THE UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

Tanzania National Multisectoral Strategic Framework for HIV and AIDS 2018/19 to 2022/23

November 2018

Foreword

For more than twenty years, HIV and AIDS has continued to be a public health threat in Tanzania. The Government of Tanzania established and placed Tanzania Commission for AIDS (TACAIDS) under the Prime Minister's Office to coordinate a multi–sectoral national response through provision of strategic leadership in prevention, care and treatment, an enabling environment, advocacy for social behavioural change and gender equality as well as research, monitoring and evaluation of the national response.

TACAIDS has thereafter, developed and overseen the implementation of three National Multi-sectoral Strategic Frameworks (NMSFs) that have supported the country to make progress in combating HIV and AIDS. Significant progress has been made to ensure availability of HIV prevention, care and treatment services and behavioural change towards creation of demand and the right to access health and other related services. The number of clients enrolled into ART has increased, AIDS-related mortality and new HIV infection has declined and there is less HIV related stigma and discrimination.

Lessons from implementation of previous NMSFs call for more resolute efforts to prioritize and scale up interventions in order to maintain the country sustainably on the path for epidemic control. Sustainable epidemic control will require additional resources, improved resource allocation and efficiencies, and more effective monitoring to work towards an AIDS free nation. A paradigm shift that entails geographical prioritization and population targeting is needed to address the diminishing resources, while aiming at increasing efficiencies and effectiveness of the national programme.

The country efforts have always embraced global and in-country best practices and evidence. The fourth National Multi-sectoral Strategic Frameworks (NMSF IV 2018/19 to 22/23) is therefore informed by the Five Year Development Plan II with a focus in building stronger Human Resources, election manifesto aiming at reducing new HIV infection as well as increasing domestic financing. In international arena the Framework is supported by Joint United Nations Programme on HIV and Aids (UNAIDS) Fast-Track Commitments to End AIDS by 2030; The WHO Global Health Strategy for HIV and viral hepatitis; the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) which aims at investing to end the Malaria, AIDS and TB epidemics and the Tanzania Investment Case which applied epidemiological synthesis and programmatic and economic analyses to develop scenarios for moving Tanzania towards the global goals. The Framework has also addressed Tanzanian's commitment to the implementation of the UN Political Declaration on HIV and AIDS in 2015, Sustainable Development Goals (SDGs) and the Africa Union Agenda 2063. For Tanzania to realize ambitious goals as per international and in country best practices we are working towards achieving 90-90-90 (90 percent of people living with HIV/AIDS tested, 90 percent of those tested access ARVs and 90 percent of those on ARV are virally suppressed) targets by 2020

This NMSF IV should therefore be used by all sectors as a guide to inform their HIV and AIDS planning and mainstreaming. The dissemination of NMSF IV document should launch a renewed spirit in combating HIV with emphasis on high impact interventions such as HIV Testing Services, ART for all, Condom Programming, Voluntary Medical Male Circumcision and targeted interventions for Key and Vulnerable Populations including the Adolescent Girls and Young Women as well as meaningful community engagement and empowerment. The strengthening of social, policy and legal environment should also be given attention. Implementers should be keen to adequately address the recommended strategic shift and avoid doing business as usual. Building from the current achievements, there is no room for complacent or reluctance.

Hon. Kassim Majaliwa Majaliwa
Prime Minister
13th November, 2018

Preface

Tanzania has continued its progress towards universal access to HIV and AIDS services. The fourth National Multi Sectoral Strategic Framework 2018/19 -2022/23 is pursuing the objective, with inspiration from the global targets of "zero new HIV infections, zero HIV-related deaths and zero stigma and discrimination due to HIV". The NMSF IV has adopted the investment case approach to ensure strategic targeting of Key and Vulnerable Populations including Adolescent Girls and Young Women (AGYW), Men who have Sex with Men (MSM), Female Sex workers (FSW), People who Inject Drugs (PWID) & People who Use Drugs (PWUD), as well as Prison inmates, Miners, and Fishermen with a clear focus on geographical locations with a high disease burden and the epidemic hotspots.

The development of the NMSF IV itself, which was carried out in 2018, has been based on broad participation of all key actors involved in addressing HIV and AIDS in Tanzania. Key actors involved include communities, civil society organizations, ministries and development partners. As a result, we are confident that the strategies identified in the framework are those that are the most likely to achieve the ambitious results aimed for. Understanding that the NMSF IV will be implemented in the challenging financial environment, strategies and interventions are prioritized on the basis of Tanzania investment case approach that emphasizes on effectiveness and targeting.

This prioritization exercise required difficult choices to be made during the NMSF IV development process and will continue to do so during the implementation period. It is now our responsibility to rise to the challenge and combine the necessary individual and collective resources in our drive towards universal access to HIV services. Let us continue our work with renewed energy and determination.

Dr. Hedwiga Swai
Chairperson
Tanzania Commission for AIDS (TACAIDS)

Acknowledgement

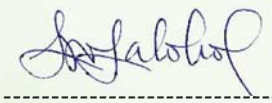
The development of National Multisectoral Strategic Framework IV 2018/19-2022/23 was an interactive exercise involving various multi-sectoral stakeholders from national to sub-national levels. The government through TACAIDS acknowledges the contribution of individuals and institutions who participated in developing this multi-sectoral strategic framework. Development and completion of this framework was due to generous contributions, support, commitments and efforts put forth by all involved institutions and individuals. Indeed, their tireless involvement and active engagement in the open and participatory processes have indeed contributed to the success of the process and quality of this document in terms of comprehensiveness, preciseness and logical.

Specifically, the government is indebted to UNAIDS for their financial assistance, guidance and support provided throughout the process. Special appreciations are extended to the National Joint Thematic Working Group, TACAIDS management team, members of the task team, and members of Technical Working Committees for their tireless guidance and readiness to respond to our many questions and demands. Special thanks go to TACAIDS staff including Regional Coordinators who participated effectively in defining the strategic direction and enriching this document.

We are also thankful to the consulted representatives from Government Ministries, Agencies and Departments (MDAs), representatives of Development Partners Group (DPG) supporting the national response, Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs), Faith-Based Organizations (FBOs), and relevant private sector stakeholders.

While it is not possible to list everyone, who supported us in one way or another in the whole exercise, we owe much to the People Living with HIV/AIDS (PLHIVs) umbrella organization, networks and clusters, youth organizations, key and vulnerable populations for providing us with their valuable opinions and perceptions.

Last but not least, we would like to express our sincere gratitude to our consultants: Dr. Simon Mchiru, (International Consultant), and Dr. Stigmata Tenga, Julie Tumbo, and Dr. Emmanuel Matechi (Local Consultants) for their technical expertise in facilitating the development of this strategic document. Their immeasurable experiences have made possible the development of a framework with clear prioritization and realistic goals.



Dr. Leonard L. Maboko
Executive Director
Tanzania Commission for AIDS (TACAIDS)

Acronyms

ACT	Accelerating Children's HIV/AIDS treatment
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral
ATE	Association of Tanzania Employers
ATF	AIDS Trust Fund
C&T	Care and Treatment
CCP	Comprehensive Condom Programming
CHW	Community Health Worker
CMAC	Council Multisectoral AIDS Committee
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisations
CTC	Care Treatment Centres
CTX	Cotrimoxazole
DBS	Dry Blood Spot
DNA-PCR	Deoxyribonucleic acid
EIMC	Early Infant Male Circumcision
eMTCT	Elimination of Mother to Child Transmission
FANC	Focus on Antenatal Care
FP	Family Planning
FSW	Female Sex Worker
GF	Global Fund
HBC	Home Based Care
HBV	Hepatitis B virus
HCV	Hepatitis C Virus
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HTS	HIV Testing Services
IBBS	Integrated Biomedical-Behavioural Survey
IEC	Information Education and Communication
IPT	Isoniazid Prophylaxis Treatment
KP	Key Population
KVP	Key Vulnerable Population
LARS	Life Assessment and Response System
LLAPLA	Life Long ART for Pregnant and Lactating Women
LTF	Lost To Follow

M&E	Monitoring and Evaluation
MAC	Multisectoral AIDS Committee
MDA	Ministries Departments and Agencies
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MSD	Medical Store Department
MSG	Mother Support Group
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
MTEF	Medium Term Expenditure Framework
NACOPHA	National Council of People Living with HIV and AIDS
NBTS	National Blood Transfusion Services
NCD	Non Communicable Diseases
NGOS	Non-Governmental Organisations
NMSF	National Multisectoral Framework
OI	Opportunistic Infections
P1	Primary Investment
PEPFAR	Presidents Emergency Fund for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PSCM	Procurement and Supply Chain Management
PSI	Population Services International
PWID	People Inject Drugs
PWUD	People Who Use Drugs
WWUD	Women Who Use Drugs
RNMCH	Reproductive Neonatal Maternal Child Health
SBCC	Social and Behaviour Change Communication
SDM	Service Delivery Models
SI	Strategic Information
SR	Sub- recipient
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Rights
STC	Save the Children
STI	Sexually Transmitted Infections
STI-RTI	Sexually Transmitted Infections – Reproductive truck Infections
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund
TAT	Turn Around Time
TAYOA	Tanzania Youth Alliance
TB	Tuberculosis
TDHS	Tanzania Demographic Health Service

TMARC	Tanzania Marketing and Communication Company Limited
TOMSHA	Tanzania Output Monitoring System for HIV and AIDS
TTI	Transfusion Transmissible Infections
UNAIDS	Joint United Nations Programme on AIDS
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VAC	Violence Against Children
VAW	Violence Against Women
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation

Executive summary

The planning and implementation of the national multisectoral and decentralized HIV and AIDS response in Tanzania will be guided by the fourth National Multisectoral HIV and AIDS Strategic Framework (NMSF IV) – 2018/19 to 22/23. Given the multisectoral nature of the response, implementation will take place at national, regional, district and community levels based on individual stakeholders mandate, comparative advantage, resources and technical expertise. Implementing partners are drawn from government agencies, private sector, civil society organisations, communities, and support by development partners.

NMSF IV recognises that meaningful community and PLHIV engagement and empowerment has great potential to contribute to increased coverage of services, sustained access and utilisation, and long-term sustainability of the national response.

The NMSF IV has adopted the investment case approach to ensure strategic targeting of key and vulnerable populations including Adolescent Girls and Young Women (AGYW), Men who have Sex with Men (MSM), Female Sex workers (FSW), People who Inject Drugs (PWID) & People who Use Drugs (PWUD). Others include prison inmates, road construction camps, Long Distance Truck Drivers (LDTDs), miners and fishermen with their surrounding community. Clear focus on geographical locations with a high disease burden and the epidemic hotspots is envisaged. This approach will optimise the use of resources through efficiency gains in the design and delivery of services.

Priority objectives of the NMSF IV are:

- ***First,*** to support acceleration and intensification of targeted high impact interventions aimed at preventing new HIV infections and reducing AIDS related deaths.
- ***Second,*** to promote both efficiency and effectiveness, strategic partnerships and meaningful participation by all stakeholders, and in particular communities in the implementation of the national HIV and AIDS multisectoral and decentralised response.
- ***Thirdly,*** to leverage financial, technological, information, and human resources necessary to sustain the implementation of the national HIV and AIDS multisectoral response.

It is anticipated that effective, efficient and sustained implementation of the national response will result to the achievement of the following national priority impact results:

1. New HIV infections reduced by 75% in 2020, and by 85% in 2023
2. New HIV infections among children reduced to less than 5% by 2023 and below 2% by 2030
3. AIDS related deaths reduced by 50% in 2020, 70% in 2023 and 80% by 2030
4. Zero stigma and discrimination by 2030[1].

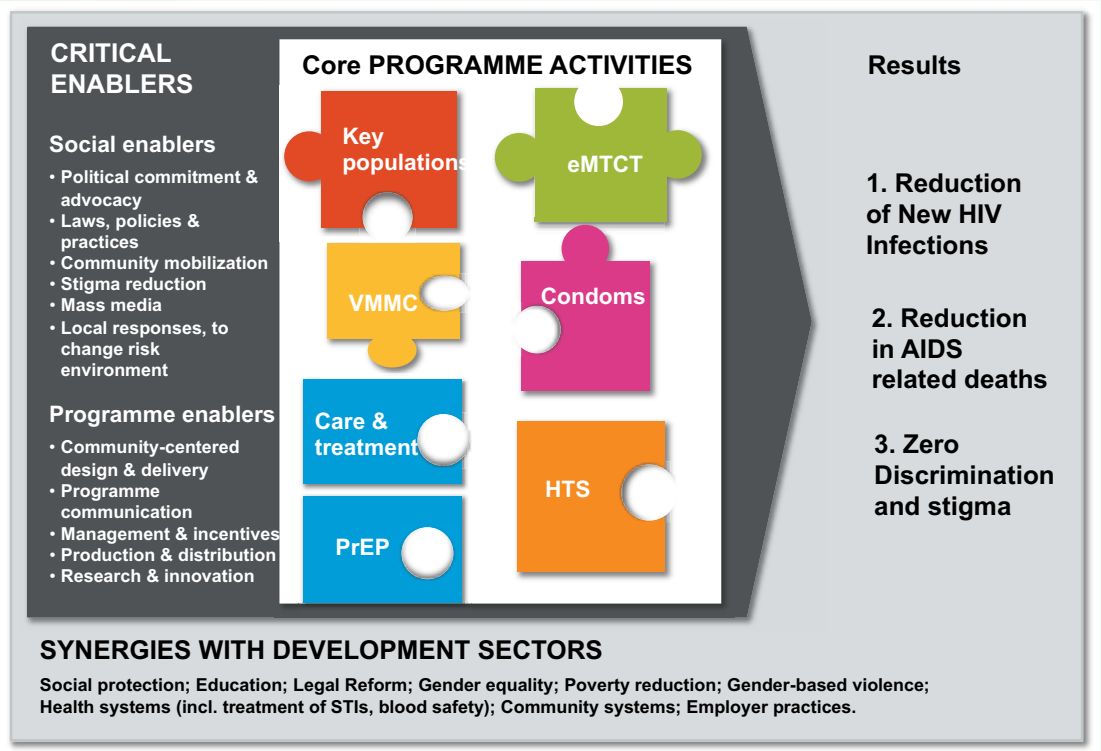
There are several outcome results that will contribute to the achievement of these impact level results that are articulated in the NMSF IV "Results Framework" (Annex 2)

NMSF IV has prioritised the core programmes indicated in figure 1 below. These programmes are prioritised based on their evidence-based efficacy as the core priority programmes for investment to deliver the above impact results. Implementation will be premised on the ***combination prevention approach.*** HIV Testing Service (HTS) has been prioritised given its strategic niche as an entry point to most of the programmes and services.

[1] Note: for impact number 4 – there is no current data. Data will be collected with the current Global Fund support.

The implementation impact of the core programmes will also depend on the efficient and effective implementation of the critical social and programmatic enablers i.e., Gender Based Violence (GBV), Violence Against Women (VAW), food security, poverty, retention of girls in schools and cross cutting issues such as Social Behavioural Change Communication (SBCC), gender and human rights. This is in addition to stigma and discrimination that has been found to be a critical bottleneck to the access and uptake of services.

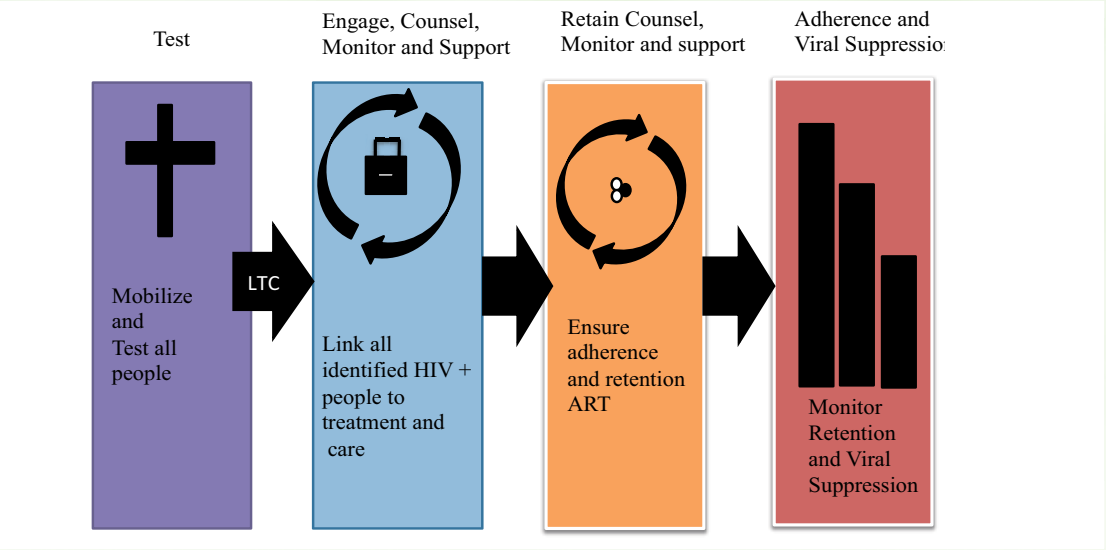
Figure 1: NMSF Critical Enablers, Core Programmes, and Potential Synergies with Other Sectors



Service delivery will be premised on differentiated models in order to ensure effective reach and uptake by the targeted sub population in the general population and in specific geographical hotspots. The primary mode of prevention interventions is the combination prevention approach intended to strengthen synergies and linkages within and between services. The approach is expected to increase efficiencies.

