and WMACs should be strengthened to work with assistance of DACs and CHACs in planning, implementation and monitoring of community level activities.

Civil Society Organization (CSOs) and networks of PLHIV

The CSOs and PLHIV networks will continue to play an important role in the implementation and monitoring of HIV prevention. The CSOs and PLHIV networks will work closely with TACAIDS and its structures including proving information on implementation and monitoring of activities under their umbrella entities. At sub-national level (regional, district and LGA levels), CSOs operating at that level should work with the corresponding multisectoral and health sector HIV/AIDS committees.

Development Partners

The Development Partners Group (DPG) is an important stakeholder in HIV prevention. The DPG provides substantial financial, material and technical support to the country. This group must build on the progress already made in 'harmonisation and alignment' of inputs and activities. The group will support TACAIDS and stakeholders including establishment of an information / resource centre for HIV prevention.

6.2 Monitoring and Evaluation of HIV Prevention Programmes

Regular monitoring and periodic evaluation of HIV prevention programs are essential for maintaining an informed and strategically guided response. The review of HIV prevention in Tanzania highlighted constraints of the national M&E system that must be addressed.

The Monitoring and Evaluation of HIV Prevention will continue to be in line with the existing M&E systems, procedures and mechanisms of the NMSF II and the HSSP. TACAIDS through its HIV Prevention Technical Working Group and the HIV Prevention unit that will be established, shall provide oversight to monitoring and evaluation of HIV prevention. The TACAIDS M&E unit under the Directorate of Policy and Planning shall provide technical guidance of monitoring and evaluation operations. Indicators of success against which HIV prevention will be tracked are attached, *Annex 3*.

The TACAIDS TOMSHA and the Health sector's Health Management Information systems concurrently, and routine information systems of other sectors will be the main avenues for collection and reporting of data on HIV prevention activities based on the priority monitoring indicators. The frequency of reporting will depend on the type of information and the systems used to collect the information. TACAIDS will be responsible for consolidation of the information at national level on a regular basis as well as preparation and dissemination of reports. In particular, TACAIDS will produce annual performance reports of HIV prevention, reflecting performance against set targets, for consideration by the P-TWG as well as the Annual Joint HIV and AIDS Programme Review which involves development partners, MDAs and other stakeholders. The MoHSW NACP and other line ministries will also continue to obtain, analyse and prepare reports of sectoral HIV prevention activities and provide regular reports to TACAIDS according to technical areas under their mandate. Horizontal linkages with TACAIDS will facilitate reporting of priority information to TACAIDS as well as sharing of their sector reports. In addition, partners implementing various programmes will be encouraged to document best practices in HIV prevention for consideration by stakeholders. Furthermore, information from research will be reported to the Information Centre that will be established, and their findings disseminated and used in planning and policy making.

At regional, district and sub-district levels, similar processes will be replicated, with the regional and district level structures collecting, analyzing and disseminating local data to stakeholders. At these levels, M&E operation will revolve around coverage and output indicators, with performance against targets assessed. Standard indicators to facilitate this will be in line with indicators formulated at national level to facilitate consolidation.

The evaluation of this HIV Prevention Strategy will be conducted in 2012, based on terms of reference developed by the P-TWG and stakeholders, and will form the basis for revision of the strategy.

6 Annex 1: HIV Prevention Strategy: Design Summary

Goal: Reduction of the rate and Number of new HIV infections by 25% by 2012					
	Outcomes:				
1. Increased adoption of safer sexual behaviours and reduction of risk taking behaviour	2. Strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic.	3. Increased utilization of HIV prevention services, through expanded demand, coverage, uptake and quality of health services for HIV prevention	4. Risk reduction among MARPs that have a potential for increased HIV transmission	5. Strengthened information systems for HIV prevention.	6. Strengthened coordination of HIV prevention programmes
	Priority Actions:				
1.1 Promote safer sexual behavior to decrease sexual transmission of HIV with emphasis on multiple partnerships, transactional, early and cross generational sex and their root causes 1.2 Empower national, regional and community leaders to engage local communities in promotion of safer sexual behaviour 1.3 Strengthen the design, implementation, and monitoring of sound HIV prevention initiatives 1.4 Strengthen multi-sectoral coordination forums at the national, regional, and community levels to ensure high quality HIV prevention initiatives 1.5 Promote increased participation of PLHIV in HIV prevention initiatives 1.6 Increased Coverage of male circumcision	2.1 Addressing Gender norms and inequities 2.2 Addressing sexual violence 2.3 Addressing harmful socio-cultural norms 2.4 Addressing harmful socio-economic drivers of the epidemic 2.5 Expanding programmes for fighting stigma and discrimination	3.1 Promote health seeking behaviors to increase utilization of HIV prevention services, while addressing barriers 3.2 Provision of appropriate biomedical services as part of the minimum package of HIV prevention services for specific target audiences 3.3 Empowering national, regional, and community leaders to engage in the promotion of high quality HIV prevention services 3.4 Strengthening the supply chain management of medical and pharmaceutical supplies for prevention 3.5 Increased participation of PLHIV in HIV prevention service delivery 3.6 Integration of HIV prevention services in clinical and community settings to maximize access to quality services 3.7 Increased access to and utilization of HIV Prevention services 3.7.1 HCT services 3.7.2 PMTCT services 3.7.3 STI services 3.7.4 Availability and uptake of condoms 3.7.5 Medical Infection Control 3.7.6 Safe blood transfusion 3.7.7 HIV prevention among HIV Infected individuals and HIV sero-discordant couples	4.1 Strengthen Tanzania's response to substance abuse and addiction treatment, with a focus on IDU and alcohol abuse	5.1 Regular impact and outcome evaluation of HIV prevention programmes 5.2. Regular tracking, analysis and dissemination of programme coverage data 5.3 Regular tracking of HIV prevention resources 5.4 Operational research and documentation of best practices 5.5 Wide dissemination of results, feedback into planning and implementation	6.1 Strengthening national Level Coordination 6.2 Strengthening the HIV Prevention Technical Working group 6.3 Strengthening Regional and District Level Coordination of HIV Prevention 6.4 Strengthening Ward and Community Level coordination of HIV Prevention