All people who test for HIV will be offered one of the two pathways. First, those who test HIV positive will be linked to treatment, care and support. They will be supported to ensure adherence, and retention, minimising lost to follow up, and increasing the potential for those retained on treatment to achieve viral suppression. It is anticipated that adherence, retention and viral suppression will contribute to reduction of morbidity and mortality amongst PLHIV. Second, all people who test HIV negative will be linked to HIV prevention programmes, and empowered through social mobilisation, information and education, to enhance adoption and adherence to non-risk behaviours. Both pathways are intended to have an incremental value. The treatment will follow the cascade that is aligned to the 90-90-90 targets (refer Figure 2)

Figure 2: The Treatment and Care Cascade



The NMSF IV has also articulated strategies to address other factors / bottlenecks that prevent Tanzania from achieving the optimal level HIV and AIDS programmes efficacy. These include: weak Procurement and Supply Chain Management (PSCM) systems, linkages between health facilities and communities, shortages of human resources, inadequate funding and use of appropriate technologies to support implementation, high numbers of people lost to follow-up; and a weak monitoring and evaluation (M&E) system. The Framework further recommends strengthening of the socio-policy and legal environment, strategic partnerships and alliances necessary to support and complement community efforts including sustained demand creation and social protection, as well as stigma and discrimination reduction. Implementation of innovative approaches such as HIV self-testing, Pre-Exposure Prophylaxis (PrEP), provision of social nets improvements of household and PLHIV livelihoods, and legal reforms will also be accelerated.

HIV mainstreaming will support development sectors to address the challenges of the epidemic. Internal mainstreaming will focus more on HIV workplace interventions that will be closely linked to existing wellness programmes. External mainstreaming will focus on ensuring that development projects don't fuel the spread of HIV.

Coordination and management of the HIV and AIDS multisectoral response will be strengthened, including monitoring and evaluation, research and resource mobilisation. Given that coordinating structures are established at all levels, the focus of NMSF IV will be on improving coordination efficiencies, harmonising and aligning the different responses based on the three-one principles, (One coordinating structure (TACAIDS), one Multi-sectoral HIV and AIDS strategy (NMSF), one Monitoring and Evaluation System.

Tanzania will embark on developing and implementing a "sustainable HIV and AIDS financing strategy" that will ensure adequate and sustained funding, with an expanded diverse donor base, and strengthening the scope of the Tanzanian AIDS Trust Fund. These strategies are intended to ensure a reduction on external funding dependency and reduction of the national response financing gaps.

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Chapter 1: Introduction

1.1 The Fourth National Multi-Sector Strategic Framework (NMSF IV)

This document presents the fourth generation of NMSF covering the period from 2018 to 2023. The development of the NMSF IV has been informed by the results of the mid-term review of NMSF III, the outcomes of the THIS, emerging issues and technology (i.e. PrEP, self-testing), and national, regional and global commitments to fast track HIV and AIDS response to achieve the 90-90-90 targets by 2020, and move towards eliminating AIDS by 2030.

The Framework has also addressed Tanzanian's commitment to the implementation of the UN Political Declaration on HIV and AIDS in 2015, Sustainable Development Goals (SDGs) and the Africa Union Agenda 2063. The Framework has attempted to harmonise and align different programmes supporting the national response including the USG / PEPFAR interventions (i.e. COP 17 and COP 18), the support from Global Fund, and several other bilateral and multilateral initiatives.

In implementing the NMSF IV prioritization will be necessary to ensure that cost-effective interventions are funded optimally, with funds reallocated away from less cost-effective interventions. Prioritization of population-group and geographical prioritization will be critical, and should be informed by more granular data with active involvement of decentralization coordination and implementation structures of the national response.

NMSF IV sets a new target to significantly reduce new HIV infection and AIDS related death by 2023. Tanzania also aims to eliminate HIV related stigma and discrimination.

1.2 The Purpose of the Framework

The NMSF IV intends to inform and guide the planning, programming, coordination and monitoring of the multisectoral and decentralised HIV and AIDS response. The Framework will also influence policy, practices (planning and services delivery), and advance knowledge within the context of the national multisectoral and decentralised HIV response. By influencing policy and practice, the Framework will enhance and accelerate the harmonisation and alignment of the different stakeholder's initiatives and place the national response implementation process at the cutting edge. Its strategies will enhance innovation and best practices, necessary to drive the Fast Track Strategy to achieve the 90-90-90 targets and move towards ending AIDS by 2030.

1.3 The Process of Developing the Framework

The process of developing the NMSF IV was participatory, involving selected key stakeholders drawn from government, civil society organisations (CSOs), and private sector and development partners. The process started with a comprehensive desk review of the performance of NMSF III, complemented by stakeholder consultations based on key informant interviews, focus group discussion (FGDs), stakeholder workshop and the use of self-administered questionnaire. This

was followed by, data analysis and preparation of a technical review report. The report was presented to the National Multisectoral Steering Committee established to oversee the NMSF IV development for consideration and approval. The findings have being used to inform the NMSF IV development process.

The NMSF IV development started with the conceptualisation and prioritisation of high impact interventions necessary to contribute to the desired impact and outcome results. The drafts were presented to stakeholders for review and comments before they were finalised. The final draft was then presented to a larger stakeholder's workshop for validation and approval. The development of the NMSF IV was conducted hand in hand with the development of the M&E and Operational Plans.

1.4 Guiding Principles

The NMSF IV is based on an in-depth analysis of epidemic trends, a review of Tanzania's response to HIV from 2013/14 -2017/18, and a review of global evidence on the most effective strategies. The NMSF IV is aligned to global fast track strategy that recognizes the need for locally tailored responses within a framework that fosters regional and local leadership and accountability. The strategy aims to rapidly scale up effective HIV services by 2020. In line with the global fast-track approach, the principles of the NMSF IV are:

- **Ambition:** ensuring leadership, political commitment and ambitious national targets;
- **Focus:** investing in services in locations and populations most affected;
- **Change:** scaling up effective responses and innovating community-based approaches;
- **Speed:** front-loading investment to accelerate scale-up of effective and efficient services;
- **Saturation:** investing in high-impact services with intensity and quality;
- **Human rights:** ensuring effective, equitable, people-centred HIV responses.

Chapter 2:
HIV and AIDS Situation in Tanzania

2.1 Country Context

The United Republic of Tanzania (URT) is the largest country in East Africa covering 947,300 square kilometres. It is an ethnically and culturally diverse, low-income country with a population of about 55 million, distributed in 31 regions and 169 districts. 51% of the population female and 63% is aged 24 years and younger and 68% of Tanzanians live in rural areas.

The United Republic of Tanzania is a low-income country which has experienced significant economic growth in recent years and is aiming to become a middle-income country by 2025 (NBS, 2016a). Tanzania's Gross Domestic Product (GDP) has continued to grow over the past decade, growing at 7.1% in 2017 and growth is projected to continue increasing.

The most recent figures on poverty levels in the mainland indicate that 28.2% of the population live below the basic needs poverty line, while 9.7% live below the food poverty line, a decrease from 34.4% and 11.8% respectively in 2007 (ibid). Many people live close to the poverty line and remain highly vulnerable to economic shocks. Roughly 80% of the poor and extremely poor population in Tanzania live in rural areas. Poverty is more prevalent among large households and households headed by elderly persons, while 19.09% of poor households and 21.16% of extremely poor households are headed by women (ibid).

Estimated population of 52 million by 2017 (based on 2012 Census projections),

The poverty level is estimated at 33.6 for rural areas and 21.7% for urban areas and on average about 28% of Tanzanian live below the poverty line. Agriculture is still the major source of income for the majority of population, however, its productivity has remained low.

2.1.1 National HIV Response

The national multi-sectoral HIV response is guided by 3-one principles (one plan, one coordinating body and one monitoring and evaluation plan). Tanzania response has been led by Tanzania Commission for AIDS, a legal institute mandated to provide strategic leadership and coordinate national response. TACAIDS has developed and coordinated implementation of the first, second and third National Multi-sectoral Strategic Frameworks, that inform and guide the implementation of the national response. The national response is informed by in-country and global strategies that are derived from existing and new evidence. Tanzania has joined the world by committing to bold target in the Sustainable Development Goal (SDG) of ending the AIDS epidemic by 2030. The country has adopted and is monitoring the UNAIDS, in its Fast-Track commitments on HIV Combination Prevention strategy.

2.1.2 Implementation of the NMSF III

The Third National Multi-sectoral Strategic Framework for HIV and AIDS (NMSF III) 2013/14 – 2017/18 intended to reduce new HIV infection, AIDS-related deaths and stigma and discrimination in Tanzania. By its design, the implementation of this strategic plan was categorized into five primary investments areas, six secondary investment areas and cross-cutting components.

[2] Indeed, when using the international poverty line of $1.25 a day, the data shows that 43.5% of the population lived in poverty in 2011.

At impact level the number of new HIV infections in Tanzania has decline to 81,000 (THIS,2016) from about 200,000 cases estimated to have occurred annually in the early 1990s (spectrum estimates). Estimated AIDS related mortality has also declined to 33,800 in 2017 from 72,983 estimated to have occurred in 2005. The trend indicates that the country is making progress toward reduction in HIV incidences and AIDS related deaths. This is attributable to the effectiveness of the scale-up of interventions in the national HIV response.

Key achievements that were noted when implementing the primary and secondary investment areas are described in table 1 and 2 below:

Table 1: NMSF III Achievements: Primary Investment Areas

NMSF III Achievements: Primary Investment Areas
ART: Adopted WHO recommended "treat all" approach and scaled up of ART from 431,896 clients to reach 839,544 by end of 2016
HTS: Increased in coverage of HIV testing to 7million Tanzanian annually. By 2016 52.2 percent of PLHIV ages 15 to 64 years reported that they knew their HIV status.
PMTCT: Nearly all HIV-infected pregnant women enrolled on ART in 2015 resulting into reduction of MTCT of HIV to 3% at 6 weeks and 7.6% after breastfeeding
Condom Programming: Adopted the National Multi-sectoral Condom Programming Strategy, and launching of new public sector-brand condom – "ZANA" which has improved condom availability. The number of condoms distributed in a year also increased to over 100million in 2016 meeting the national target

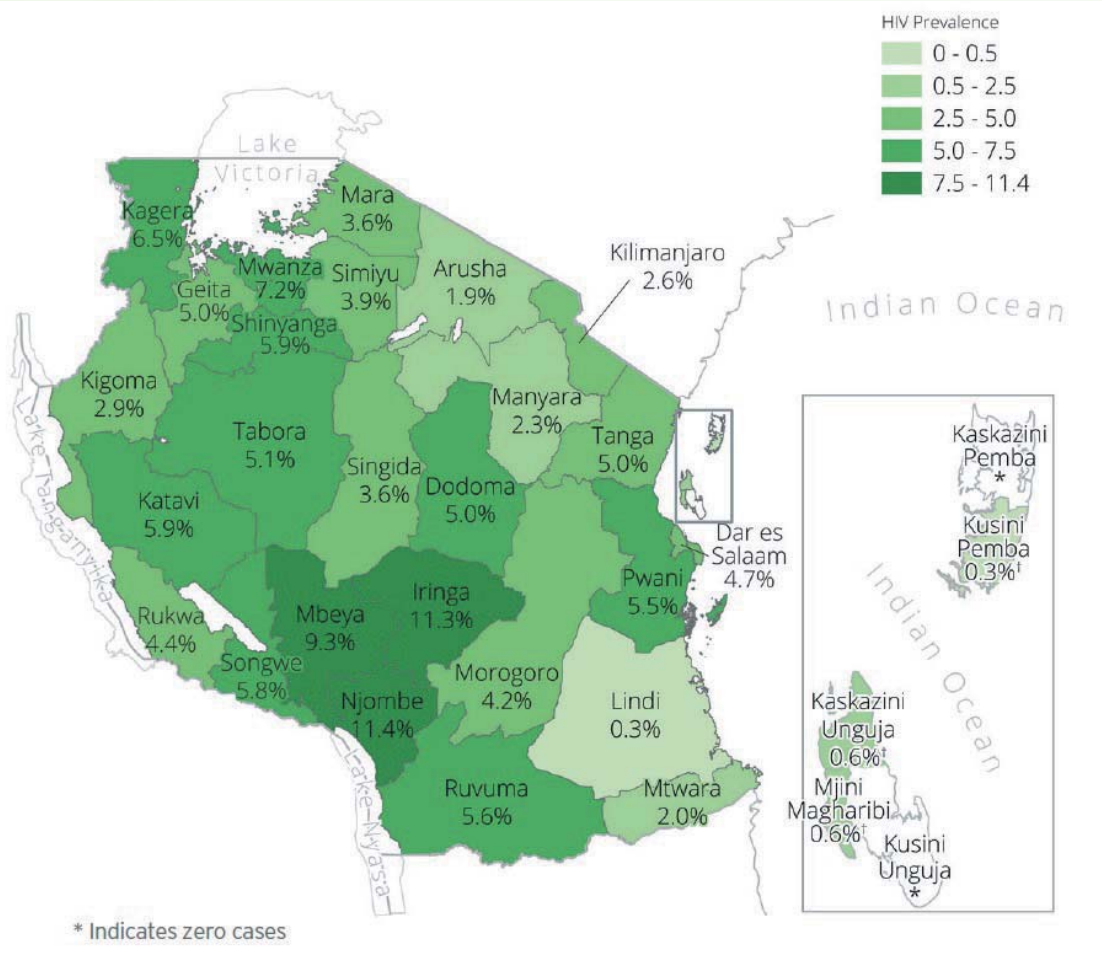
Table 2: NMSF III Achievements: Secondary Investment Areas

NMSF III Achievements: Secondary Investment Areas
VMMC: By the end of 2016, 2.2 million (78.6%) had been circumcised in targeted regions. Increased in circumcision prevalence rate to 81%
Blood Safety: Blood collection activities were decentralized to local government councils countrywide resulting into significant increase number of units collected. In 2017 NBTS collected a total of 233,953 blood units (78% of the target)
SBCC: National Campaign contributed to awareness raising efforts aimed at behavior change. Roll out of combination prevention intervention for key and vulnerable populations and
STI: The STI management guidelines were recently updated in line with the latest epidemiological data on antimicrobial susceptibility, and services were integrated in the provision of HIV care and programmes for key and vulnerable populations.
Community Services: Increase coverage of community based care and support services. Increased engagement of community groups including PLHIV networks and clusters supporting community initiatives including identification, adherence and follow up of PLHIVs.

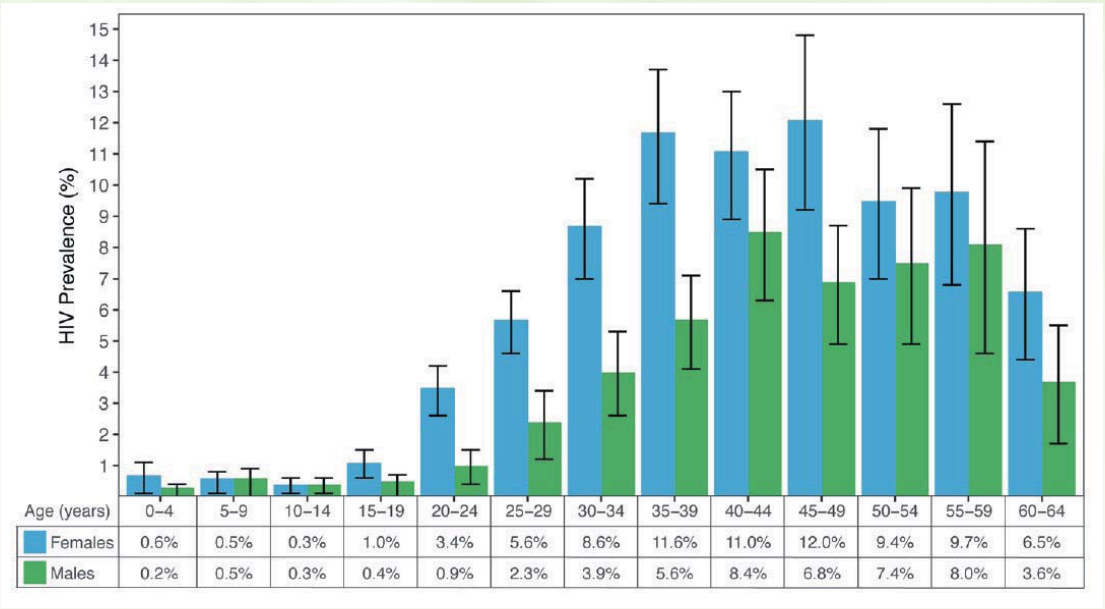
Key challenge in implementing NMSF III, among others, was related to lack of adequate resource to scale up all intervention identified, signalling need for a strategic shifts and increased prioritization, coordination and efficiencies during the implementation of NMSF IV.

2.2 HIV Epidemiological context in Tanzania

The HIV prevalence has steadily declined over the past decade from 7% in 2003 to 4.7% in 2016 . HIV prevalence in Tanzania is characterized by significant heterogeneity across age, gender, social-economic status and geographical location, which implies differentials in the risk of transmission of infection. HIV prevalence is higher in urban areas than in rural areas, 7.5% versus 4.5% respectively. Njombe region has the highest prevalence estimate (11.4%) followed by Iringa (11.3%) and Mbeya (9.3%). Lindi region has the lowest HIV prevalence of less than 1%.



[3] Tanzania HIV Impact Survey, 2016/17



Age (years)	0–4	5–9	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64
Females	0.6%	0.5%	0.3%	1.0%	3.4%	5.6%	8.6%	11.6%	11.0%	12.0%	9.4%	9.7%	6.5%
Males	0.2%	0.5%	0.3%	0.4%	0.9%	2.3%	3.9%	5.6%	8.4%	6.8%	7.4%	8.0%	3.6%

The THIS 2016 shows that HIV prevalence is higher among women than men, standing at 6.2 % and 3.1% respectively. The prevalence of HIV is less than 2% among 15-19 years for both males and females and then increases with age for both sexes. The age disparities in new HIV infections suggest an increase in numbers of new infections among younger populations.