Annex..: Results Frame work

Results to be achieved	Indicator to measure whether result has been achieved	Baseline/year	2012 Target	2015 Target	Data sources / Comments
A: Impact of HIV Prevention (Long term Results)					
1. New Infections reduced by 25% • Total number of new infections reduced • Incidence rate of new infections reduced • Vertical Infections reduced	1. Estimated annual number of new infections in Tanzania	T 200,000 (2008) M NA F NA	175,000	150,000	ANC HIV surveillance Projections/Estimates
	2. Estimated HIV Incidence rate among adults 14-49 years	1%	0.85%	0.75%	Mathematical modelling/ Other incidence measures
	3. Percentage of young adults aged 15–24 who are HIV infected (UNGASS (22), MKUKUTA)	T M F			Population Surveys / ANC Surveillance
	4. Percentage of infants born to HIV infected mothers who are HIV positive (UNGASS (25)				PMTCT M&E
	5. Estimated annual number of vertical HIV infections				Projections/estimates
Outcomes of HIV Prevention (Intermediate Results)					
1.**Increased adoption of safer sexual behaviours and reduction of risk taking behaviours** • Reduced no. of sex partners • Reduced transactional sex • Reduced early sex • Reduced cross generational sex	6. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (UNGASS (16)	M 18% F 3%	10% 2%	5% 1%	Population Surveys
	7. Percentage of adults aged 15-49 years who report having had sex with a non-marital, non-cohabiting partner in the previous 12 months	M 16% F 29%	12% 20%	8% 15%	Population Surveys
	8. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 (UNGASS (15), UA6)	M 10% F 11%	7.5% 7.5%	5% 5%	Population Surveys
	9. Percentage of girls (15-19 years) engaged in cross-generational sexual partnerships	8%	6%	4%	Population Surveys
	10. Percentage of never-married teenagers (15-19 years) that have never had sex (primary abstinence)	M 66% F 70%	70% 75%	80% 80%	Population Surveys
	11. Percentage of men who paid for sex during the last 12 months	8%	6%	4%	Population Surveys
2.**Reduced risk of HIV transmission during exposure to high-risk sex** • Increased consistent condom use • Increased coverage of male circumcision	12. Percentage of women and men aged 15–49 that had more than one sexual partner in the past 12 months who reported use of a condom during the last casual sex (UNGASS (17)	M NA F NA			Population Surveys
	13. Percentage of men and women aged 15-49 years who had sex with a non-marital, non-cohabiting partner in the past 12 months that used a condom at last sex with such a partner	M 53% F 43%	70% 65%	80% 80%	Population Surveys
	14. Percentage of males who used a condom during the last sex with a sex worker				Special Surveys
	15. Percentage of discordant couples practicing safe sex				Population Surveys

Results to be achieved	Indicator to measure whether result has been achieved	Baseline/year	2012 Target	2015 Target	Data sources / Comments
	16. Percentage of female & male sex workers using a condom				Special Surveys
	17. Percentage of adult males (15-49 years) that are circumcised (by region)	67%	70%	85%	Population Surveys
3.**A strengthened and sustainable environment that mitigates underlying factors that drive HIV infection** • Social and gender norms have changed to encourage protective HIV-related behaviour and attitudes	18. Percentage of women who feel that a wife is justified in refusing sex or proposing condom use if she knows her husband has a sexually transmitted infection	M 91% F 92%	95% 95%	100% 100%	Population Surveys
	19. Percentage of schools that provided life skills-based HIV education in the last academic year (UNGASS (11)				
	20. Percentage of adults expressing accepting attitudes towards people with AIDS	M 26% F 35%	40% 50%	50% 60%	Population Surveys
					Special surveys
4.**Increased coverage, quality and utilisation of HIV Prevention Services** • Improved coverage and quality of PMTCT, HCT, STI, blood safety, medical infection control • Improved demand for and uptake of HIV prevention services • Improved logistics and supply management of HIV prevention commodities	21. Percentage of women and men aged 15-49 who have ever received an HIV test and received their results				
	22. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and received their results				
	23. Percentage of women who were pregnant in the previous 24 months that were offered an HIV tested and received their test results				
	24. Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission (UNGASS (5), UA3)				
	25. Percentage of randomly selected retail outlets and service delivery points that have condoms in stock				Condoms availability surveys
	26. Percentage of STI patients attending health facilities that are managed (diagnosed, treated and counselled on risk reduction) according to national guidelines				Population Surveys, Programme M&E
	27. Percentage of facilities that meet the minimum standards for infection control				Service provision assessment surveys
	28. Percentage of AIDS care facilities that have integrate HIV prevention and offer a comprehensive package of prevention with positives				
5.Increased understanding of behaviours that can potentially exacerbate the HIV epidemic	29. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected (UNGASS (21)				Special surveys
	Percentage of drug abusers practicing safe sex				
Outputs of HIV Prevention Efforts (Immediate Results)					
BCC: All individuals receive appropriate messages and life skills for HIV prevention	30. Number of persons reached with HIV prevention programmes, by target group				TOMSHA, Programme M&E
	31. Percentage of large[21] workplaces (public & private) that have prevention and care policies and programmes				
Social Change: Opinion leaders					

[7] The operational definition of 'large' for purposes of this framework will be any workplace which is employing 20 or more persons

Results to be achieved	Indicator to measure whether result has been achieved	Baseline/year	2012 Target	2015 Target	Data sources / Comments
in the community are able to facilitate processes to change harmful gender and social norms in communities					
PLHIV Involvement:	Number of networks and organizations with positive prevention programs				TOMHSA
Condom distribution: Sufficient number of condoms available especially for MARPs, hotspots, rural areas	Number of male and female condoms distributed to end users in the last 12 months (UA5)				HMIS
PMTCT:	Number of PMTCT Service delivery outlets				
	Percentage of RCH facilities that provide a complete PMTCT service package				
	Percentage of pregnant women attending ANC who are counselled, tested, and receive test results				HMIS, PMTCT M&E
	% of HIV+ pregnant women attending ANC who receive a complete course of ARV prophylaxis for PMTCT				
	# of positive mothers accessing PMTCT services for preventing negative born children from being infected				HMIS, PMTCT M&E
STI management	Percentage of public and private facilities providing STI services	61%	75%	85%	Service statistics
HCT	Number of adults (15-49 Yrs) counselled & tested for HIV, and receiving result in the past 12 months				Population Surveys, Programme M&E
	Percentage of districts with at least 6 HCT service delivery outlets				Service statistics
	Number of sites providing HCT services				Service statistics
Blood Transfusion Safety	Percentage of donated blood units screened for HIV in a quality assured manner (UNGASS (3)				Service statistics
	Number of low risk non-remunerated blood donors recruited				Service statistics
Medical Infection Control	Percentage of health facilities providing post-exposure prophylaxis				Service statistics
	Percentage of caregivers trained in standard precautions, transmission-based precautions and infection prevention control				Service statistics
	Percentage of caregivers and healthcare workers who receive post-exposure prophylaxis				Service statistics
Drug Abuse:	Number of programs IDUs and other MARPS with HIV prevention services, information and products				TOMSHA
Male circumcisions	Number of facilities routinely providing medical male circumcision services				Service statistics
	Number of males circumcised in health facilities				

Annex 2: Two Year Action Plan for HIV Prevention 2009/10-20/11

The strategic priorities in the National HIV prevention strategy and priority actions for the first 2 years are outlined in the table below. These priority activities reflect what is needed to reinvigorate HIV prevention in Tanzania based on the drivers of the epidemic.

Annex 2: HIV Prevention Action Plan Matrix

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
Outcome 1: Increased adoption of safer sexual behaviours and reduction of risk taking behaviour				
1.1. Promote safer sexual behaviors to decrease HIV transmission with emphasis on multiple partnerships, transactional, early and cross generational sex and their root causes	Develop standardized, culturally and age appropriate HIV prevention messages and tools/ guides for specific target audiences, aligned to the drivers of the epidemic	General population, youth (in and out of school, those with multiple partners, OVC, and MARPs (sex workers and partners, IDUs, transport workers, uniformed)	IEC/BCC Messages and tools/guides for the general population and the most important MARPs and other vulnerable groups developed by end of year 2	MoHSW, TACAIDS MoEVT, CSOs MoLYDS, Media
	Design / update national communications strategies and guidelines for communication on safer sexual behaviour, utilizing an effective mix of interactive mass media, promotional, and interpersonal communication	Communication strategies for TACAIDS, health sector, other sectors including education, gender etc	TACAIDS and MoHSW Communication strategy reviewed , Life skills and peer education curriculum standardized / developed	MoHSW, TACAIDS MoEVT, Sectors
	Develop and disseminate communications "kits" for local community leaders to integrate standardized messages on the drivers of the epidemic into on-going interpersonal communication	Community Leaders e.g. religious leaders, peer group leaders, workplaces, etc	Community leaders in at least 80% of wards provided communication guidelines / kits	MoHSW, TACAIDS MoEVT, CSOs, MoLYDS,
	Countrywide dissemination of messages and behavioural interventions through multiple channels i.e. interactive mass media, promotional, and interpersonal communication	Adults, young people and specific population groups, migrant workers	At last 80% of villages, schools, workplaces reached with educational messages	MoHSW, TACAIDS MoEVT, CSOs , MoLYDS
	Identification, adaptation/adoption and mass production of educational materials for youth	out-of-school youth, in-school youth, and general public	At least 80% of schools and youth clubs have educational materials	MoEVT, NGOs
	Scale up of life skills programmes for in-school and out-of-school youth through appropriate training of teachers, school counselors and peer group leaders, rehabilitation/establishment of youth centres	out-of-school youth, in-school youth, and general public	At least 80% primary, secondary and tertiary schools and vocational training institutions	MoEVT, NGOs
	Standardized training for peer group leaders and networks and training for fighting cross-generational, early and transactional sex through school clubs and sports activities for out-of-school youths	primary schools, higher learning institutions, vocational training, youth centres	At least 80% of schools, youth clubs etc have trained peer group leaders countrywide	MoEVT, NGOs
1.2 Empower national, regional and community leaders to engage local communities in promotion of safer sexual behaviour.	Community cultural dialogue country-wide on socio-cultural and gender norms that promote HIV infection.	Community Leaders e.g. religious leaders, peer group leaders, VHTs	At least 80% of VMACs, WMACs, health facilities reached	MoGCDY, NGOs, CHACs,
	Roll out a standardized participatory approach to bolster community knowledge of and participation in prevention of sexual transmission initiatives.	Community Leaders e.g. religious leaders, peer group leaders, VHTs	At least 80% of VMACs, WMACs, health facilities reached	MoGCDY, NGOs, CHACs,
	Strengthen the role of community leaders in oversight of prevention of sexual transmission initiatives	Village health team, VMACs and WMACs, workers leaders	At least 80% of VMACs, WMACs, health facilities	MoGCDY, NGOs, CHACs,
	Support communities to review and enforce laws and by laws that discourage cross-generational and early sex and provide safe spaces for vulnerable youth	Community Leaders e.g. religious leaders, peer group leaders, VHTs	At least 80% of VMACs, WMACs, health facilities supported	MoGCDY, NGO, CMACs,