HIV prevalence is higher among Key and Vulnerable Populations (KVP) including Men who have Sex with Men (MSM), People Who Inject Drugs (PWID) and Female Sex Workers (FSW). The HIV prevalence of FSW is estimated at 26%, MSM at 25% and PWID at 36% .

2.2.1 Progress towards achieving 90-90-90 targets

It is estimated that there were 1,400,000 PLHIV in Tanzania in 2016. Of these, 120,000 are children aged below 15 years and 750,000 are women aged 15 and above. The national population-based survey conducted in 2016-17 shows that 52% of PLHIV reported that they knew their HIV status, of which 90% had started ART and 87% were virally suppressed.

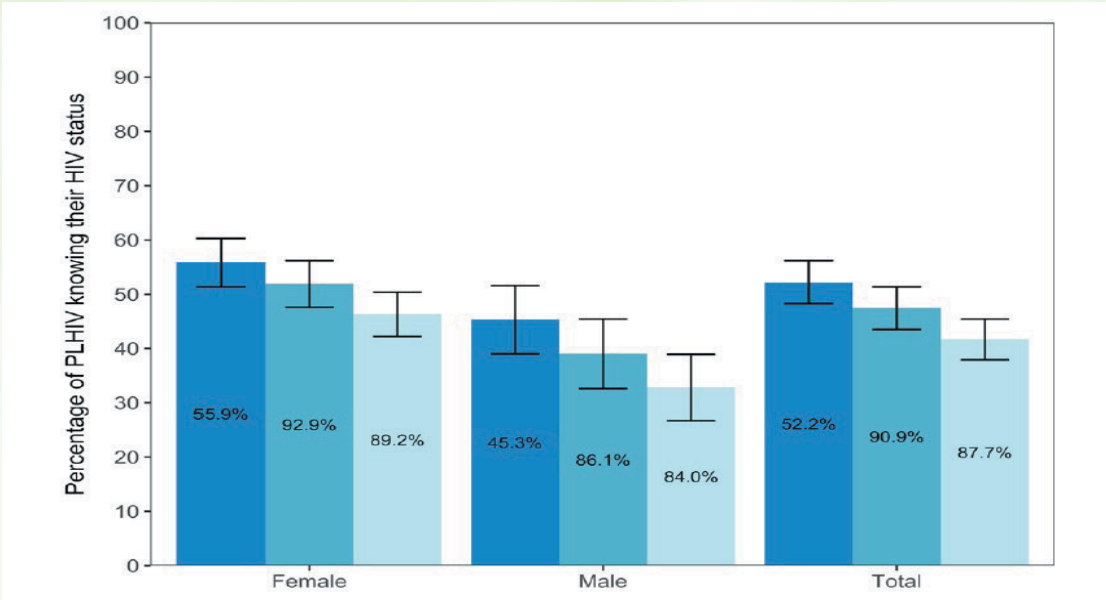
2.3 Strategic Orientation of NMSF IV

2.3.1 The Changing Paradigms and Response Environment

The multisectoral HIV response is largely influenced by Tanzania's political commitment and leadership to maintain HIV prevention as a national priority, and to continue providing comprehensive treatment, care and support to PLHIV. The national response has also been inspired by, the national vision 2025, five year development plans, ruling party election manifestos, the sustainable development goals (SDGs) and The Fast Track Commitment to End AIDS by 2030. The country is working to achieve the 90-90-90 targets by 2020.

The national response will strategically target key and vulnerable populations – adolescent girls and young women (AGYW), people who inject drugs (PWID), men who have sex with men (MSM), female sex workers (FSW), prison inmates, fishermen, and miners. Interventions will focus on geographical areas with a high disease burden, underserved areas and epidemic hotspots.

[4] Consensus Estimates on Key Population Size and HIV prevalence in Tanzania through Integrated Biological and Behavioral Surveillance (IBBS) Survey conducted between 2010 and 2014



Services to all migrant and mobile populations will be maintained and mainstreamed in health and other development sectors for improved effectiveness and efficiency,

New technologies and approaches such as PrEP and self-testing have also emerged and coupled with improved treatment, are redefining the way delivery of HIV and AIDS services are planned. The quality of ARVs and their administration has significantly improved, making adherence and retention much easier for PLHIVs. Equally, improved ART has increased viral suppression and survival rates. As PLHIV live longer, home-based care services are being redefined and orphanhood significantly delayed.

Communities are emerging as strategic partners in the response, both as beneficiaries and being part of the planning and service delivery at the same time, communities are increasingly demanding for accountability and transparency. Strategic and sustained partnerships with communities will strengthen ownership, governance, accountability, transfer of skills, knowledge and technology, leveraging of resources and technical assistance.

While the multisectoral and decentralised approach has created new opportunities for many and diverse stakeholders, it has also come with many challenges, ranging from multiple coordination structures, competition for financial resources and territory, political recognition, and representation. Although the “Three Ones” principle has been institutionalized while coordination of stakeholders at all levels needs to be strengthened.

2.3.2 Strategic Operational Approaches

With a rapidly changing operational paradigm – involving many and diverse stakeholders, coupled with a strong and increasing call for efficiency, effectiveness, transparency and accountability, NMSF IV has prioritised the following operational approaches to the intended objectives.

The multisectoral & decentralised Approach

NMSF IV is designed to be catalytic, supporting delivery of innovation strategies and best practices, necessary to ensure provision and sustainability of quality, comprehensive and effective HIV and AIDS services. The national response will continue to be multisectoral and decentralised involving diverse stakeholder at national, regional, district, communities and sector levels. The response will be anchored on the 'Fast-Track Commitment to End AIDS' by 2030 and will focus on achieving the 90-90-90 targets by 2020.

Harmonisation and Alignment with national and Global HIV and AIDS policy frameworks

During the implementation of NMSF IV, all stakeholders will be encouraged to align and harmonise their responses with national priorities and prioritised programmes and approaches. This is in addition to ensuring alignment with national targets and harmonisation of indicators. The approach will also support the institutionalisation and consolidation of the three-ones Principle.

Social and programmatic enablers and cross cutting issues:

The NMSF IV strategy is designed to ensure that social and programmatic enablers, and cross cutting issues are infused in the core programmes to support effectiveness and efficiency of the core programmes. Critical enablers tend to be more HIV specific and their contribution is assessed in terms of their effectiveness in improving the uptake, equitable distribution and coverage, efficient service delivery. They address barriers to services uptake, i.e. stigma & discrimination, GBV/IPV, and gender inequity.

Population and Geographical Targeting:

A key strategy of the NMSF IV is to accelerate interventions targeting key and vulnerable populations (KVP), geographical areas with a higher disease burden and epidemic hotspots. Among the key and vulnerable populations prioritised – AGYW, MSM, FSW, PWID/PWUD, prison inmates, miners, and fishermen. In all migrant and mobile population, provision of services will be maintained and mainstreamed in health and other development sectors.

Community engagement and empowerment:

Communities (including support groups of PLHIV) are both strategic partners and beneficiaries of the HIV response. It is imperative that they are engaged and empowered to participate in the planning, implementation and monitoring of community-based interventions. They play a critical role in community and social mobilisation, service delivery and demand creation, access and sustained utilization of services. Community engagement strategies will include but not limited to community conversations, interpersonal communications, and involvement of community and religious leaders, and men. Strategic partnerships between communities and other stakeholders will be strengthened and in particular with health facilities. A key community role will be to catalyse and influence local responses to change risk environments at community level and address negative social and cultural practices that fuel the spread of HIV.

HIV Mainstreaming:

Mainstreaming will expand the scope of the national response by engaging public and private sectors. NMSF IV has suggested a minimum package of services for internal (workplace) mainstreaming, and key consideration for external mainstreaming that include a requirement for HIV social assessment as part of environmental impact assessments (EIA) on all large/capital projects. These considerations will require a review of the scope of the National Mainstreaming Guidelines.

The life-cycle Approach:

NMSF IV will use the "Life Cycle" approach specifically to target adolescent's girls and boys during their transition from childhood, to adolescence, and young adults. The approach will take into account their age and gender specific needs as they transit from childhood, to adolescents and young adults.

Strengthen social, policy and legal environment:

An enabling social, policy and legal environment is a pre-requisite for an efficient and effective response delivery. Within the current environment, monitoring of compliancy and implementation of existing policies and laws necessary to remove policy and legal barriers to services uptake has been inadequate. A need for maintaining and intensifying public debate on these issues at the national and community levels cannot be over emphasised. NMSF IV implementation shall pay attention on a comprehensive review of laws to ensure HIV and gender sensitivity.

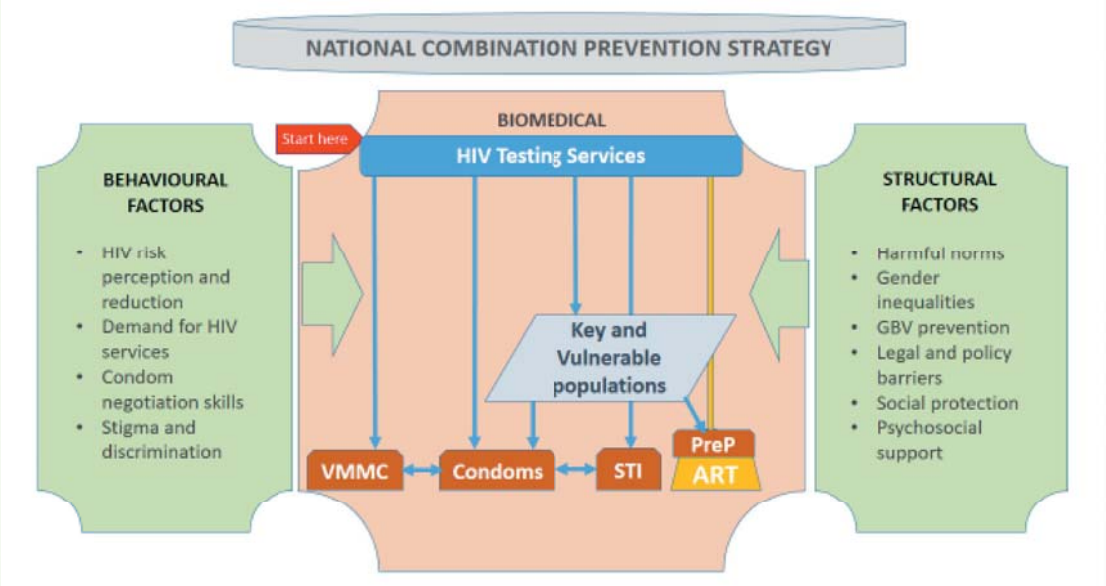
Chapter 3:
NMSF IV Core Programmes

3.1 Conceptual Framework

3.1.1 Overview of combination prevention strategy

Efforts towards HIV epidemic control cannot be successful without significant reduction in new infection. The global and country targets are to reduce the number of new HIV infections by 75% between year 2010 and 2020. Country efforts towards these targets have been intensified through primary prevention programmes and scale up of ART.

Figure 3: National Combination Prevention Strategy



The country efforts to prevent new infections are governed by the combination prevention strategy and targeting populations at highest risk of infection. In implementing NSMF IV, Tanzania will continue to deliver behavioural, biomedical and structural HIV prevention intervention aiming at first identification of HIV status followed by scaling up prevention programmes for key and vulnerable populations; strengthening national condom programmes; ensuring provision of safe blood; expanding VMMC in targeted regions and the rapid scale up of self-testing and PrEP strategies.

3.1.2 Behavioural Interventions

Behavioural interventions are usually guided by principles of Social and Behaviour Change Communications (SBCC). In implementing NSMF IV, SBCC is treated as cross cutting intervention across all the prioritised interventions with two objectives. First to improve comprehensive knowledge of, HIV and AIDS and awareness of services being provided. Secondly, having improved awareness and better knowledge, SBCC will be used as an entry point to create demand for different HIV and AIDS services. The implementation of SBCC interventions will be

premised on a social ecological framework, where individual actions are shaped by immediate life conditions, including self-esteem, relationships, community, social and occupational groups, and organizations, and by broader societal factor.

The NMSF IV SBCC efforts will emphasize community mobilization specifically the involvement of parents and community leaders including political, faith and cultural leaders. Messages that emphasize risk perception among young people will be intensified. PLHIV should be involved in demand creation for services and promotion of adherence, treatment and retention. In addition, SBCC interventions will focus and emphasize on the prevention of GBV, violence against women (VAW), elimination of stigma and discrimination and promotion of safer sexual behaviour based on local context.

Furthermore, SBCC has a special role in raising awareness and appropriately communicating the "treat all" approach as the approach diverts from the previous messages on eligibility criteria for ART initiation. Going forward, innovative, technology based SBCC approaches that has been successful such as use of text messages, helpline services and socio-media platforms will be scaled.

3.1.3 Biomedical Interventions

Key programmatic interventions that will be scaled during the NMSF IV include condom programming, targeted VMMC and programmes for key and vulnerable populations. Each of these interventions are supported by HIV testing services, risk reduction social and behaviour change communication and prevention of gender violence among others. Provision of STI diagnosis and management and safe blood are also key interventions aiming at preventing new HIV infection. Scale up of ART on the other hand, will continue to play a critical role in supporting prevention, by suppressing viral load and thus limiting transmission. NMSF IV also advocates for scale up of related interventions such as Blood safety and Management of STIs. Specific described of key operational strategies for each of the prioritized interventions is further described in section 3.2.

3.1.4 Structural Interventions

Structural factors —socio-cultural, economic, political, gender inequality, legal and other contextual factors contributes to increasing vulnerability to HIV. NMSF IV recognizes that addressing these factors would be achieved when they are integrated and mainstreamed in all prioritized HIV interventions. A multi-sectoral approach will be adopted in addressing structural interventions. While the health sector will continue to take lead in increasing access of integrated HIV care, treatment and prevention services to those with low access; other development sectors are required to address the socio-environmental and poverty dimensions that are influencing the epidemic. In particular, education sector, CSOs (FBOs, NGOs and CBOs) and media partners will have to take a role in addressing harmful norms, gender inequality, GBV/VAW prevention, as well as stigma and discrimination. The legal and justice sector working with health sector will continue to address legal and policy barriers that limits access to HIV services especially among AGYW. Social protection programmes that have shown success such as DREAMS and AGYW will have to be scaled up. The private and informal sectors will continue to leverage their platforms (through HIV workplace interventions) to support prevention, reduction of stigma and discrimination.

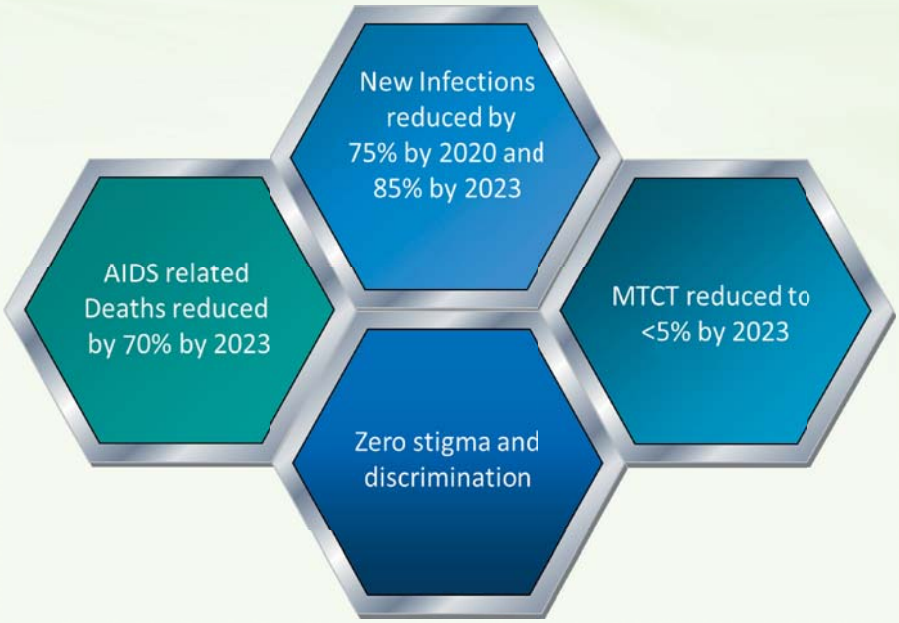
Table 3: Key strategies towards epidemic control

Interventions	Key Strategies
Behavioural	• Scale up innovative, age and gender sensitive programmes that addresses HIV risk perception and risk reduction strategies using appropriate behaviour change theories • Use effective community mobilization including community radio to create demand for HIV prevention, care and treatment services e.g. HTS, condoms, VMMC and ART • Empower men, women, girls and boys to access and negotiate for correct and consistency use of condom • Increase engagement and empowerment of PLHIV clusters and networks to address HIV stigma and discrimination at facility, community settings
Biomedical	• Scale up differentiated HTS models (PITC, CITC, home testing, mobile, self-testing) as well as referral and linkage to prevention, care and treatment services • Enhance enrollment and retention of men, women, girls, boys and KPs in HIV care and treatment services • Mobilize and create demand for VMMC in priority regions and linkage to other services • Scale up accessibility, availability and programmes to ensure correct and consistency use of condoms • Increase integration of HIV prevention, family planning, NCD and SRH services • Scale up provision of PreP to prioritized populations • Improve provision of quality prevention, care and support services that catalyzes uptake by men, young people and KPs. • Strengthen provision of syndromic management of STIs.
Structural	• Increase advocacy and programming that address harmful norms and gender inequalities • Increase capacity for protection and treatment of GBV/VAW • Enhance compliancy and address legal and policy barriers that limits access to HIV services • Strengthen legal and psychosocial support systems to enable HIV prevention and support care seeking behaviours • Enhance political will and resources to support and scale up stigma reduction activities in health care and community settings

3.1.5 Expected Outcomes and Impact

At outcome level, the country aims to reach the global commitment by achieving 90-90-90 targets by 2020, and 95-95-95 targets by 2025. Furthermore, in line with the global commitments the NMSF IV aims at reducing the number of new infection is from 81,000 in 2017 to less than 15,000 in 2023. This will translate to 85% reduction from the 2010 baseline. During this period, the country intends to virtually eliminate mother to child transmission of HIV. NMSF IV interventions will also reduce HIV related death by 80%. By 2017, the number of people who died of AIDS-related causes was 33,800 (a 50% reduction from the 2010 baseline). NMSF IV sets a new target to reduce AIDS related death to less than 15,000 by 2023. Tanzania also aims to eliminate HIV related stigma and discrimination. By 2023, the proportion of PLHIV who report experiences of HIV related discrimination in healthcare settings should be zero.