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
1.3 Strengthen the design, implementation, and monitoring of sound HIV prevention educational initiatives	Strengthen the capacity of organizations, CBO and FBO institutions, to design, implement, and monitor HIV prevention initiatives and functional referral systems	NGOs, CSOs, FBOs, WMACs, VMACs, CMACs, MDAs especially high HIV prevalence regions	At least 80% of VMACs, WMACs, health facilities	MoGCDY, NGOs, CMACs,
	Design and implement a QA approach to monitor the quality of messages, the appropriateness of targeting, the provision of the minimum package of prevention services, and functioning of referral systems	NGOs, CSOs, FBOs, WMACs, VMACs, CMACs, MDAs especially high HIV prevalence regions	At least 80% of VMACs, WMACs, health facilities	MoHSW, TACAIDS MoEVT, CSOs Media
	Ensure that communication channels (mass media and interpersonal) mutually reinforce each other and provide interaction with target audiences.	NGOs, CSOs, FBOs, WMACs, VMACs, CMACs, MDAs	At least 80% of VMACs, WMACs, health facilities	MoHSW, TACAIDS, MoEVT, CSOs
	Undertake appropriate studies on magnitude, distribution and dynamics of not-well understood behaviors or MAPRs, e.g. IUDs, alcohol abuse, OVC.	MARPs (IDUs, MSM, CSW and their partners, miners, truckers, fisher folk etc)	Studies conducted on each of these groups	Academic Institutions, TACAIDS, MoHSW
	Update the quality and comprehensive context of existing materials and approaches based on the appropriate minimum package of prevention services utilizing existing communications channels, especially interpersonal communication	workplace and school based programs, Peer education programs, decentralized structures, Entrepreneurship skills projects, school- clubs, theatre groups etc	Curricular and materials and approaches for the key HIV prevention services reviewed and updated	MoHSW, TACAIDS, MoEVT, CSOs
1.4 Promote increased participation of PLHIV in prevention of sexual transmission initiatives	Facilitate and build the capacity of PLHIV networks to participate in the design, implementation and monitoring of HIV prevention educational initiatives	Networks of PLHIV, CBOs especially regions with high HIV prevalence	At least 80% of districts with active involvement of PLHIV	NGOs, PLHIV networks, TACAIDS,MDA
	Advocate for the active participation of PLHIV and organizations in district- and community-level education, advocacy, and oversight activities	Networks of PLHIV, CBOs	At least 80% of districts with active involvement of PLHIV	NGOs, PLHIV networks
	Support networks of PLHIV to conduct public education activities including public testimonies	Networks of PLHIV, CBOs	At least 80% of districts with active involvement of PLHIV	NGOs, PLHIV networks
1.5 Expand the availability of condom especially for MARPs and rural areas	Develop guidelines for distribution and promotion of condoms, promoting public-private partnership and community/workplace distribution	Public, private and community distribution outlets for condoms, workplaces especially migrant	Guidelines for condom distribution developed and disseminated	MoHSW, NGOs, CBOs
	Establishment of condom distribution outlets among MARPs in hot-spot areas, urban slums, hotels and lodges, bars, peer group leaders etc	MARPs and residents of hot-spots, urban slums, hotels and lodges, bars, peer group leaders	Condom outlets at community level established in all urban hot spots, bars & high HIV prevalence areas	MoHSW, NGOs, CBOs
	Develop and rollout an initiative to engage distribution outlet owners in HIV prevention education and skills building with clients	Owners of community level condom outlets	All owners and operators of community level condom outlets trained	MoHSW, NGOs, CBOs
	Review and expand the availability of condoms in PwP/ discordant couple/ youth/ MARP – friendly outlets	PwP/discordant couple/ youth/ MARP – friendly outlets	Condoms routinely provided in at least 80% of service outlets	MoHSW, NGOs, CBOs
	Set up a condom distribution desk for the public sector	National, regional and district level	Condom distribution guidelines and	MoHSW, NGOs,

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
	and develop guidelines for condom distribution to ensure steady availability of condoms in communities	institutions	institutional framework streamlined	CBOs
	Condom promotional campaigns for long-standing relationships and unknown partner sero-status	Adults, MARPs	Promotional activities conducted among MARPs, urban hotspots etc	MoHSW, NGOs, CBOs
1.6 Targeted introduction and roll out of quality Medical Male Circumcision:	Develop and disseminate policies and guidelines for male circumcision	Health facilities	Policies developed/adapted, and disseminated	MoHSW, NGOs, FBOs
	Roll out neonatal and adult male circumcision in public health facilities in regions with the highest HIV prevalence through appropriate capacity building (skills, infrastructure, and equipment)	Adult males and neonates in high HIV prevalence regions with low male circumcision prevalence	All public health facilities in 8 high HIV prevalence regions equipped to provide male circumcision services	MoHSW, NGOs, FBOs
	Finalisation and dissemination of national plan for male circumcision, prioritizing services in regions with low MC and high HIV prevalence	Stakeholders of medical male circumcision	National plan finalized and disseminated	MoHSW, NGOs, FBOs
	Establish referral linkages between counselling and testing and male circumcision services	Clients for Male circumcision	Referral linkages to HCT established in high prevalence regions	MoHSW, NGOs, FBOs
	Determine the appropriate role of traditional male circumcisers, and strengthen their capacity to contribute to adult male circumcision activities	Traditional circumcisers	Policy on role of traditional circumcisers developed	MoHSW, NGOs, FBOs Academia
	Studies on policy, cultural, and operational aspects of medical circumcision in eight regions with low prevalence of circumcision but high HIV prevalence	cultural, and operational aspects of medical circumcision	Studies on policy, cultural, operational and feasibility aspects of male circumcision conducted	MoHSW, NGOs, FBOs, Academia
	Public education campaigns on male circumcision through TV, radios, leaflets, brochures etc with emphasis on guarding against behavioural disinhibition	Adult males and females in the general population, MARPs	Messages on male circumcision disseminated countrywide and campaigns regularly conducted	MoHSW, NGOs, FBOs
Outcome 3: A strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic				
2.1 Empower communities to address harmful gender and socio-cultural norms and gender based violence	Support local governments to translate GBV action plans into concrete components of community by-laws	Local Governments and community leaders	At least 50% of local governments engaged to develop bye laws	TACAIDS, NGOs, CHACs
	Build capacity of community leaders to speak against harmful cultural practices, beliefs, cultural and gender norms while reinforcing positive cultural practices	Traditional, religious and community leaders as well as opinion leaders	At least 50% of community, traditional and religious leaders in each district sensitized	TACAIDS, NGOs, CHACs, MoCGDC
	Sensitise workers on existing laws, regulations, standing orders code of conduct on sexual relationship at work place and support their enforcement	Workers in the public and private sector	Workers in at least half of the districts in the country sensitized in the workplace	TACAIDS, NGOs, CHACs, MoCGDC
	Support the police to expand gender desks and provide training to police staff	Police and law enforcement officers	At least 50% of police and low enforcement officers trained	TACAIDS, NGO,MoCGDC
	Advocacy for the development of a specific law on domestic violence	Stakeholders in community development and the legislature	Legislature lobbied for a law on domestic sexual violence	TACAIDS NGO,MoCGDC