Figure 4: NMSF IV Expected Impact



3.2 Priority Interventions

3.2.1 HIV Testing Services

3.2.1.1 Overview

HIV testing services coverage and uptake increased significantly during the implementation of NMSF III surpassing the targets for 2015 and reaching about seven million individuals in 2016. Despite this progress only 52.2% (THIS 2017) of PLHIV ages 15 to 64 years (55.9 percent of HIV-positive females and 45.3 percent of HIV positive males) knew about their HIV positive status by 2016. By 2017, only 52% of PLHIV who self-reported, that they knew their HIV status.

There is low up-take of HTS among men and other people at highest risk of HIV, particularly those who do not interact regularly with the health system.2 HTS is only offered to adults who are more than 18 years limiting provision of services to sexually adolescents and youth who are below the age band. It has been noted that some areas in the country still face stock-outs of HIV rapid test kits. The HTS services are also faced with inadequate health workforce and infrastructure to comply with HIV RT testing standards. It has also been noted that there is inadequate linkage of HIV-positive individuals to care, treatment and support services.

3.2.1.2 Programmatic Approach

During the NMSF IV implementation period, HTS will be integrated in all other health care and HIV/AIDS services. Service delivery will adopt a mix and or differentiated models to ensure optimal results. The differentiated and targeted models will include but not limited to index testing, targeted community outreach, PICT, VCT, mobile testing, moonlight testing, self-testing, couple testing and testing as an entry point for another service. Self-testing will be rolled out targeting

[2] Mitchell S, Cockcroft A, Lamothe G, Andersson N. Equity in HIV testing: evidence from a cross-sectional study in ten Southern African countries. *BMC international health and human rights.* 2010;10:23.

key and vulnerable populations. Capacity will be strengthened including task shifting. To achieve optimal results in HTS, stakeholders will also address critical bottlenecks including stigma and discrimination, gender inequality, gender based violence (GBV) and VAW. A vibrant monitoring system to collect and interpret data will also be set up.

3.2.1.3 Operational Strategies

i. Scale up targeted HIV testing services using differentiated service delivery models (SDM) for HTS
ii. Reduce structural and policy barriers to testing e.g. age of consent
iii. Establish effective referral and linkage to prevention and care, treatment and support services
iv. Strengthen HIV test kits forecasting, procurement and timely distribution to avoid stock outs
v. Fast track adoption of task sharing for HIV testing to improve community based HTS
vi. Scale up differentiated HTS models that targets men – such as workplace programmes, campaigns that include non-communicable diseases (NCD) screening and integrating NCD screening at antenatal clinics
vii. Roll out HIV –self testing and collect timely data to inform programme improvement
viii. Integrate stigma and discrimination-reduction into health worker formation curricula, accreditation processes, and continuing medical education curricula/systems to foster long-term, sustainable change.

Table 4: HTS indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Number of individuals who test for HIV and received their results (by age and gender and category (key populations))	7m	2016	9m	9m	HMIS/DHIS
Proportion of PLHIV who knows their HIV status at the end of reporting period	52%	2017	90%	95%	THIS

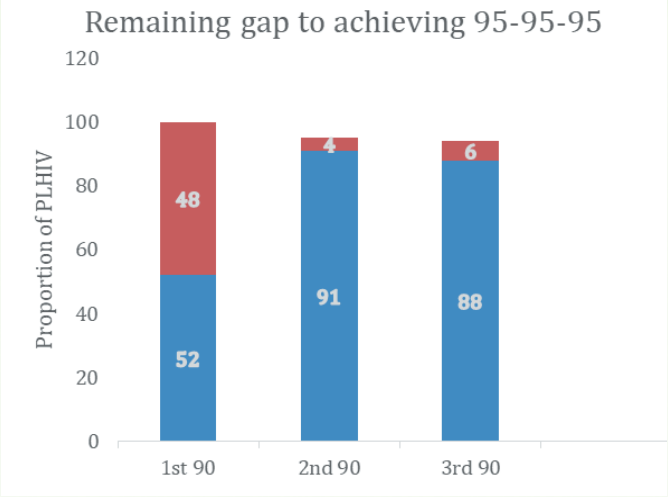
3.2.2 Treatment, Care and Support

3.2.2.1 Overview

In Tanzania, ART programme was initiated in 2005, with support from Government and development partners. Since then, the country effort to increase access of ART has produced commendable results. The country programme is guided by WHO recommendations, and of recent Tanzania has adopted the WHO 2015 guidelines for treating all HIV-infected individuals irrespective of disease stage. The adoption of this guidance in 2016 and support from development partners such as PEPFAR and Global Fund has led to increased number of PLHIV enrolled into care and treatment. During the implementation of NSMF III, ART services were scaled up to increase number of PLHIV (adults and children) from 432,338 clients in 2012 to 965,081 by December 20173. Uptake of ART is higher among females as compared to men. Preliminary results of the Tanzania HIV Impact Survey (THIS) shows that for clients who reported to know that they were living with HIV, 91%

[3] Programmatic data, NACP, 2017

Figure 5: Remaining gap to achieve 95-95-95 targets



were on ART, and 88% of them were virally suppressed4. However, THIS showed that viral load suppression is lower in males than in females (41.2 versus 57.5). It has also been reported that only 78% of clients who are initiated on ART, remain in care after 12 months of follow up.

There is generally low uptake of ART among children resulting into lower suppression, only 12% of children below 14 years were virally suppressed. The coverage of VL monitoring is also limited coupled with unreliable sample and results transportation system. Clients on ART are also required to pay for service when accessing services related to management of HIV comorbidities including Cotrimoxazole (CTX) and Isoniazid Prophylaxis therapy (IPT). In some areas, PLHIV also have to travel a long distance to access services and in some clinics have high client load resulting into congestion that compromises quality of care. Practices related to stigma and discrimination are still prevalent among PLHIV and within the health care settings.

3.2.2.2 Programmatic Approach

Care, Treatment and Support services remain the major and most significant pillar in HIV response. Investing in this area, is one of the promising strategy towards epidemic control. Tanzania is well suited to use this strategy to achieve the fast-track 90-90-90 targets by 2020 and drive the country towards epidemic control by 2030. Firstly, ART when used appropriately enable those living with HIV to live longer, healthier and productive lives, secondly, ART reduced the risk of perinatal transmission of HIV and thirdly ART reduced risk of new HIV infection, particularly among individual who have achieved viral suppression. Building of the country success during the implementation of NMSF III, NMSF IV will guide the country to scale up delivery of comprehensive ART services to meet these achievable targets.

This can best be done through increased enrolment based on the new “Treat All” approach while paying attention to monitoring, adherence and retention in care and viral suppression. During the implementation of NMSF IV the country will address key gaps and challenges especially those related to disparities and quality of care, treatment and support services. The following overarching strategies will be implemented.

i. Scale up adoption of recommended service delivery models to ensure provision of client centred, comprehensive and quality care for children, adolescents, pregnant women and adults.
ii. Improve laboratory services using recommended technologies. This will be done with close attention to improvement of quality of laboratory services. Specifically, the country will introduce ARVs drug resistance testing, to support identification of treatment failures. Viral load monitoring of ART clients was introduced during the implementation of NMSF III, and now the country will continue to scale these services and adopt innovative solutions for sample and result transportation to reduce results turnaround time (TAT) for both VL and EID.

[4] Tanzania HIV Impact Survey, 2017

iii. Strengthen financing mechanisms to support PLHIV access OIs and other co-morbidities laboratory tests and medications. This will include increasing allocation of OIs drugs within the domestic resources envelope and exploring innovative solutions to enrol more PLHIV into insurance schemes.
iv. Ensure availability of most efficacy and easy to use ARV drugs. This will be done by switching to appropriate regimen for first and second line, and also establishing a salvage regimen as per national guidelines.
v. Improve the supply chain management through facility management capacity building and improvement of the supply chain systems for HIV commodities. This will be done by continuing to collect data that will inform timely quantification, forecasting and procurement to avoid stock outs
iv. Intensify community models that will support delivery of HIV services at community level. This will be done within the context of the new Community Health Workers (CHWs) cadre and peer-based outreach services that have shown success in supporting adherence and retention.
v. Scale up implementation of models that attracts and retain male in care. This will include differentiated care models that addresses challenges of working men such as time and clinic days
vi. Identify and mitigate all form of stigma and discrimination in health care and community settings, that might affect access to HIV care, treatment and support services
vii. Develop and disseminated treatment literacy materials which addresses ARV side effect, adherence, VL monitoring, retention, stigma and discrimination. This should be done using print, audio, video, SMS, Helpline, socio-media and other innovative and efficient platforms

Furthermore, in order to ensure delivery of comprehensive patient centred and quality care NMSF IV recommends differentiated service delivery models that focus on sub-groups of PLHIV. Key strategies to be considered for each group are descried in table 8 below.

Table 5: Treatment Care and Support Differentiated strategies

Adults-women (Adult-ART)	• Strengthen delivery of family centred comprehensive quality ART services • Enhance provision of facility and community-based adherence support • Strengthen provision of family planning services • Strengthen access to diagnosis and management of HIV co-morbidities and NCDs • Scale up delivery of differentiated care models to improve quality of care
Adults- men (Adult- ART)	• Enhance peer and partner led support for adherence and retention • Enhance provision of facility and community-based adherence support • Strengthen access to and management of HIV co-morbidities and NCDs • Scale up delivery of differentiated care models to improve quality of care • Strengthen provision of outreach services in workplaces

Adolescents and youth (Adolescents ART)	• Enhance peer support groups and scale up innovations in providing friendly services such as adolescents clinic day, clubs and other ways of support • Strengthen provision of sexuality education, livelihood and life planning skills • Create supportive environment of adolescents living with HIV in and out of schools • Improve awareness and access to condom • Strengthen provision of GBV prevention and response • Empower young people living with HIV to be active agent of change in their own health as well as in HIV policies and programmes
Children (below 14 years) (Paediatric ART)	• Increase efforts to appropriately disclose HIV status to children • Enhance community and facility-based identification and adherence support • Improve transition from paediatric care to adult services • Intensify IED • Strengthen provision of psychosocial support at facilities and communities and in households • Create supportive environment of children living with HIV in schools • Scale up programmes for assessment and provision of nutrition support
Key and vulnerable populations (Adult ART)	• Scale up delivery of differentiated care models to reach KVPs e.g. outreach services • Enhance peer led support for adherence and retention • Strengthen programmes with support structures including provision of nutrition support • Increase awareness and provision of condom • Strengthen provision of Family planning services • Strengthen access to and management of HIV co-morbidities with attention to TB, and HBV

Table 6: Treatment Care and support Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percentage and number of adults and children on ART among all adults and children living with HIV at the end of the reporting period	70%	2017	90%	95%	HMIS-DHIS-2
Percentage of adults and children living with HIV known to be on ART 12 months after starting	78%	2016	90%	97%	Care and Treatment report
Percentage of people living with HIV newly enrolled in HIV care started on TB preventive therapy	9.6%	2016	100%	100%	Care and Treatment Report

3.2.3 Elimination of Mother to Child Transmission of HIV

3.2.3.1 Overview

Tanzania adapted and has been implementing option B+, a cost-effective strategy to achieve elimination of mother-to-child HIV transmission since 2013. Under this strategy all HIV–infected pregnant, postpartum and breastfeeding women are provided life-long antiretroviral treatment upon diagnosis irrespective of their CD-4 T-cell count or disease stage. This is in addition to the other three prongs of PMTCT namely: reducing HIV infection among women of reproductive age, reducing the unmet need for family planning, and provision of antiretroviral treatment to family members.

Tanzania has achieved a 72% reduction in new paediatric HIV infection since 2009.The coverage of PMTCT services with efficacious ARV regimen increased year after year with 90% of HIV-infected pregnant women enrolled on ART in 2014, and nearly universal coverage in 2017. The MTCT rate at 6 weeks fell to 3.6% at mid-term while that after breast feeding declined to 7.6%. The persistent high transmission amidst very effective interventions for PMTCT is attributed to large proportion of women who initiate antenatal care late in pregnancy (third trimester) and test positive for HIV for the first time and loss to follow up especially among younger pregnant and lactating women.

3.2.3.2 Programmatic Approach

In order to consolidate the gains in the elimination plan for vertical infections and work towards virtual elimination of eMTCT, cascade monitoring for all elements of the 90-90-90 cascade for pregnant women and children, along with longitudinal birth-cohort monitoring to improve tracking of HIV-exposed infants through the end of breast-feeding should be strengthened. Integration of PMTCT into reproductive health to address the unmet need for family planning by HIV-infected women will be essential and innovative approaches should be explored and implemented. Innovative strategies to strengthen male involvement in eMTCT services need to be explored, piloted, scaled up, and monitored during the implementation of NMSF IV.

3.2.3.3 Operational Strategies

i. Strengthen delivery of family centred comprehensive quality ART services
ii. Enhance preparedness and continued adherence support using HCW, CHW and peers
iii. Strengthen provision of PreP for discordant couples
iv. Strengthen male involvement in ANC, post-natal and immunization clinics
v. Scale up and support peer support groups e.g. MSGs
vi. Increase emphasis on care of exposed infant including recommended breastfeeding practices
vii. Support timely access of EID test and results tracking

Table 7: PMTCT Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percent of HIV-positive pregnant and lactating / breast feeding women who know their HIV status	90%	2016	100%	100%	HMIS-DHIS-2
Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV	97.9%	2017	100%	100%	THIS
Percent of HIV-positive pregnant and lactating / breast feeding women with viral suppression	87%	2017	100%	100%	HMIS-DHIS-2

3.2.4 Comprehensive Condom Programming

3.2.4.1 Overview

Tanzania is implementing a total market approach (public, social marketing, commercial) for condoms programming. As part of this strategy, Tanzania has rebranded the public-sector condoms to address perceptions of low quality. Generally, condom availability and accessibility have become more stable over recent years. The number of condoms distributed in a year increased to over 100 million in 2016 meeting the national target. Evidence from the field shows that condoms are available and accessible in public and private outlets; however, the distribution mechanism needs to be strengthened in order to ensure focus on populations in need. Female condoms, on the other hand are less popular and not easily accessible.

There is still limited access for condoms, especially among adolescents and youth, mainly due to stigma associated with asking or buying condom, cost, stock outs, poor marketing and distribution outlets range. Among young people, only 37% of women and 41% of men reported to have used a condom the last time they had sex.5 Condom use during last sex with non-marital, non-cohabiting partner is below 36% for females and below 30% for males.6 In Tanzania, girls and women do not have enough skills to negotiate for condom use due to gender inequities and cultural norms. On the other hand, availability of data (including market analytics) to inform condom programming is limited and condom programming has not adequately been integrated in reproductive health. Linkages between sexual and reproductive health rights and HIV need to come out more clearly. Another prevailing challenge is the low programmatic knowledge on female condom distribution, accessibility, desirability and use by both men and women.

3.2.4.2 Programmatic Approach

NMSF IV will build from the success of the implementation of first national multisectoral Comprehensive Condom Programming Strategy (2016-2018) which employed a total market approach. Gaps observed, especially those related to availability of evidence on condom programme will be addressed by strengthening a national multisectoral M&E system for condoms.

[5] Tanzania Demographic and Health Survey 2015/16

[6] THIS 2016/17

Barriers to access and use of both male and female condoms will be studied and addressed. During the implementation of NMSF IV, targeted distribution of condoms to hotspots and amongst key and vulnerable populations will be increased, intensified and tracked. The country will also continue to coordinate and improve the roles of social marketing, commercial and public sector to achieve equity and sustainability.