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
	Support the MoCGDC to develop a multi-sectoral GBV network; and support it to advocate for GBV budget	Stakeholders in community development	SGBV network developed	TACAIDS, NGO,MoCGDC
2.2 Mainstream gender considerations in all HIV and AIDS services	Incorporate GBV and equity in HIV and health policies and plans and track their implementation	HIV and health policies, health workers and AIDS service providers	Health & HIV/AIDS policies reviewed and policies updated accordingly	TACAIDS, NGO,MoCGDC
	Codify a minimum package of services for survivors of gender based violence	survivors of gender based violence	Minimum package of services developed and rolled out	TACAIDS, NGO MoCGDC
	Incorporate GBV screening and referrals into all health and HIV services and clinics	health and HIV services and clinics	SGBV screening conducted in at least	TACAIDS, MoCGDC,NGO
	Pilot a one-stop service center for GBV survivors	survivors of gender based violence	Centre for survivors of SGBV piloted	MoCGDC NGO
	Link GBV and HIV in behavior change mass media and interpersonal communications campaigns	IEC/BCC stakeholders	SGBV incorporated in HIV/AIDS IEC and BCC campaigns	TACAIDS, MoCGDC NGO
Outcome 3: Increased utilization of HIV prevention services, through expanded demand, coverage, uptake and quality of Health services for HIV Prevention				
3.1 Promote health seeking behaviors to increase utilization of HIV prevention services, while addressing barriers to their use	Develop culturally and age appropriate messages targeting health-care seeking behaviors to increase use of specific HIV prevention services.	General adult population, youth and MARPs (sex workers and partners, IDUs, truckers, uniformed	Messages for general population and MARPs and other vulnerable groups developed by end of year 2	MoHSW TACAIDS MoEVT, CSOs
	Design and roll out national communications strategies to increase demand for and use of services, using mass media, promotional and interpersonal communication.	Health facilities and other outlets of HIV prevention services	Communication strategies developed	MoHSW TACAIDS
	Develop communications "kits" to integrate messages on health-seeking behaviour into on-going interpersonal and other community level communication and educational activities	Clients and eligible individuals for HIV prevention services in the general population and MARPs	Communication kits developed for different target audiences	MoEVT, NGOs MoHSW, CSO MDCGC, Media,
3.2 Provision of HIV prevention services as part of the minimum package of HIV prevention services for specific target audiences	Define the minimum package of services for the general population and specific population groups including MARPs	general population and specific population groups e.g. MARPs	Minimum HIV prevention packages for various groups defined	MoHSW, MDAs, TACAIDS
	Inventory and mapping of all prevention, care, treatment, and OVC resources in conjunction with district and community leaders and partners and establish appropriate referral networks.	HIV Prevention Service Outlets, District and Community leaders especially high HIV prevalence areas	Appropriate referral networks established in at least 80% of Wards for various population groups	MoHSW, TACAIDS, CMACs, NGOs
	Strengthen coordination and referral systems at the district level using the minimum packages of prevention services defined for each target audience	HIV Prevention Service Outlets, District and Community leaders especially high prevalence regions	Appropriate referral networks established in at least 80% of Wards for various population groups	MoHSW, TACAIDS, CMACs, NGOs
3.3 Empower national, regional, and community leaders	Roll out a standardized participatory approach to bolster community knowledge of and participation in service delivery in collaboration with health units.	Community leaders, health services outlets	Participatory approach rolled out to at least 80% of districts	MoHSW, TACAIDS, CMACs, NGOs

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
on biomedical HIV prevention	Strengthen the role of community leaders in the oversight of district-level service delivery	Community leaders, health services outlets	Community leaders participation enrolled in 80% of districts	TACAIDS, CMACs, NGOs
3.4 Strengthening the supply chain management of medical and pharmaceutical supplies for HIV prevention	Assess the procurement and supply chain management system, and act upon recommendations for improving the supply chain management system	Health facilities, Community outlets of HIV Prevention Services	Annual Assessment of the PSM conducted	MSD, MoHSW, Private sector
	Forecast, procure and distribute commodities, supplies and equipment for HIV prevention i.e. HIV test kits, STI treatment kits, condoms, protective clinical equipment, biohazard disposal boxes, sharps-disposal boxes, single use syringes with auto-destruct features, chlorine products , and MC surgical kits	Public and private Health facilities, Community outlets of HIV Prevention Services	At least 80% of facilities reporting no stock outs of essential commodities for HIV prevention	MSD, MoHSW, TACAIDS, Private sector
	Advocate for inclusion of appropriate commodities and supplies into council health plans	Regional, district and ward councils	80% of councils include procurement of HIV prevention commodities	MSD,MoHSW, TACAIDS
3.5 Promote increased participation of PLHIV in HIV prevention and biomedical service delivery	Advocate for participation of PLHIV in task-shifted activities, such as expert patients, lay counselors, peer and community education	HIV Prevention stakeholders, service delivery outlets, PLHIV networks	At least 80% of HIV prevention services include participation of PLHIV	PLHA net-works, MoHSW, TACAIDS
	Build the capacity of PLHIV networks to participate in the design, implementation, monitoring, and evaluation of services and communications initiatives	PLHIV networks, service delivery outlets	At least 80% of PLHIV networks trained in HIV prevention service delivery	PLHA networks, MoHSW, TACAIDS
	Advocate for the active participation of PLHIV and organizations in district- and community-level education, advocacy, and oversight activities	HIV Prevention stakeholders, service delivery outlets, PLHIV networks	At least 80% of community and district level activities involves participation of PLHA	PLHA networks, MoHSW, TACAIDS
3.6 Integration of HIV prevention services within clinical and community settings to maximize exposure to high quality HIV prevention services	Review the status of integration of HIV prevention services within clinical and community settings	clinical and community HIV prevention service outlets	Status of integration reviewed with appropriate recommendations made	MoHSW, TACAIDS
	Review the comprehensiveness of current policies, standards and guidelines on integration of HIV prevention services in clinical and community settings and revise or update as required	current policies, standards and guidelines on integration of HIV prevention services in clinical and community settings	Review report with appropriate recommendation	MoHSW, TACAIDS NGOs
	Technical assistance and training to facilities and communities to scale up integration of HIV services and referrals	clinical and community HIV prevention service outlets	At least 80% of HIV prevention service outlets supported to integrate services	MoHSW, TACAIDS NGOs
3.7 Expand the scope, coverage and quality of HIV Counseling and testing services	Expand access to gender sensitive, couples-oriented, adolescent ,and youth friendly HCT services, with a focus on high prevalence areas and populations	Adults, Couples, MARPs, Residents of high HIV prevalence areas, urban areas etc	At least 60% of residents of high prevalence areas ever tested for HIV	MoHSW, NGOs
	Expand the reach of mobile HCT targeted to MARPs, difficult to reach populations, and rural areas	MARPs, difficult to reach and rural areas and populations, workplaces	At least 80% of communities having static or mobile outlets	MoHSW NGOs
	Review and advocate for national technical policies for task-shifting and lay-counselors in HCT service delivery	HCT service outlets, lay counselors, PLHA networks	Policies for task shifting of some aspects of HCT service delivery to lay	NACP and HCT subcommittee