3.2.4.3 Operational Strategies

i. Expand distribution of public sector condoms using community outlets, workplaces and hotspots
ii. Improve condoms forecasting, procurement and distribution at all levels and in particular at community level
iii. Build a strong national M&E system for condom to create evidence and inform condom programming
iv. Improve the roles of social marketing, commercial and public sector to achieve equity and sustainability
v. Address stigma related to accessibility of condoms among young people, especially sexually active adolescents girls and boys

Table 8: Comprehensive condom programming indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Proportion of adult 15-49 who reported to have used a condom at last sex with non-regular partner	M: 35% F: 27.78%	2017	50%	95%	THIS
Percentage of youth 15-24 who used a condom at last sexual intercourse	M: 42% F: 37%	2016	60%	80%	TDHS
Proportion of sex workers reporting using a condom with their most recent client	32%	2013	80%	100%	IBBS

3.2.5 Voluntary Medical Male Circumcision

3.2.5.1 Overview

In the case of Voluntary Medical Male Circumcision (VMMC), service delivery priority is given to regions with low coverage of male circumcision and high burden of HIV transmission. VMMC services started in 2009 in thirteen priority regions with a target to circumcise 2.8 million by 2017. This was required to meet the coverage saturation target of 80% in all regions. By the end of 2016, 2.2 million (78.6%) had been circumcised, and only two regions out of thirteen had attained VMMC saturation coverage of 80%. According to the 2016 demographic and health survey, 10 regions had not achieved saturation. These regions are Geita, Kagera, Katavi, Kigoma, Mbeya, Njombe, Rukwa, Shinyanga, Simiyu and Tabora.[7]

[7] TDHS-2016

Early Infant Male Circumcision (EIMC) was successfully piloted in Iringa region and efforts to roll out to other prioritized regions are underway. Initially, Tanzania's VMMC strategy targeted young men aged 10 to 29 years for immediate impact. However, programmatic data showed that up to 40% of current VMMC clients are aged 10-14 years, calling for a more "older men" targeted approach. The VMMC program also does not adequately meet adolescent needs in terms of age-appropriate approaches including counselling, communication and client-provider interactions. It was also noted that VMMC services are offering an important opportunity to reach young men with other HIV and health services as well as that they had not adequately focused on high-risk groups or locations such as mines, fish landing sites, and other hotspots.

3.2.5.2 Programmatic Approach

Since, the initial VMMC targets have been met, the NMSF IV has set new country target to attain 90% male circumcision rate by 2020. Tanzania will scale up the early infant male circumcision (EIMC) services in regions that have attained the 80% coverage target for adults and in non-priority regions as part of long-term sustainability. VMMC services will also target hard to reach and high-risk groups with low access to these services.

3.2.5.3 Operational Strategies

i. Increase innovative demand creation for VMMC e.g. those which involved female partners, in regions with low circumcision rate.
ii. Scale up VMMC in prioritized regions using a mix of static and outreach.
iii. Targeted VMMC services for high risk groups or locations.
iv. Scale up of EIMC for long impact sustainability.
v. Validate the impact of VMMC coverage and the operationalization of the service package in reduction of risk behaviours and reduction of new infections.

Table 9: VMMC Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Proportion of men 15-29 circumcised	81%	2016	90%	95%	THIS
Number of male circumcisions performed according to national standards during the past 12 months	667,316	2017	703,055	500,000	HMIS/ DHIS-2

3.2.6 Pre-Exposure Prophylaxis (PrEP)

3.2.6.1 Overview

The efficacy of using oral ARVs as Pre-Exposure Prophylaxis (PrEP) have been shown in randomized trials since 2015. World Health Organisation (WHO) recommends that people at substantial risk of HIV infection should be offered PrEP as an additional prevention choice, as part of comprehensive prevention. Tanzania is in the process of adopting the implementation of PreP. The country is conducting demonstration studies to determine acceptability and feasibility of PreP and self-testing. Findings will be used to inform the scale up of the intervention.

3.2.6.2 Programmatic Approach

Tanzania is committed to roll out PreP interventions to prioritized groups. There is adequate commitment from government and development partners to support scale up of PreP. During the NMSF IV, the country will roll out this intervention. The initial roll out will be supported by, a vibrant process of data collection and interpretation, in order to document challenges and lessons to inform programme improvement.

3.2.6.3 Operational Strategies

i. Scale up provision of PreP to selected groups of key and vulnerable populations

ii. Develop and disseminate literacy materials that will promote uptake and appropriate use of PreP among the prioritized groups

iii. Collect timely data on PreP implementation to inform program improvement

Table 10: PrEP indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Number of people who received oral PrEP at least once during the reporting period			30% coverage for KPs	75% coverage for KPs	Programmatic data

3.2.7 Key and Vulnerable Populations

Overview

In Tanzania, as it is in many other countries where data are reliably collected and reported, KVPs to include PWID/PWUD, MSM, FSW as well as prison inmates, miner and fishermen are shown to be at higher risk of contracting HIV than the general population. They also have higher morbidity and mortality rates, and lower access to HIV-related services. Using the modified Delphi method to estimate population, in Tanzania mainland it is estimated that there are 30,000 PWID, 49,500 MSM, and 155,450 FSW. Evidence from the small number of studies done estimated a number of other KVPs including prison inmates (8,700); fishermen (5,400); and people in mining industry (225,000). Further evidence indicates HIV prevalence among three groups: MSM, PWID, FSW and prison inmates is estimated at 25%, 36%, 26% and 6.7%, respectively.

KVP's vulnerability to HIV is made worse by limited access to HIV and AIDS related health services. The accessibility is denied through; gender inequalities in the availability of and access to services, but also Violence against Women (VAW), insensitivity, lack of awareness or rejection from service providers. They suffer verbal abuse or physical violence; experience of stigma and discrimination from attempting to access the services they need. In addition to these barriers, KVPs face more general social marginalization and economic disenfranchisement, which can increase their vulnerability to HIV and decrease access to needed services. These factors are often still more extreme for KVPs living with HIV.

Beyond the general vulnerabilities, each KVP groups have specific vulnerabilities, which have been taken into account when designing programs and service-delivery approaches for NMSF IV.

Programmatic Approach

The programmatic approach to KVPs is to use the combination prevention, in this case; evidence informed and community owned programmes that use a mix of biomedical, behavioral, and structural interventions, prioritized to meet the current HIV prevention needs of individual and communities, so as to have the greater and sustained impact on reducing new infections.

A key strategy for NMSF IV is to accelerate interventions targeting on KVPs, targeting geographical areas with a higher disease burden and epidemic hotspots. Targeted KVPs are AGYW, MSM, FSW PWID/PWUD, prison inmates, miners and fishermen. Services to other vulnerable populations including migrant and mobile populations will be maintained. NMSF IV will scale up programmes to support AGYW including advance sexual reproductive health (SRH) and rights. It is expected that by the end of the five years of implementation, new HIV incidences amongst AGYW will be reduced.

NMSF IV will ensure the meaningful engagement of KVPs as key partners in planning as they can develop solutions that will more accurately respond to their life and work environment. The country will continue to scale up services using the guidelines for HIV in KVPs management (2017). To support implementation, data on KVP groups through routine and surveys need to be continuously collected, analyzed and used. It should also be noted that there is no baseline data on KVP, the country is working on size estimate. The Integrated Biomedical-Behavioral Survey (IBBSS) to be conducted during the NMSF IV implementation period will avail national baseline information on KVPs. The specific program approach for each of the KVP group is further elaborated in the sections below.

3.2.7.1. Adolescent Girls and Young Women (AGYW)

3.2.7.1.1 Overview

In Tanzania mainland, the estimated number of AGYW (aged 15-24) is 4,388,568 (Population and Housing Census, 2012). Of the estimated 81,000 new HIV infections occurred in 2016, youth aged 24 years and below accounted for 43%. This indicates that, there is high new HIV infections among young people. Out of newly infected adolescents, 70% are girls. HIV prevalence increases 2.2-fold among girls during their transition to adulthood (0.8% for aged 15-19 years to 2% for 20-24 years old). According to THIS 2017, HIV prevalence among young women aged 15-19 years is more than twice than men of the same age group, and it is 3.6 times higher for women aged 20-24 years.

While the evidence shows that adolescent women are at particularly heightened risk for HIV, the uptake of HTS is significantly lower for men (THIS 2017). Interventions will also target specific needs for boys and young men as an opportunity for HIV prevention, and for serving as a gateway to HTS and other health and social services. This is rooted in biological differences and gender relations, which disproportionately affect AGYW. Structural barriers prevent uptake of services by AGYW, including HIV prevention, testing, treatment and care. To be effective, it is crucial that HIV programmes to include specific interventions to address specific barriers for AGYW to access harm reduction services include age restrictions, criminalization of drug use and drug possession, parental consent requirements and lack of confidentiality, which are still significant in the country. Keeping AGYW in school, especially at the end of primary and into secondary level, not only reduces their vulnerabilities to new HIV infection, but has the potential to create a critical mass of healthy, educated and financially independent women who make well-informed choices about their lives, including family planning.

3.2.7.1.2 Programmatic Approach

Investments in adolescence are often referred to as having a "triple dividend". NSMF IV will effectively prioritize issues related to AGYW. The framework is designed to support the implementation of the "Fast Track Commitments to end AIDS by 2030" focusing on enhancing young people's skills, knowledge and capacity to protect themselves from HIV and have access to SRH services. HIV prevention interventions will be tailored to the specific needs of AGYW and address structural barriers that limit their access to health services. Programmes for AGYW at higher risk should reach these sub-populations early and effectively, as a significant proportion of new infections may occur soon after they begin to sell sex.

NMSF IV recommends provision of social protection, parenting programs and parental monitoring to keep AGYW in school. Provision of social protection and other socio-economic support have a potential to increase school attendance and reduce teenage pregnancy and child marriage. Livelihood support should be considered for girls and young women that are not in school, including female heads of households.

3.2.7.1.3 Operational strategies

- Increase access to comprehensive HIV prevention and other health services
- Enhance capacity of CHWs on human rights and medical ethics relate to HIV
- Strengthen the provision of vocational training, income generation and employment
- Scale up Interventions addressing gender, economic and social inequality including GBV/VAW
- Enhance compliance and reforming of laws protecting the rights of AGYW
- Scale up social protection targeting poor family

Table 11: Adolescent Girls and Young Women Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percentage of adolescent girls and young women in high-incidence districts/ locations reached with dedicated program package in the past 12 months	0	2018	10.2%	15%	Dedicated programs refer to availability of a standard package
Percentage of schools that offer CSE or LSE HIV education in schools	0	2018	30%	60%	EMIS
Percentage of youth reached by SBCC programmes	0	2018	6%	15%	EMIS/LGMD

3.2.7.2 People who Inject Drugs (PWID)

3.2.7.2.1 Overview

In Tanzania, as it is in many other countries where data are reliably collected and reported, PWID/PWUD are shown to be at higher risk of contracting HIV than the general population. HIV prevalence rate is 36% (national estimates 2014) among the estimated 30,000 PWID/PWUD. Stigma, discrimination and open hostility towards PWID/PWUD are a significant problem in Tanzania, posing a challenge for the delivery of quality friendly HIV and other specific services. The human rights laws apply and protect the rights of PWID/PWUD as a precondition to improving their access to health services. Sharing used injecting equipment among PWID is one of the most common ways of transmitting blood-borne viruses such as HIV and viral hepatitis. Thus, providing safe injecting equipment and education to PWID through NSPs, along with additional evidence based harm reduction services, prevents the risks of infections and epidemics among PWID and in the wider community. During the NMSF IV implementation, evidence-based needle and syringe programmes (NSPs) will distribute sterile injecting equipment to PWID, which facilitate the use of sterile needles and syringes, prevents sharing of injecting equipment/material between PWID, and therefore, reduces the risk of HIV and other blood borne infections such as hepatitis B and hepatitis C among this population.

Additionally, NSPs serve as essential entry points to other social and care services such as HIV testing, access to ART, Medically Assisted Therapy (MAT), which PWID might otherwise be reluctant to use. PWIDs will be encouraged to use safe disposal containers for disposal of used injecting equipment and will be educated on safer injecting behaviours via NSPs and information, education and communication (IEC) activities. Effective supply and distribution of condoms, via adequate comprehensive condoms programs and IEC activities will enable safer sexual practices. NSPs should engage community members, and also serve as platforms in which individual's risks, opportunities to reduce risks and referral to available risks reduction services should be discussed with the PWID. HIV services, prevention and testing for viral hepatitis B and C, prevention and treatment of sexually STI services, prevention, diagnosis and treatment of TB, condom programs, IEC activities and overdose prevention and management will be accessible

comprehensively. Medically Assisted Treatment (MAT) will be administered for PWID/PWUD who are Opioid Dependent including pregnant women PWUD, to reduce associated risks of drug use such as overdose, infection and transmission of blood borne viruses, improving psychosocial outcomes, as well as reduce criminal activity. MAT is also effective for encouraging adherence to ART and TB treatment.

3.2.7.2.2 Programmatic Approach

The first priority is to implement harm reduction strategies that will protect PWID from harms related to drug use. These strategies will include prevention of new HIV infections, and ensuring that PWID who test HIV positive are linked to care and treatment. Communities, health and social protection systems will be strengthened to ensure sustained access to services by PWID. During the implementation of the NMSF IV, Tanzania will identify and strengthen the capacity of PWID led organisations, networks and or those providing services.

3.2.7.2.3 Operational strategies

- Scale up of community-based NSPs as a high priority to reduce HIV transmission among PWID.
- Strengthen availability, utilization and access to MAT to all opioid dependent users and reach more PWID.
- Strengthen the availability of comprehensive harm reduction services in a community-based approach to reach PWID.
- Improve gender-responsive interventions to address the complex needs of women PWID with special attention to address their SRH health rights.
- Strengthen advocacy with various sectors and local community
- Scale up the provision of condom and IEC materials.
- Increased availability and utilization of sterile needles and syringes through hotspots and outreach programmes.
- Strengthen the capacity of health care providers to support voluntary cessation of MAT only after stabilization of client.
- Improve the mainstreaming of rehabilitation and reintegration of PWID into society through mapping and working with CSOs (FBOs, NGOs, and CBOs).

Table12: PWID Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Number of needles and syringes distributed per PWID / per year	10 - 15	2017	200	230	GAM 2016 & MdM NSPs Data

3.2.7.3 Men who have Sex with Men (MSM)

3.2.7.3.1 Overview

Men who have sex with men experience increased HIV risk if they practice unprotected anal sex, but in many countries they are also vulnerable to violence, including sexual violence, because they

are seen as contravening gender and sexual norms. The HIV prevalence rate is 36% out of the estimated 49,500 MSM in Tanzania. Data on transgender people is not available in Tanzania, but levels of violence against these people are globally reported to be extremely high, and social and economic marginalization forces many of them into sex work, further exposing them to HIV risk.

3.2. 7.3.2 Programme Approach

The primary NMSF IV focus is to prevent new HIV infections, and to ensure that MSM who test HIV positive are linked to care and treatment. Communities, health and social protection systems will be strengthened to ensure sustained access to services by MSM. Additional studies are required to measure and compare the effectiveness of adult male circumcision to prevent HIV and STI among MSM who practice assertive and receptive anal sex. Circumcision should be provided to MSM who request for it, unless there are contraindications, as part of comprehensive package for HIV prevention.

3.2.7.3.3 Operational strategies

- Integration of MSM specific needs in ART and prevention services
- Scale the availability of comprehensive prevention programmes
- Scale up the provision of condom and ICE materials.
- Scale up provision of VMMC for HIV preventative and encourage uptake
- Strengthen the capacity of Health Care Providers (HCPs) to be respectful of diversity and informed of the specific health and social needs of MSM.
- Enhance capacity and empower MSM communities to participate in social and political life.
- Integrate stigma and discrimination-reduction into health worker formation curricula, accreditation processes, and continuing medical education curricula/systems to foster long-term, sustainable change.

Table 13: MSM Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percentage of MSM in contact with/ reached by prevention services	0	2018	28%	70%	LGMD
Percentage of men who have sex with men who used a condom at last anal sex	48	2012	58%	68%	IBBSS

3.2.7.4 Female Sex Worker (FSW)

3.2.7.4.1 Overview

In Tanzania, as it is in many other countries where data are reliably collected and reported, FSW are shown to be at higher risk of contracting HIV than the general population. It is estimated HIV prevalence is 26% among FSW. Although the links between FSW and HIV vulnerability have been recognized since the earliest days of the epidemic, surveys indicate that FSW have inadequate information and access to HIV prevention services, and it is believed that their access is even more limited for appropriate treatment, care and support. The ability of FSW to negotiate condom

use may be constrained by their working environment, economic need, or by lack of individual empowerment. FSW are also vulnerable to extortion and to violence, including rape.

3.2.7.4.2 Programme Approach

The NMSF IV takes note that Tanzania needs to bring HIV prevention interventions targeting sex workers to scale. However targeting sex workers alone is not sufficient to address the HIV and AIDS challenges associated with sex work. In the context of NMSF IV, strategies will also target clients of FSW, and provide social protection to children or adolescents girls living with FSW. Targeted interventions will range from HIV testing, management and control of STIs, ensuring availability of condoms and other family planning services, protection from sexual partner violence to access to ART and PrEP.

3.2.7.4.3 Operational strategies

- Increase access to health services free of discrimination.
- Enhance compliancy of HSPs, law enforcement agencies and police with laws and regulations
- GBV/VAW prevention and treatment for FSW
- Community and multi-sector dialogue on harmful gender and cultural norms which increased GBV/VAW
- Monitoring, reporting of GBV/VAW experiences
- Social protection schemes, i.e., livelihood enhancement, loans, IGAs, insurance, etc.
- Integrate stigma and discrimination-reduction into health worker formation curricula, accreditation processes, and continuing medical education curricula/systems to foster long-term, sustainable change.
- Meaningful participation of FSW in the design and delivery of services targeting FSW and their networks

Table 14: FSW indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percentage of FSW in contact with/ reached by prevention services	69%	2017	28%	70%	LGMD
Percentage of sex workers reporting to have used a condom with last client	34%	2013	70%	95%	IBBSS

3.2.7.5 Prison Inmates

3.2.7.5.1 Overview

The HIV prevalence for the prison inmates is estimated to be 6.7%. Being imprisoned does not mean that humane treatment and dignity are to be removed or that the standard of health services offered inside prison are to be low. Prison inmates and other closed settings (such as jails, police detention, juvenile detention, and pretrial detention) are vulnerable to HIV through unprotected sexual contact, sexual violence, or the sharing of unsterile drug-injecting equipment. The latter

applies for prison inmates who use drugs, because specialized harm reduction services such as needle and syringe programs (NSPs) and OST are not provided at the prison level as well as condom programs.

3.2.7.5.2 Programme Approach

NMSF IV will ensure HIV prevention, care, treatment and support services are made available to prison inmates and prison staff using available guidelines. Peer development and capacity building of prison staff are basic interventions to be implemented, supported by specific advocacy focused on policy makers and prison authorities to allow for integration, mainstreaming and sustainable implementation of proposed HIV prevention, care, treatment and support for needy prison inmates. The implementation of a series of proposed strategies will create an enabling and non-discriminatory environment for inmates and supporting social reintegration of offenders upon release.

3.2.7.5.3 Operational strategies

- Integrate strategies for protection from violence and abuse, and to effective referral to the community once inmates are released.
- Scale up national HIV and TB and drug dependent treatment programming.
- Strengthen linkage with outside health and social services in delivering health care in prisons.
- Provide legal counselling, advice and support.
- Strengthen interventions addressing gender, economic and social inequality.
- Improve laws protecting the rights of PLHIV, particularly women.
- Build the capacity of prison officers on HIV and SRH rights of inmates, esp. women.
- Provide rehabilitation-occupational therapy, vocational training, income generating and employment.

Table 15: Prison Inmates Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percentage of Prison Inmates in contact with/ reached by prevention services	0	2018	28%	70%	LGMD

3.2.7.6 Fishermen

3.2.7.6.1 Overview

Although there is limited empirical data on HIV prevalence among fishing community, studies suggest high HIV transmission on fish landing sites. In addition, STIs continue to remain a major health concern. The proposed IBSS Study will also target this group. Recent surveys indicate that fishermen have inadequate information and limited access to HIV prevention services; and, there is a widespread insensitivity, high stigma and discrimination towards those with PLHIV, particularly women fish processors and food vendors, which can deny their right to health services. The Framework clearly recognizes fishermen vulnerability and anticipates advocating for their access to friendly quality HIV preventive, care, treatment and social support services. Syndromic approach will be adopted as a cost effective intervention for management of STIs among fishermen.

3.2.7.6.2 Programme Approach

The NMSF approach is to ensure that fishermen have access to HIV prevention and treatment when they are at home or when fishing. Services will also be available at the fishermen camps targeting owners, leaders and workers, actual fishermen, fish processors and vendors, as well as the surrounding community. The minimum package of HIV prevention services will apply.

- Operational strategies
- Condom use and harm reduction programmes.
- Facilitate use of media and community engagement to address harmful gender and cultural norms which increased GBV.
- Capacitate networks and peer support on HIV and SRH&R.
- Interventions addressing gender, economic and social inequality, i.e., entrepreneurship, savings and loans, etc.

Table 16: Fishermen Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percentage of Fishermen in contact with/ reached by prevention services	0	2018	28%	70%	LGMD
% of fishermen who used a condom with last client	0	2018	30%	55%	IBBSS

3.2.7.7 Miners

3.2.7.7.1 Overview

The mining sector is a key source of foreign exchange in Tanzania as it is for many other countries. It is estimated that there are 225,000 people in mining industry. Most mining is conducted at sites far from population centres forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex with non-marital or co-habiting partners. Many become infected with HIV and spread that infection to the surrounding communities and their spouses when they return home. Young girls migrant workers trafficked from rural areas to urban areas to work as cheap labour in the homes as domestic servants or maids, or sex workers in brothels or bar maids are highly at risk. Alcohol and drug abuse are among risky behaviours being practiced in the camps. Although there is limited empirical data on HIV prevalence among miners, studies suggest high HIV transmission on mining camps. The proposed IBSS Study will also target this group. Recent surveys indicate that miners have inadequate information and limited access to HIV prevention services. There is a widespread insensitivity, high stigma and discrimination towards those with PLHIV, particularly women and girls migrant workers, which can deny their right to health services.

3.2.7.7.2 Programme Approach

The NMSF IV clearly recognizes miners' vulnerability and anticipates advocating for their access to friendly quality HIV preventive, care, treatment and social support services. Multisectoral and right based approach to reducing HIV transmission will be deployed in mining camps, with a focus on ensuring HTS as an entry point to access ART, care and other social services to the most

vulnerable and miners PLHIVs. Owners of the mining sites will be encouraged to mainstream HIV in their business by developing and reporting on the results from the implementation of work place interventions.

- Operational strategies
- Capacitate HCPs on post GBV care (PEP, ECs, STI and counselling)
- Meaningful engagement in planning and monitoring workplace activities
- Capacitate PHIV clubs/networks to support dissemination of HIV and SRH information and correct use of condoms
- HIV mainstreaming on company works, i.e., SII on insurance, social security, social protection schemes.

Table 17: Miners Indicator

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percentage of miners in contact with/ reached by prevention services	0	2018	60%	85%	LGMD
Percentage of miners who used a condom with last client	0	2018	45%	70%	IBBSs

3.3 Addressing Stigma and Discrimination

Stigma and Discrimination has been posing a strong barriers to the efforts made by the government NGO's, FBOs and CBO's in providing services the people living with HIV and AIDS in the country HIV and AIDS interventions have not been effectively achieved largely because of stigma and discrimination. Efforts to scale up prevention care and treatment support to the infected, Impact mitigation of consequences of stigma and discrimination have received a little pace of acceptance in responding to the epidemic

The victims of stigmatizations and discriminations suffer from loss of employment inability to a access and control of their resources and properties alienation from families' friend's workmates, communities and face a risk of violence. People living with HIV and AIDS are deprived of their human rights while marginalized groups vulnerable to HIV infection commercial sex works homosexuals prisoners drugs user barmaids face a double discriminations when tested positive. Today, human rights issues, particularly stigma and discrimination, inequality and violence against women and girls, misuse of criminal and punitive laws and approaches affecting key and vulnerable populations remain among the main barriers to effective HIV responses

In order to contain these social-economic evils pertaining people living with HIV there is a need for a National multi-sectoral strategy to guide reduction of stigma and discrimination in order to scale up HIV and AIDS intervention.

Today, human rights issues, particularly stigma and discrimination, inequality and violence against women and girls, misuse of criminal and punitive laws and approaches affecting key and vulnerable populations remain among the main barriers to effective HIV responses

3.3.1 Operational Strategies

- Integrate stigma activities in all HIV combination prevention interventions.
- Integrate of stigma and discrimination-reduction into health worker trainings, accreditation processes, and continuing medical education curricula/systems to foster sustainable change.
- Review operational policies to mainstream guidelines on stigma and discrimination reduction in the workplaces including health care settings.
- Create awareness of stigma and discrimination work with PLHIV network and clusters to advocate and sensitize on reducing Stigma and discrimination.
- Monitor stigma through stigma index studies.

Table 18: Stigma and Discrimination Indicator

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percentage of people expressing accepting attitudes towards people living with HIV	25% women 40% men	2012	100%	100%	General population based survey
Percentage of people living with HIV who have been stigmatized or experienced discriminatory acts due to their HIV status	28%	2013	0%	0%	Stigma Index
Percent of health facility staff who worry about getting HIV when providing care or services to patients living with HIV	45%	2017	0%	0%	facility-based surveys

Chapter 4:
Coordination, Governance and Leadership

4.1 Coordination and Management

4.1.1 Overview

As from the year 2001, Tanzania has adopted a multisectoral and decentralised approach for the coordination of the national HIV and AIDS response. The coordination framework is informed by the National HIV/AIDS policy 2001, the TACAIDs Act 2001 and the three ones principle, of having one national coordinating agency, one national strategic framework and one national M&E plan. Despite of many advantages of having a well-defined multsectoral coordination framework and mechanism, the multisectoral coordination has created new opportunities and challenges as the process becomes complex and dynamic. First, the number and diversity of stakeholders have increased with most of them having different mandates, comparative advantages, roles and responsibilities. Their governance structures, accountability and reporting lines are equally different and often complex. Second, HIV and AIDS services, geographical and client coverage has increased and expanded. Third new technologies and approaches that influence the way HIV and AIDS services are planned and delivered have been introduced. Finally, communities have moved from being merely service beneficiaries to strategic partners in ensuring ownership, sustainability, demand creation, adherence and retention of clients (HIV positive and negative) on services. Communities are demanding for clarity of service; provider mandates, roles and responsibilities; the need for transparency and good governance; for a more participatory and enabling environment that promotes strategic partnerships and alliances, and participation by all people – "no one should be left behind". Communities are also anxious to see better linkages and coordination between them and other stakeholders and especially with the community-based health facilities.

Coordinating structures have been established at national, sector, regional, LGAs, and community levels. Although, in most cases these structures are functional, their potential in ensuring equitable distributions of services, good governance, transparency, efficiency, accountability and meaningful participation and involvement by all stakeholders and in particular communities has not been fully realised. At national level, coordination tend to focus on issues of policy development, joint planning and programming, resource mobilisation, technical assistance, monitoring and evaluation, national and global reporting, harmonisation and alignment of development partner programmes with national policy frameworks and programmes.

TACAIDS has the overall legal mandate of coordinating the national multisectoral response with support of six multisectoral Technical Advisory Committees (or Technical Working Groups /TWG) which report to the Joint Thematic Working Group (JTWG). The six technical working groups are: (i) Prevention which include three sub-committees (adolescents and young adults stakeholders, comprehensive condom programming and key and vulnerable populations); (ii) Care, Treatment and Support; (iii) Impact Mitigation; (iv) Enabling Environment; (v) Monitoring, Evaluation & Research; and (vi) Finance and Audit.

MOHCDGE, given its mandate and technical responsibility for health, coordinates the health sector-based HIV and AIDS response through the National AIDS Control Programme (NACP). NACP in particular is responsible for coordinating the process of setting quality standards and the development of relevant prevention and treatment protocols. NACP also manages specific health sector-based

committees on Prevention; Pediatric ART and eMTCT; Treatment, Care and Support; Community HIV Response; Medicines and Technology (Procurement and Logistics); and Monitoring, Evaluation and Research. They complement the TAC under TACAIDS.

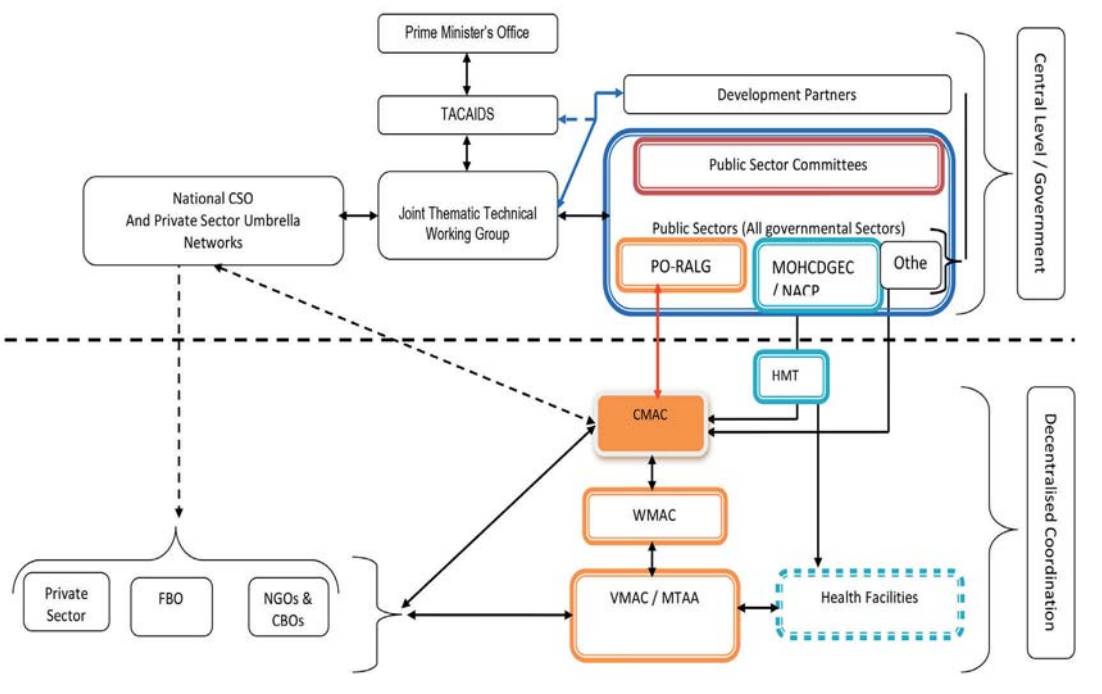
Other Government sectors have sector-based HIV coordinating mechanism. Similarly, Tanzania has established coordinating structures at regional, district and community levels. These structures include the Council Multisectoral AIDS Committee (CMAC), The Ward Multisectoral AIDS Committees (WMAC), the Village Multisectoral AIDS Committee (VMAC) and in urban centres the MTAA Multisectoral AIDS Committees. At regional and community levels, the primary focus is on service delivery, community mobilisation, demand creation and implementation of prioritised interventions.

Beyond the established government coordination structures, the other players have in place some forms of coordination structures. CSO for example are coordinated through umbrella organisations or networks such as NACONGO, NACOPHA and the private sector is coordinated through the Association of Tanzania Employers (ATE), in collaboration with the Tanzania Private Sector Foundation (TPSF). On the other hand, UN agencies are coordinated by UNAIDS, as part of the UNDAP (UN development assistance plan) through the Joint UN Country Team for HIV and AIDS. Development Partners are coordinated through the DPG AIDS (Development Partners Group) on HIV/AIDS and the Global Fund grant is coordinated by the Tanzania National Country Coordinating Mechanism (TNCM).

In the case of other partners, coordination is undertaken by, committees established for that purpose.

Cognizant of the fact that the TWGs address a health issue in a multi-sectoral context, the linkage with technical working groups/teams in the health sector or others that address HIV and AIDS such as NACP advisory groups, TNCM, or DPG cannot be overemphasized. Figure 6 below illustrates the relationship and linkages between these coordinating structures.

Figure 6: Coordination Framework



During the implementation of the NMSF IV, it is envisaged that effective coordination at all levels will leverage resources, improve access to technical assistance, facilitate skills transfer and sharing of knowledge and best practices and enhance exchange of experiences especially with communities. It will also ensure equitable distribution of services, accountability, good governance, and transparency. By harmonising and aligning different interventions and approaches with national priorities, the process will contribute to narrowing the gap between supply and demand for services.

4.1.2 Programme Orientation

The key focus for NMSF IV will be two-fold. First, to strengthen the efficiency and effectiveness of these structures, and secondly to ensure harmonisation and alignment of the different programmes and service delivery approaches. It is evident that effective coordination systems will be characterised by clearly defined mandates, roles and responsibilities, and by having a participatory planning and programme development and implementation mechanism.

4.1.3 Operational Strategies

i. Build capacity of coordinating structure personnel on strategies to improve on coordination efficiency and effectiveness;
ii. Intensify advocacy on harmonisation and alignment of different plans and services delivery mechanism;
iii. Strengthen governance and leadership, joint planning, monitoring, and reporting skills;
iv. Provide financial and technical resources to ensure optimal functionality of coordinating structures;
v. Promote sharing of lessons and emerging practices through annual conference for coordinating structures to share experiences and best practices.

4.2 Strategic partnerships

4.2.1 Overview

The multisectoral and decentralised approach to the national response implementation demands the collaboration of different stakeholders based on their mandates, technical expertise and comparative advantage. Strategic partnerships and alliances are expected to leverage resources, access to technical assistance and strategic information, transfer of skills, knowledge and best practices, improve and increase client and geographical coverage, access and utilisation of services and increase retention of clients on services.

In the context of the NMSF IV, existing partnerships and alliances will be consolidated and new ones established where need arises. In particular, partnerships and linkages will be improved between communities with other service providers especially with community-based health facilities and community health workers. The nature of partnership will depend on intended purpose.

Tanzania will strengthen and expand the scope of the Public-Private Partnerships (PPP) to support HIV and AIDS response such as Geita Gold Mine under the Kili Challenge among others. The expansion of the PPP modality is strategic in expanding the pool of expertise and competencies available to the national multisectoral response. The PPP strategy will be anchored on the principles of shared and common interests, shared resources (time, money, expertise, and people), shared risks and benefits. A well-managed strategic partnerships arrangement will have great potential to promote and strengthen country and community ownership, and long-term services sustainability.

4.2.2 Programme Orientation

The focus will be on strengthening and improving coordination efficiency and effectiveness at all levels of the response. TACAIDS will also facilitate a process of articulating stakeholder mandates, roles, responsibilities and accountabilities.

4.2.3 Operational Strategies

i. Operationalize the PPP concept
ii. Map out all stakeholders classified by their core business and the regions they cover. This information will be placed on the TACAIDS website.
iii. Strengthen partnerships especially between communities, CSOs and health facilities.

Table 19: Strategic Partnerships Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
National Composite Policy Index	TBD	2018	100%	100%	UNAIDS

4.3 Regional and International Partnership

Tanzania is a member of regional and international bodies including East African Community (EAC), Southern Africa Development Community (SADC), African Union (AU) and the United Nations (UN). The government of Tanzania has signed international and regional declarations in addressing ending AIDS as a public health threat. Country efforts have always embraced global and in-country best practices and evidence.