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
	including trained PLHIV		counselors adapted	
	Update HCT guidelines to incorporate risk reduction counseling, positive prevention, and couple counseling, testing, and disclosure	HCT stakeholders	HCT guidelines updated	NACP and HCT subcommittee
	Review pediatric HCT guidelines, and expand services, with an initial focus on OVC	HCT stakeholders	HCT guidelines updated	NACP, HCT committee
	Increase the active participation of prominent leaders, PLHIV ,and celebrities in promoting counseling and testing, and partner disclosure of HIV sero-status	HCT stakeholders and service outlets	Popular individuals actively supporting HCT, couple counseling and disclosure of test results	stakeholders, NGOs, MoHSW
	Expand PITC within home based care settings in high prevalence regions	Residents of high HIV prevalence areas especially urban hotspots	PITC rolled out to all high HIV prevalence areas, hotspot venues etc	MoHSW NGOs
	Review the addition of other services to the counseling and testing platform, such as screening for gender-based violence, STIs, and substance abuse	Clients or victims of gender-based violence, STIs, and substance abuse	Guidelines / policies for addition of services to HCT platform developed	MoHSW NGOs
	Build capacity of CBOs and FBOs for HCT, especially premarital testing, disclosure, post-test clubs	community and FBOs	CBOs and FBOs in all high HIV prevalence areas trained in HCT	community and FBOs
	The NACP and HCT subcommittee to adopt revised policies and guidelines within a 12 month period, as per the above revised and expanded services	MoHSW (NACP) and HCT subcommittee	Revised / updated policies available in 12 months	MoHSW (NACP) & HCT subcommittee
	Recruit and train health care workers, social workers, and lay counselors for HCT service provision	HCT stakeholders and service outlets	Task shifting scheme rolled out to at least 50% of facilities	NACP, MoHSW
3.8 Expand the scope, coverage and quality of HIV Prevention with Positives	Develop appropriate guidelines for integration of HIV prevention into AIDS care and treatment and other aspects of "positive prevention"	AIDS care and treatment service outlets, health care providers	Policies developed and disseminated	MoHSW (NACP) CTC committee
	Scale up PwP services within facilities, and community programs, such as home based care	AIDS care and treatment service outlets, health care providers	All facilities and community programmes providing PwP services	MoHSW NGOs
	Define and roll out to all HIV/AIDS prevention, care, and treatment programs in the country a HIV prevention package for HIV discordant couples at the facility and community level, with a focus on risk reduction counseling and condom use.	AIDS care and treatment service outlets, HCT outlets, health care providers	HIV Prevention package for HIV sero-discordant couples developed and rolled out to all facilities and service outlets	MoHSW (NACP) CTC committee TACAIDS P-TWG
	Define and rollout case managers using a task-shifting scheme to include non-clinical staff	AIDS care and treatment service outlets, health care providers	Task shifting scheme rolled out to at least 50% of facilities	MoHSW, NGOs, CBOs
	Train and support PLHIV to provide appropriate PwP services to peers	PWHA networks	At least 50% of PLHIV networks trained in PwP initiatives	MoH/NACP, PLHIV N/work
	Expand the provision of mobile PwP services to MARPs and difficult to reach populations	MARPs and difficult to reach populations	PwPs introduced for MARPs and hard to reach populations in 8 regions	NACP, PLHIV network
	Integrate HIV positive prevention in treatment, care and	AIDS care and treatment service	All HIV/AIDS care and treatment	MoHSW, NGOs,

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
	support programs	outlets, health care providers	outlets integrating PwP packages	CBOs
3.9 Expand the scope, coverage and quality of PMTCT Services	Expand CT services to 80% of labor and delivery wards and RCH clinics including the training of health workers	RCH outlets, Antenatal women and their families	At least 80% of RCH clinics provide PMTCT services	MoHSW, RCH clinics, NGOs
	Review, update, and roll out the revised ARV prophylaxis regimens to all PMTCT outlets	All PMTCT outlets	All HIV-positive antenatal women receive combination ARV prophylaxis	MoHSW, NGOs, CBOs
	Strengthen facility- and community-based post natal follow up and infant feeding support	All PMTCT outlets	Post natal follow up provided to at least 80% of HIV-positive AN women	MoHSW, NGOs, CBOs
	Review definition of and provision of basic preventive care package to mothers and infants; address gaps	RCH clinics, Antenatal women and their families	Report of the review of basic package for infants and children	MoHSW, NGOs, CBOs
	Provision of alternative infant feeding options to HIV-negative exposed children	HIV-negative exposed children	Alternative infant feeding provided to at least 50% of exposed infants	MoHSW, NGOs, CBOs
	Capacity building for CBOs to manage mother support groups	community organizations, mother support groups	Community organizations in high prevalence areas supported	MoHSW, NGOs, CBOs
	Scale up the integration of gender-sensitive PMTCT into reproductive and child health services	reproductive and child health services	Gender concerns integrated into all PMTCT and RCH services	MoHSW, NGOs, CBOs
	Expand provision of family planning services to HIV positive women	HIV-positive women and their families	At least 80% of HIV-positive women and their families provided FP	MoHSW, NGOs, CBOs
3.10 Expand the scope, coverage and quality of STI Services	Scale up provision of and referrals for STI management services	Youth, facility staff	STIs services and referral networks expanded to at least 80% of facilities	MoHSW, NGOs, FBOs
	Set up targeted STI management services in hotspots, fishermen, truck drivers, MSM, IDUs and CSWs	MARPs e.g. fishermen, truck drivers, MSM, UDUs and CSWs	Targeted STI services available for at least 80% of mapped MARPs	MoHSW, NGOs, FBOs
	Review STI syndromic management guidelines and incorporate HSV -2	STI service delivery stakeholders	STI management guidelines revised to incorporate treatment for HSV-2	MoHSW, NGOs, FBOs
	Conduct STI syndrome aetiology validation and antimicrobial susceptibility studies to inform the formulation of syndromic management guidelines	STI clients, Facilities	STI syndrome aetiologies validated and data available	MoHSW, NGOs, FBOs, Academia
3.11 Expand the scope, coverage and quality of Medical Infection Control and PEP in health facilities and communities	Rollout occupational exposure guidelines and PEP to all facilities	Health facilities and Community care settings	Guidelines available in at least 80% of settings	MoHSW, NGOs, FBOs
	Rollout Hepatitis B vaccines for all health care workers	Health care workers	HBV vaccines available for health workers in 80% facilities	MoHSW, NGOs, FBOs
	Print and disseminate guidelines for infection control to all public and private health facilities	Health facilities and Community care settings	Guidelines available in at least 80% of settings	MoHSW, NGOs, FBOs
	Train 100% of health care workers from each district on infection control	Health facilities and Community care settings	100% of clinical staff trained in medical infection control	MoHSW, NGOs, FBOs
	Provide information to health care providers on PEP through training & educational materials in all districts	Health workers, community members	Information on medical infection control available in 80% of settings	MoHSW, NGOs, FBOs
	Establish and support functional infection control committees in heath facilities	All health facilities	Infection control committees functional in at least 80% of health	MoHSW, NGOs, FBOs

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
			facilities	
	Increasing access to PEP for all people exposed to contamination of blood, blood products, including care-givers, raped individuals and medical staff	Health workers and community members exposed to potentially infectious materials	All health workers exposed to potentially infectious materials having access to PEP	MoHSW, NGOs, FBOs
	Incorporate infection control and PEP in pre-service training of health care workers	All pre-service health worker training institutions	All pre-service training institutions training in infection control and PEP	Training schools
	Support development of Infrastructure for medical waste management	Health care facilities	At least 80% of facilities having medical waste management facilities	MoHSW, DP, NGOs,
2.13 Expand the scope, coverage and quality of Safe blood transfusion services	Ensure 100% of blood supply is accurately screened for HIV according to national standards	Health facilities, blood transfusion recipients	Increase coverage of safe blood to at least 80% of health facilities	MoHSW–NBTS, NGOs
	Increase the number of blood transfusion centers in the country from zonal level to all regions	Health facilities, blood transfusion recipients	All regions having a blood transfusion centres	MoHSW–NBTS, NGOs
	Strengthen the distribution, testing and storage capacity to the blood transfusion centers and facilities	Health facilities, blood transfusion recipients	All NBTS centres having transport facilities for distribution of blood	MoHSW–NBTS, NGOs
	Strengthen HIV prevention among blood donors through counseling and testing	All blood donors	All blood donors provided adequate CT including risk reduction	MoHSW–NBTS, NGOs
	Distribute blood transfusion and blood donor recruitment & retention guidelines to health facilities	All health facilities transfusing blood to clients	Blood transfusion policy and guidelines available in all facilities	MoHSW–NBTS, NGOs
	Expand recruitment of low-risk-non remunerated blood donors, with participation from communities,	Voluntary non-remunerated blood donor clubs, facilities	Proportion of blood from voluntary donors increased to 80%	MoHSW–NBTS, NGOs
	Increase recruitment of VNRBD through establishment of blood donor clubs, mobilisation campaigns, strengthening the data-base of voluntary donors.	blood donor clubs, schools	Number of blood donor clubs increased by 100%	MoHSW–NBTS, NGOs
	Expand coverage of the quality assurance scheme for the national blood transfusion services	Blood transfusing facilities, private hospitals.	All blood transfusing facilities countrywide under the QA scheme	MoHSW–NBTS, NGOs
3.12 Expand scope and coverage of services for HIV sero-discordant couples and HIV-infected people	Develop a HIV prevention package for HIV sero-discordant relationships and for PwP and roll out to all HIV/AIDS prevention, care and treatment programmes	HIV sero-discordant couples AIDS care, treatment and prevention programmes	HIV prevention for discordant couples developed and rolled out to at least 80% of facilities	MoHSW, NGOs, FBOs
	Scale up provision of condoms to HIV-infected individuals as part of their ongoing care	HIV sero-discordant couples AIDS care, treatment and programs	All CTC centres providing condoms to AIDS clients	MoHSW, NGOs, FBOs
	Promote condom use among HIV discordant couples and longstanding relationships	Couples in long standing and HIV serodisordant relationships	Messages on condom use in sero-discordant and long-standing relationships disseminated	MoHSW, NGOs, FBOs
	Promote premarital HCT and develop educational messages & materials on extramarital/premarital sex	Married and pre-marital couples, religious leaders	Premarital HCT promoted by at least 50% of religious leaders	MoHSW, NGOs, FBOs
Outcome 4: Risk reduction among other most-at-risk populations that have a potential for increased HIV transmission				
4.1 Strengthen Tanzania's	Undertake appropriate studies on magnitude, distribution,	MARPs (IDUs, MSM, CSW and their	Formative Behavioural studies	TACAIDS,