The fourth NMSF is therefore informed by the UNAIDS Fast-Track Commitments to End AIDS by 2030 and the country is working to achieve 90-90-90 targets by 2020; The WHO Global Health Strategy for HIV, viral hepatitis; the Global Fund (GFATM) which aims at investing to end the Malaria, AIDS and TB epidemics. The Framework has also addressed Tanzanian's commitment to the implementation of the UN Political Declaration on HIV and AIDS in 2015, Sustainable Development Goals (SDGs) and the Africa Union Agenda 2063. The country will continue to monitor its commitment towards fulfilling these goals.(Annex 1)

Chapter 5:
Sustainable Financing of the NMSF IV

5.1 Funding Status and Resource Mobilisation

5.1.1 Overview:

The main funders of national multisectoral HIV response are the Government of Tanzania and a limited number of international donors. Analysis of 2015-2017 funding indicates that domestic funds accounts for 4.1% of the total funding, Global Fund accounts for 15.8% while PEPFAR accounts for the largest amount – 39%. Approximately 1.1% of the funding comes from development partners including the UN agencies (0.5%), Canada (0.3%) and the private sector (0.3%). This leaves a gap financial gap of 39.9%. It is evident that the response is largely dependent on external funding.

To sustain and even increase the scope of services, it will require concerted efforts to increase both domestic and external funding. To achieve this objective, Tanzania will need to commit to a long term strategy for sustainable financing the response. Already some efforts towards this goal have started with the establishment of the Tanzanian AIDS Trust Fund. However, the potential for the trust fund has not been realised.

During the NMSF IV period the resource tracking mechanism will be strengthened and will ensure all funding earmarked for HIV and AIDS, through the government channels or directly from the donor to the implementing partners are well tracked to ensure value for money invested. In principle the system should track resources from both the demand (implementing partners) and supply (donor) sides.

Tanzania will also explore where financial gains can be realised through efficient and effective service delivery mechanisms. Part of this strategy is strategically investing in high impact interventions, developing synergies with development sectors and in particular ensuring that development sectors mainstream HIV in both the internal and external responses.

Although the core of the financial sustainability strategy is finances, it will also be necessary to review and strengthen other areas necessary to support sustainability. The two critical areas include organizational systems development and human resources for health.

Total resource needs for the national response over the NMSF period will be estimated using an activity-based costing model premised on the activities articulated in the NMSF IV National Operational Plan (NOP)

5.1.2 Programme Approach

Tanzania will develop a long-term financial sustainability strategy that will also include strengthening and expanding the scope of the HIV AIDS Trust Fund. Tanzania will also intensify advocacy with government and external donors to increase both domestic and external funding. Stakeholders will also explore service delivery areas where efficient gains can be made.

5.1.3 Operational Strategies

i. Develop a financial sustainability strategy
ii. Intensify advocacy with Government to increase domestic funding
iii. Intensify advocacy with current donors to increase their funding levels
iv. Diversify donor base.

Table 20: Resource Mobilisation Indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Domestic and international HIV expenditure by programme categories and financing sources	US$ 485,296,049	NASA 2014/15	US$ 1,150 million	US$ 1,548 million	NASA

5.2 Sustainability strategies

The following are some suggested innovative sustainable funding mechanisms for consideration during the implementation of NMSF IV. Funding mobilised through these options will be channelled through the Tanzania AIDS Trust Fund

- Domestic Resources: Intensify advocacy to increase domestic funding from Government and the private sector. In the case of private sector, the government may consider tax exemption incentives for the private sector.

- External Funding: Currently the national response is largely dependent on external donors. It is important for Tanzania to retain the current donors, while aggressively expanding the donor-base including bilateral, multilateral and private foundations.

- Private Sector: The potential for funding from the private sector has not been adequately realized, and neither has it been institutionalized. Private sector can contribute in many ways ranging from direct donations, funding workplace HIV programmes, subsidizing employee medical aid schemes to cost sharing health insurance as well as social security fund. Government should consider providing incentives to private sector institutions in form of tax-exemption based on their contributions.

- HIV Integration and Mainstreaming: HIV mainstreaming if well managed is a good strategy for HIV financing through internal and external mainstreaming. HIV workplace costed interventions are integrated in the overall sector strategic plan providing a unique opportunity for them to be funded through the sector budgets. In some countries, HIV workplace programmes have been integrated and funded as part of the Health and Wellness Programme. Other countries have prescribed a % of the sector's usual budget to be devoted for HIV and AIDS. To strengthen this strategy there will be need to review the impact of current related initiatives.

  In the context of external HIV mainstreaming, sectors are required to conduct Environmental and Social Impact Assessment (ESIA) that incorporates HIV and AIDS for all large development projects. The sectors would then use the recommendations of the ESIA

reports to mainstream budget in the project costs to support HIV and AIDS response. A review of existing initiatives would be necessary to draw and disseminate emerging good practices.

- **Services Levy:** There are a number of service provision areas where a small amount of fees can be levied to generate funding for HIV and AIDS. Such areas include – Air Tickets, Motor Vehicle Road Licenses and hotel and guesthouses fees, renewal of passports and national identity cards among others.

- **Levy on Popular Consumables:** Consider a small levy on most commonly used consumables such as water and electricity. In 2017, a similar levy on fuel covering petrol, diesel and kerosene was introduced. Levy on consumables could be integrated with the VAT.

- **Sin Taxes (levied on harmful products):** The tax is levied on products that pose threats to life or cause ill health. The most common ones including tobacco, alcohol, sugar and salt. These consumables are associated with cancer, risk behaviours, diabetes and cholesterol. 10% of the global disease burden is linked to conditions related to such products. Consequently, levying a tax will generate funding to support prevention and treatment. Such taxes are not entirely new as several countries are already levying taxes on such products. The tax is often levied on the basis of quantity, value or consumer price. Sin taxes offer a 'win-win' situation because they have been found to lead to reductions in risky health behaviours. However, arguments against such taxes include the potentially increased level of smuggling or black market production and tend to affect most the lower-income consumers.

- **Social Impact Bonds:** Social impact bonds focus investments toward programs that yield effective social outcomes – in this case, impact in the fight against HIV. An investor (a donor or private sector organization, for example) provides upfront financing to a service provider who delivers the programs (often a nongovernmental organization). If the pre-agreed outcomes of the program are met, the outcome payer (usually the government or a donor) repays the investment, sometimes with interest. In some cases, charitable foundations or organizations may guarantee all or part of the social impact bond, to provide additional security for the investor.

- **Currency Exchange Levy:** This levy could be applied on all transactions involving foreign currency exchange or purchase. With all the foreign transaction that take place through the banks or Bureau de Change, the levy has the potential to raise huge amounts of money even if the levy was calculated at small base point – i.e. 0.5%.

- **Diaspora bonds:** The basic rationale behind this mechanism is that the diaspora purchases bonds issued by their country of origin with a patriotic discount, meaning that they do not seek as high a risk premium as pure market logic would suggest. The Diaspora bonds thus have an element of philanthropy since the motivation to purchase them is not linked solely to financial gains. At the same time, they go beyond simple "patriotic charity" since they enable the leveraging of this philanthropy into a long-term financing instrument that has the potential to raise large amounts of capital for needed investments. India for example has issued several types of bonds designed and destined for the diaspora, collecting US$11

billion in total. The mechanisms provide a vehicle for a stable and cheap source of external revenue.

- **Tourism Levy:** Tanzania could consider a small levy on all local and international tourists – similar to the current levy on hospitality training collected by all registered hotels upon the sale of food. The levy could be differentiated between the different local and foreign tourists.

- **Mobile Phones:** The use of mobile phones has increased in the last ten years and has changed the way we communicate or transact business. Putting a small levy on mobile phone use could generate large amounts of money. The levy charge is better put at the point of airtime sale. Mobile phone taxes could either cause a reduction in profit margins or increase the price for the consumer. Experiences from one country showed a price increase before the competition between the service providers pressured them to lower prices and absorb the impact on their profit margins.

- **Debt2 Health:** This programme was launched in 2007 by Global Fund to generate domestic resources for health financing through debt swaps. To benefit from the programme a country has to forgo repayment of a portion of their sovereign debt on condition that they invest an agreed amount in their health system through the Global Fund. To date, debts swapped agreements total close to €170 million, involving Australia and Germany on the creditor side; Côte d'Ivoire, Egypt, Ethiopia, Indonesia and Pakistan on the beneficiary side.

- **Sustainable Financing Initiative (SFI):** The initiative is managed by USAID to help a country to mobilize domestic resources. In 2014, PEPFAR committed $63.5 million, to be disbursed over multiple years, through the SFI to support ongoing country-led efforts (including Tanzania) to further mobilize their own resources to address the needs of people living with HIV/AIDS. To meet this need, USAID leads the coordination and implementation of the SFI for the U.S. President's Emergency Plan for AIDS Relief's (PEPFAR's), which aims to control the HIV/AIDS epidemic through shared financial responsibility with the country Government host.

- **Blended Finance:** Blended finance combines grant funding and private capital flows such as loans for government health investments to ensure a smooth transition from traditional donor support to fully nationally funded health programs and systems. Blended finance loans typically have long maturity horizons and flexible terms, enabling governments to spread the related costs over time. Partner lending institutions are able to expand their portfolio to include national health projects with the knowledge that funds are invested under the Global Fund's model, which includes rigorous monitoring and evaluation controls on program quality, risk management procedures, and a focus on maximizing impact. The Global Fund is exploring partnerships to multiply its impact through blended finance and to learn from similar models. For example, through the Unfunded Quality Demand program, the Global Fund identifies quality programs that lack sufficient funding. The Global Fund provides this list of programs to the Lives and Livelihoods Fund, a mechanism supported by the Bill & Melinda Gates Foundation and the Islamic Development Bank that provides affordable financing through a combination of grants and concessional loans

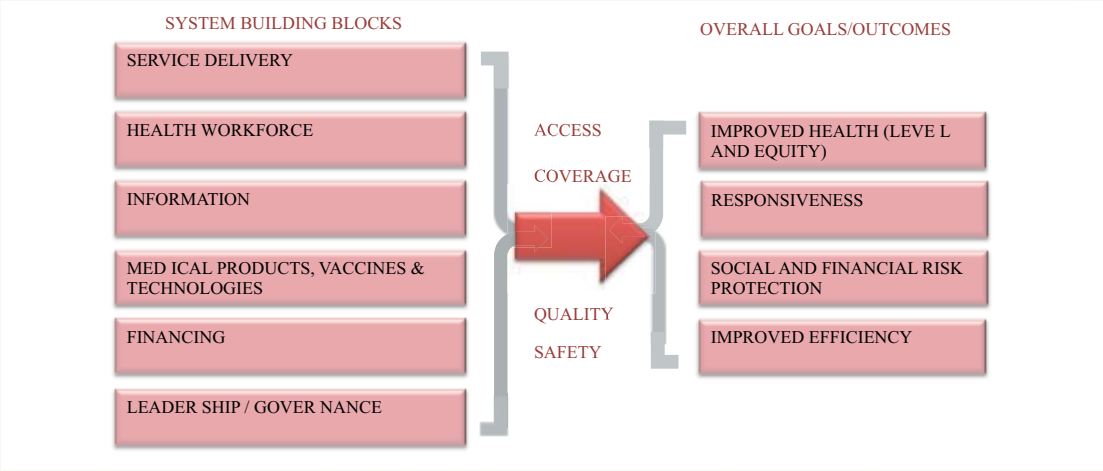
Chapter 6:
Strengthening Health and Community Systems

Comprehensive capacity development for NMSF IV will revolve around health and community systems strengthening (CSS). Strategies for health systems strengthening is premised on the WHO's six blocks of systems strengthening while CSS is based on Global Fund guidance.

6.1 Resilient Sustainable Systems for Health

Resilient health systems are essential to ensure sustained availability, access and utilisation of quality and comprehensive HIV and AIDS services. Strong HS, supports HIV/AIDS services integration with the broader health care services and mainstreaming in the sector internal and external sector programmes. Fully functional HS ensure no stock out of drugs and related commodities, improves services delivery efficiency and effectiveness, and provides for efficiency gains.

Figure 7: Health Systems Strengthening Framework



Source: Strengthening Health Systems to Improve Health outomes – WHO Framework for Action

6.1.2 Programmatic approach:

The NMSF will advocate for health systems strengthening as a whole, with emphasis on strengthening strategic information management, Human resources for health (adequacy, skills and competencies), organisational capacity (operational systems, financial resources and technology), Sustainable financing and service delivery. It is critical that HSS is capable of generating strategic data and information necessary to inform choices and decision in the national response decision making on where to invest strategically.

6.1.3 Operational Strategies

The following strategies will be used to strenghten the health systems.

Table 21: HSS strategies

Focus area	Strategies
1. Strengthen the Human for health - adequacy, skills and competencies	i. Review the Human resource capacity for health with a focus to determine its adequacy, skills and competencies to support the implementation of the NMSF IV ii. Development and Implementation of a comprehensive HRH capacity building and strengthening plan iii. Develop a system to offer on going mentorship and supportive suppervision (especially at community level) iv. Accelerate the implementation of the "Task shifting" policy and the PPP arrangment to expand the pool of expertises by bringing on board private sector based experts.
2. Strengthen the management of HIV trategic, Information, data and knowledge	i. Strengthening the national capacity for strategic information and knowledge management ii. Strength and harmonise the existing M&E systems to support effective and efficient data collection, analysis, dissemination, use and feedback. iii. Establish a repository of HIV/AIDS work conducted in Tanzania.
3. Strengthen service delivery systems	i. Strengthen community linkages with health facilities ii. Review and strengthen service delivery mechanism within the context of health and community systems.
4. Develop the organisational capacity to delivery services	i. Review and strengthen service delivery systms ii. Strengthen community based structures to support community based service delivery iii. Strengthen capacity for M&E at all levels of the response iv. Review and strengthen the procurement and supply management systems, strengthen the capacity of coordinating structure to ensure good governance and leadership at all levels.
5. Leadership and governance	i. Mobilise and strengthen the capacity of community, religious and political leaders for effective engagement in the national multisectoral response ii. Train coordinating committees on governance, leadership and management skills
6. Sutainable Financing	i. Accelerate resource mobilisation strategies ii. Develop and implement a Sustainable Financing Strategy for HIV and AIDS.

6.2 Community Systems Strengthening

6.2.1 Overview

The NMSF IV has adopted the CSS approach to promote and strengthen the development of informed, capable and coordinated communities and community-based organisations (CBOs) and structures. Community systems will contribute to the development and improvement of knowledge and access to improved health service delivery. It is through community structures that community members and CBO interact, coordinate themselves, and deliver community solutions.

Community systems strengthening aims at increasing community engagement, participation and leadership in supporting community-based and community led HIV and AIDS interventions. Systems strengthening approach promotes the development of informed, capable and coordinated communities, and community-based organizations, groups and structures. An effective community system will enable communities to initiate local responses to change risk environments, bring about positive changes by addressing critical bottlenecks including negative social and cultural norms, cultural and religious beliefs that negatively influence risk behaviours. Community systems will also facilitate sustained community mobilisation and engagement of KVP.

Strong systems will support communities to address issues of GBV/IPV, gender inequalities, alcoholism and drug abuse, stigma and discrimination among others. Empowered communities will be able to design and delivery and sustain community driven solutions

Communities in all the regions and districts are mobilizing and organizing themselves in community action groups, support groups of people living with HIV and in other forms of community-based organisations. Some regions have active CMAC, WMAC, and VMAC/ MTAA while in some regions these committees are not fully functional.

Some community organizations are located in rural or remote areas, operate with limited human resources, and are often staffed by volunteers. Many also lack sufficient experience and systems to access resources that could strengthen their underlying management systems, thereby improving their operational and implementation effectiveness in service delivery or HIV and AIDS.

The Government realizes the potential for community participation and involvement in scaling up the national response. A number of initiatives have been started or continued to support and strengthen community efforts through government, PEPFAR and Global Fund among other development partners.

6.2.2 Programme Approach

CSS strategies will prioritize adequate and sustainable funding for community- based initiatives, – not only funds for specific project activities and services, but crucial core funding to ensure organizational stability for operations and for networking, partnership and coordination with others, accompanied by skills development in community mobilisation, services delivery, advocacy, monitoring and active referral to supporting adherence and retention.

Table 22: CSS Strategies

Component	Description of the component
1. Enabling environment and advocacy	i. Community engagement and advocacy for improving the policy, legal and governance environment, and affecting the social determinants of health
2. Community networks, linkage, partnerships and coordination	ii. Enabling effective activities, service delivery and advocacy, maximizing resources and impacts, and coordinated, collaborative working
3. Resources and capacity building	iii. Including human resources, with appropriate personal technical and organizational capacities, finance and material support (infrastructure, information, essential commodities, including medical and other products and technologies
4. Community activities and service delivery	iv. Accessible to all who need them, evidence –informed and based on community assessment of resources and needs
5. Organizational and leadership strengthening	v. Including management, accountability and leadership for organizations and community systems
6. Monitoring and Evaluation and planning	vi. Including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management

Adapted from the CSS Framework, Global Fund 2010

Chapter 7:
Monitoring, Evaluation and Research

7.1 Situation analysis

The monitoring and evaluation of the national multisectoral response has been premised on the National Monitoring and Evaluation Plan. For the first and second generation of NMSF, the accompanying ME focused on establishing structures, deploying and training staff then designing and making M&E systems and tools operational in generating strategic information for HIV and AIDS.

Through the M&E system for the NMSF III from 2013/14 to 2017/18, stakeholders continued updating the data collection and reporting tools, modifying structures for undertaking various M&E roles, and deploying and building capacity of human resources for M&E. During the NMSF III period, the pressure for evidence-based programming and strategic information kept growing among stakeholders, and therefore there was even more finances and human resources mobilized for undertaking HIV and AIDS M&E work. However, the resources mobilized still fell short of what was required for M&E work to be fully implemented in the country. More M&E training programmes were implemented to benefit various staff within the country and also at the international levels.