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
response to substance abuse and addiction treatment, with a focus on IDU and alcohol abuse	and dynamics of IDUs and individuals who abuse alcohol	partners, miners, truckers, fisher folk etc)	conducted on at least 5 important MARPs	MoHSW, NGOs
	Pilot behavioral and structural interventions that provide the appropriate minimum package of prevention services, analyzing risk reduction and addicting treatment in a variety of settings	urban/rural, community and clinic based, and low resource settings	Results of pilot studies in different settings available	TACAIDS, MoHSW, NGOs
	Conduct a national sensitization and advocacy campaign with national, district, and community leaders to foster a greater understanding of substance abuse and solutions in Tanzania.	national, district, and community leaders especially in urban areas	Leaders in at least 80% of urban areas, national and regional level sensitised	TACAIDS, NDCC
	Rehabilitate mental health facilities to accommodate IDUs for rehabilitation services	mental health facilities	At least 5 facilities per region rehabilitated	MoHSW, DCC
Outcome 5: Strengthened information systems for strategic planning and evaluation of HIV prevention				
5.1 Strengthen outcome and Impact monitoring	Regular triangulation of data from various sources to obtain estimates of HIV incidence.	Research, Surveillance and HIV prevention programmes	Annual reports of data triangulation as data on HIV incidence obtained	MoHSW, Universities
	Conduct regular national HIV and AIDS surveillance system and population based surveys as well as surveys among MARPs and dissemination of results	Surveillance sites, general population, research projects, MARPs	Annual surveillance and period facility- and population-based HIV sero prevalence and incidence data	MoHSW, TACAIDS, NBS, Academia
	Strengthening the use of results of HIV and AIDS surveillance and surveys in program planning	All HIV and AIDS programmes	Dissemination of HIV/AIDS data to regions & districts	MoHSW, TACAIDS
5.2 Strengthen tracking coverage of HIV Prevention Programmes	Operationalize TOMSHA at lower level to improve flow of information about HIV prevention activities from village to district to regional level	Non-biomedical community level HIV/AIDS programme implementers	Quarterly reports submitted by 100% wards, districts and regions to TACAIDS	TACAIDS
	Strengthen the capacity of WMACs and VMACs on reporting	WMACs and VMACs and grass roots programme implementers	All WMACs and VMACs and implementers trained in TOMSHA	TACAIDS
	Streamline TOMSHA with other District Reporting Systems	District Reporting systems	Reporting systems streamlined across sectors	TACAIDS
	Review indicators and data reported through the HMIS and revise accordingly as well as strengthening the HMIS in the health sector	HMIS	Review Report, timely reporting of HIV prevention indicators in the HMIS	MoHSW, NACP, TACAIDS
	Capacity building at TACAIDS for management and sharing strategic information for HIV prevention,	TACAIDS Management and development partners	Information resource centre functional at TACAIDS	TACAIDS, DPG
5.3 Strengthen the management, dissemination and utilisation of HIV	Establish national M&E center, to manage and share strategic information for HIV prevention including establishing web-based data access and sharing	TACAIDS Management and development partners	Information resource centre established and functional at TACAIDS	TACAIDS, DPG
	Make use of TOMSHA as one of the tools for providing inputs in formulating Council Plans	All administrative councils	All councils trained in TOMSHA and provided regular reports	TACAIDS

Main Strategies	Priority Actions for First Two Years	Target Groups	Two year targets	Lead Actors
data for HIV prevention planning	Training for Trainers (TOT) to RACs and CHAC on collection and reporting of strategic information	RACs and CHACs	All RACs and CHACs trained	
5.4 Strengthen tracking of HIV prevention Resources.	Expand the coverage of the existing financial tracking processes, particularly the HIV/AIDS Public Expenditure Review to include disaggregated data	All HIV and AIDS programmes as well as development partners	Regular reporting of disaggregated financial data to TACAIDS, established	TACAIDS
	Commission HIV prevention expenditure tracking study	All HIV prevention programmes	Study conducted in Year 1	TACAIDS
	Develop and disseminate standard template/tool (guidelines) for tracking HIV resources	All HIV prevention programmes	Tracking tool developed and disseminated to all programmes	TACAIDS
Output 6: Strengthened coordination of HIV prevention programmes and rsources				
6.1 Strengthen multi-sectoral coordination forums at the national, regional, and community levels to ensure high quality prevention of sexual transmission initiatives	Capacity building for TACAIDS for coordination and monitoring implementation of HIV prevention strategy	TACAIDS	Capacity for HIV prevention coordination at TACAIDS established	TACAIDS
	Strengthen the HIV Prevention TWG	P-TWG	Regular meeting of the P-TWG held	P-TWG
	Conduct an analysis of the strengths, weaknesses, and opportunities for outcome-focused prevention coordination working via existing structures	National P-TWG, Council HIV and AIDS Committees particularly at district & community levels,	SWOT analysis conducted with appropriate recommendations	TACAIDS
	Identify specific roles for each entity in coordinating and overseeing HIV prevention programs	VMAC, WMAC, and CMAC	Roles and mechanisms for coordination of each body identified	TACAIDS
	Strengthen coordination mechanism of HIV prevention at district and regional level and provide relevant TA	TACAIDS, RACs, CHACs, sectors and NGOs, CBOs	Adequate coordination mechanisms established	TACAIDS
	Strengthen the capacity of VMAC, WMAC, and CMAC to plan, coordinate and report HIV prevention	VMAC, WMAC, and CMAC	The capacity of multisectoral coordination entities to coordinate stakeholders enhanced	TACAIDS, RAS, CHACs