The routine monitoring systems for TOMSHA and MOH were functional in generating data and using strategic information to develop reports and other information products. In addition, a robust survey and surveillance system was in place, which generated strategic HIV and AIDS information through THMIS, TDHS, THIA, IBBSS, size estimation, stigma index survey and others. Technology and innovation in M&E and feedback gathering that has been embraced by the HMIS and other stakeholders include: health facility registry, eIDSR, and mobile phone surveys and reporting. TOMSHA and HMIS were also linked to the districts, hospitals and health facilities, which now record data directly into the information systems.

Aside from the financial shortages that previously curtailed the full operation of the M&E system, two more concerns remained as bottlenecks to full functionality of the M&E system for HIV and AIDS during the NMSF IV period. The first concern was the need to change the culture and working style of stakeholders in order to fully appreciate and comply with reporting requirements, while also consistently using strategic information for policies, programming and decision making. Under the previous arrangements, it was not easy to compel service providers and implementers to report and use data. The second concern was infrastructural challenges such as distance travelled to collect reporting forms, floods and internet connectivity issues, which affected timely and regular reporting in the system.

The M&E system also had some internal inadequacies as follows: implementers who report to TOMSHA and some health facilities still report using paper tools, yet these often stock out due to shortage of finances for printing; the gradual reduction in funding has also caused irregular data auditing and staff turnover to look for greener pastures; HIV and AIDS research reports and information were not fully disseminated and optimally used for planning and decision making; there was no enough information regarding quality, coverage and friendliness of services provided to KVPs; and some databases of LGAs and MDAs were not fully functional and the information systems were not linked.

7.2 NMSF IV monitoring, evaluation and research strategy for 2018-2023

7.2.1 Routine monitoring for the NMSF IV

The main information systems which will capture routine monitoring data for the NMSF IV are HMIS through DHIS2, TOMSHA, EMIS and NACOPHA MIS.TOMSHA captures routine monitoring data for other sectors aside from health, while the HMIS has integrated health sector data for HIV including: CTC, pharmacy, ILS, condom, PMTCT, HBC and eIMIS. Respectively, the HIV service providers who report to these monitoring systems are based in health facilities, communities, schools and networks of PLHIV who report to these systems. Since the paper based reporting system did not work due to stock-outs of forms stemming from financial shortages, during the NMSF IV these routine monitoring systems will be upgraded to allow for all service providers at health facilities, communities, schools and PLHIV clusters to directly capture and report data into the systems electronically. Direct reporting by the districts has been proven to work, known to be expedient, cost effective and accompanied by the much needed internal in-built data quality assurance functions. It is anticipated that electronic reporting by implementers will increase the reporting rates and thus functionality of the system.

Table 23: M&E indicators

Indicator Description	Baseline		Mid and end Term Targets		Data source
	Value	Year	2020	2023	
Percentage routine reporting units submitting timely reports according to national guidelines	0	2018	40%	100%	HMIS, BEST, NACOPHA, MoL, LGMD

7.2.2 Evaluation and reviews

The NMSF IV will undergo various evaluations and reviews during the period of its implementation. In the year 2020, a mid-term review will take place to assess progress, identify gaps and challenges, and propose actions for strengthening the remaining phase of the NMSF IV implementation. At the end of the NMSF implementation in 2023, an end-term evaluation will take place to assess what has been achieved as compared to the desired outcomes and impacts results. On an annual basis, performance of the NMSF will be internally assessed by stakeholders through the Joint Annual AIDS Programme Review. During the NMSF IV period, technology and innovation such as SMS and other forms of social media will be applied to obtain feedback from PLHIV and KVPs on issues concerning access, friendliness and client satisfaction with the HIV and AIDS services provided.

7.2.3 Research, survey and surveillance

The NMSF IV will maintain a robust and functional research, survey and surveillance system to provide strategic information for assessing outcomes, impacts and progress of the HIV interventions. The main HIV and AIDS related surveys include: TDHS last done in 2015/16; THIS last done in 2016/17; work-place survey which is planned for 2018/19; THMIS in 2011/12; stigma index survey in 2013; IBBSS last done in 2015/16; PER annually; and the annual NASA. The research agenda and strategy will be reviewed and updated annually to fill gaps in information required for HIV and AIDS programming. Some of the planned research during the NMSF IV period includes: impact of social protection programmes on the spread and impact of HIV; cost and burden of attending PMTCT for men; and inclusion or engagement of men in HIV services in addition to a study on community experiences.

7.2.4 Data management

NMSF related data will be stored in various databases that have been aligned to the HMIS, TOMSHA, EMIS and NACOPHA-MIS. A research repository will also be established with all reports of research conducted in Tanzania. TACAIDS will provide human resources and technology to make sure that all databases that capture HIV information at councils and within MDAs are functional. In addition, the efforts will spill over to harmonize data elements being reported, then link or integrate with the HMIS/DHIS2, TOMSHA, EMIS and NACOPHA-MIS in order to ensure that critical HIV data is directly retrieved and shared among these main information systems. The NMSF IV will also use other approaches for managing and presenting data including: the UNAIDS spectrum model which captures data, then analyses it to present and forecast incidence, prevalence and other data; goals model which is used for analysing financial investments then projecting the program outcomes and results that it will yield; EPICOR which is used by the local councils for budgeting and accounting; and PLANREP software which is used by LGAs for planning functions.

7.2.5 Dissemination and usage of high quality strategic information

The overall purpose of the M&E system is to ensure that it generates strategic information which is used in making well-informed and sound decisions during programme design, implementation, resource allocation, policy making and any other functions. The strategic information will be recorded and packaged in information products for the multi-sectoral HIV and AIDS response, such as the: Annual HIV and AIDS response report; and an annual brochure and newsletter for the HIV and AIDS response. These information products will be disseminated for stakeholders' usage in decision making through: TACAIDS and other websites, physical distribution, mass media coverage, and on social media platforms. Proven to work innovation like the score-cards, dash-boards and pay-for-performance approach will be explored and applied in order to promote data dissemination and information use.

7.2.6 Sustainable financing for M&E

Although substantial human, financial and technological resources have been mobilized over-time for M&E, there are still some shortages at LGAs levels, especially for service delivery reporting, supervision and data quality assurance. Innovative means for generating resources for M&E will be explored and applied during the NMSF IV duration. At the level of LGAs, each council will be tasked with looking for financial resources from their own sources or from national philanthropists, to support M&E work being undertaken by council officials and committees. TACAIDS will work with councils to determine and implement feasible targets for LGAs to set aside and disburse funding for M&E. Strategies for efficiency gains such as joint supportive supervision and mobile reporting through the implementers' telephones will be embraced in each ward.

Chapter 8: Annexes

Annex 1: Tracking "Fast Track Commitments" Implementation

Commitment		Progress made	Score	Source
	❶Ensure people living with HIV have access to treatment through 90-90-90 targets by 2020	PLHIV who know their status	52.2%	THIS 2016/17
		Children and adults on ART 15-49	44.2%	THIS 2016/17
		Children and adults on ART 15-64	47.5%	
		Children and adults on ART 15+	47.1%	
		Viral load suppression	87.7%	THIS 2016/17
	❷ Eliminate new HIV infections among children by 2020, while ensuring that children have access to HIV treatment by 2020	Women PLHIV receiving ARV	85.14%	Spectrum 2018
		Children newly infected	12.3%	Spectrum 2018
	❸Ensure access to combination prevention options, including PreP, VMMC, harm reduction, condoms to at least 90% of people by 2020	People who received PreP	0%	
		Men who are circumcised	81%	TDHS 15/16
		Sex workers using condom in the last sexual contact with client	34%	IBBS 2013
		Harm reduction	20%	Global Fund funding request narrative
	❹ Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020.	Violence (Intimate partner violence)	28%	TDHS 2015/16
		Discrimination (% of medical staff expressed worries about HIV transmission via touching clothing/bedding of HIV positive patient)	45%	HP+ and MUHAS baseline study on S&D in health care settings

	❺ Ensure90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to SRH services by 2020	# /% Of young people young people reached with life skills		
		% youth friendly services	30%	MOHCDGEC-RCH
	❻ Ensure that 75% of people with or at risk of HIV benefit from HIV sensitive social protection by 2020	%/# of people at high risk of HIV benefited from HIV sensitive social protection		
	❼ Ensure that at least 30% of all service delivery is community led by 2020	% Of HIV/AIDS services that are community led (Ref: Funding allocated for CSO by the Global Fund grant 2018-2020)	14%	TNCM Secretariat
	❽ Ensure that HIV investments increase by 2020 / including a quarter for HIV Prevention and 6% for social enablers	US$ 485,296,049 (NASA 2014/15)		
		% Of Investment allocated for HIV prevention HIV	26.7%	NASA 2014/15
		%of investments allocated for social enablers		
	❾ Empower people living with or at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights	No data	-	-
	❿ Commit taking AIDS out of Isolation through people-centred systems to improve universal health coverage, including TB, cervical cancer and Hepatitis B and C.	HIV and AIDS integration in the broader health care services		

Annex 2: NMSF Results Framework

NMSF IV Priority area	Code	Impact Result	Code	Outcome Result	Code	Output / Process Results
Prevention of new HIV infections	1.1	New HIV infections reduced by 75% by 2020, and by 85% by 2030 among adults	1.1.1	Proportion of people living with HIV who know their HIV status increased to 95% by 2023	1.2.1	HIV testing services provided
			1.1.2	Proportion of adults and children on antiretroviral therapy among all adults and children living with HIV increased to 90% by 2023	1.2.2	Adults and children living with HIV referred and enrolled on care and treatment
			1.1.3	Proportion of people living with HIV who have suppressed viral loads and thus lower chances of transmitting HIV increased to 85% by 2023	1.2.3	Adults and children living with HIV provided viral load testing and monitoring
			1.1.4	Increased economic resilience with higher proportions of AGYW who engage in safe practices to protect themselves from HIV infection	1.2.4	Cash transfers and other forms of economic empowerment provided to KVP
			1.1.5	Increased proportion of KVP with increased HIV knowledge and improved attitudes, practices and behaviour to protect themselves from HIV infection	1.2.5	Education and skills in HIV-related CSE, SBCC, SRH provided to KVP
			1.1.6	Increased community members adoption of safer sex, healthy gender-equality, non-violence and non-stigmatizing attitudes and practices which reduce spread of HIV	1.2.6	Condoms, prep, VMMC and community SBCC provided to promote gender equality, non-violence and non-stigma attitudes and practices
	1.2	Zero New HIV infections among children through mother to child Transmission by 2030	1.1.7	Transmission of HIV from mother-to-child transmission of HIV among pregnant women reduced to less than 5% by 2023	1.2.7	ARV provided for pregnant women living with HIV to reduce risk of mother to child transmission of HIV

Reduction of AIDS related deaths	2.1	AIDS related deaths reduced by 80% 2030.	2.1.1	Proportion of adults and children on antiretroviral therapy among all adults and children living with HIV increased to 90% by 2023	2.2.1	Adults and children living with provided HIV testing, and referred and enrolled on care and treatment
			2.1.2	Proportion of people living with HIV who have suppressed viral loads and thus lower chances of transmitting HIV increased to 85% by 2023	2.2.2	Adults and children living with HIV provided viral load testing and monitoring
			2.1.3	Increased proportion of children and adults living with HIV kept physically and psychologically healthy	2.2.3	Legal, nutritional, social and economic support provided to PLHIV
Reduction of stigma and discrimination	3.1	Zero stigma and discrimination by 2030	3.1.1	Increased percentage of people expressing accepting attitudes towards people living with HIV	3.2.1	Stigma and discrimination campaigns from national to community level implemented
			3.1.2	Increased percentage of health facility staff who report that their facility has written guidelines to protect patients living with HIV from discrimination. Reduced percentage of people living with HIV who have been stigmatized or experience discriminatory acts due to their HVI status to 0% by 2023 Reduced percent of health facility staff that hold stigmatizing views about people living with HIV to 0% by 2023	3.2.2	Stigma and discrimination-reduction integrated into health worker formation curricula, accreditation processes, and continuing medical education curricula/systems to foster long-term, sustainable change.
			3.1.3	Increased number of people infected and affected by HIV who know their legal and human rights Increased number of people infected and affected by HIV who have been able to have concrete solutions to legal and social problems that arise from their HIV vulnerability, to have access to the justice system for HIV-related problems and to obtain protection.	3.2.3	Individuals and communities empowered to address and respond to discrimination.

Annex 3: Sector Mandates, Roles and Responsibilities for HIV/AIDS response

The following table illustrates the mandate, roles and responsibilities of the different sectors in HIV internal and external mainstreaming in the development sectors. The sectors are organised on thematic basis. However the sector lead agency identified from Government, Private sector or CSO based on their mandates.

Sector	Sector lead Agency	Risks Factors	Sector Mandate	Roles and Responsibilities	Suggested Indicator
Agriculture	Ministry of Agriculture	Food insecurity and poverty that contribute to risk behaviours to augment income or exchange sex for food	To ensure sustained national food security and nutrition	• Support and strengthen strategies that promote household and community food security. • Implement comprehensive minimum package of HIV workplace programme / as part of the health and wellness programme	• % Of households and communities that are food secure • % Of sector employees access HIV and AIDS specific services
Education	Ministries of Education, Science, Technology and Vocational Training	School dropouts, absenteeism, sexual abuse, GBV, stigma and discrimination, teenage pregnancies	Ensure access and retention of all learners in schools, Provide HIV life skills-based education, and CSE	• Strengthen the policy environment to address HIV and AIDS response. • Implement HIV Workplace programmes • Provide age appropriate sexuality and life skills-based education to all learners • Strengthen schools – community partnerships	• % Of schools that provide age appropriate sexuality and life skills-based education • % Of education sector employees access HIV and AIDS specific services

Environment and Tourism	Ministry of Natural Resources and Tourism	Mobility, migration, casual and sex work, alcohol abuse, and inconsistent use of condoms	• Tourism promotion • Environmental protection and sustainable utilisation of environmental resources	• Establishment partnerships with communities to address HIV and AIDS. • Enforce Environmental Impact Assessments (ESIA) that incorporate HIV and AIDS. • Implement HIV workplace programmes	• # Of sector employees access HIV prevention and treatment services • % Of sector undertaking ESIA that incorporates HIV and AIDS
Economic Planning and Development	Ministry of Finance and Planning (National Planning Commission)	Poor integration of HIV and AIDS in the workplace and in development projects	Promote and coordinate social and economic initiatives that are HIV and AIDS sensitive and response	• Implement HIV workplace programmes - minimum package of services) • Ensure development projects mainstream HIV and AIDS based on the EIA findings	• % of public sector institutions that have done internal and external HIV mainstreaming. • % of sectors that have conducted sector specific HIV/AIDS surveys. • % Of sector employees access HIV and AIDS specific
Finance	Ministry of Finance and Planning	Risk behaviours, declining resources to fund HIV and AIDS interventions	Ensure sustainable financing of development projects including health, HIV and AIDS.	Ensure integration of HIV and AIDS response in the national 5 years Development Plan, Vision 2025, and sector budgets	• % Of sector employees accessing HIV and AIDS specific services – minimum package • % Of national annual budget allocated to HIV and AIDS response

Fisheries and Marine Resources	Ministry of Livestock and Fisheries	Mobile population / fishermen spend a lot of time away from families	Creating an enabling environment for fishermen to access health and HIV services	• Periodical review of policies ensure responsiveness to HIV and AIDS • Implement HIV workplace programmes	• % Of sector employees accessing HIV and AIDS specific services – minimum package
Governance and Leadership	Office of the President	Staff mobility, MCP, poor policy environment – that does not support HIV and AIDS response initiatives	Provide national political leadership, commitment and good governance necessary to ensure effective and efficient national coordination of the HIV response	• Ensure high-level political leadership and commitment • Advocate for sustainable financing for the national HIV and AIDS response. • Ensure effective implementation and enforcement existing policies and laws	• National Commitment Policy Index (NCPI)1 • % Of sector employees access HIV and AIDS specific services
Health	Ministry of Health, Community Development, Gender, Elderly and Children)	• Staff mobility, occupational related infections, poor provision of HIV services, poor distribution of services	• To ensure a healthy and productive nation by providing comprehensive, quality health care and HIV/ AIDS services.	• Coordination and development of the health sector-based HIV and AIDS response • Ensure availability, access and utilization of comprehensive and quality core HIV and AIDS services • Social protection of KVP	• % Of health sector employees access HIV and AIDS workplace programme services • % Of communities with strategic partnership arrangements with a health facility

[11] The NCPI is premised on a set of questions intended to explore specific areas that include and not limited to policy, leadership, governance, and participation progress and performance

Law and Human rights	Ministry of Constitutional Affairs and Justice	• Lack of awareness and adequate knowledge of policy and legal provisions, • Inadequate monitoring of enforcement and compliance of HIV and AIDS related policies and legislation	• Social protection, monitoring of respect and fulfilment of basic human and legal rights of all people and in particular PLHIV	• Create awareness of HIV and AIDS related human and legal rights • Review and mainstream HIV and AIDS in all national and sector policies, and legislation. • Train law enforcement officers and enforce compliance with existing laws and policies • Provide legal assistance and advice to PLHIV, and other vulnerable groups	• % of women and men with comprehensive knowledge of existing policies and laws related to HIV and AIDS response. • % Of Sector employees who reported having accessed HIV and AIDS specific • % Of Justice System personnel with comprehensive knowledge of HIV related gender and human rights issues
Housing and Urban development	Ministry of Lands, Housing and Human Settlements	Informal settlements, poor housing facilities, and inadequate access HIV and AIDS services	Facilitate the development of decent living conditions with appropriate physical planning	• Provide comprehensive sector-based HIV workplace / wellness -minimum package • Ensure environmental impact assessments in large projects incorporating EIA and HIV and AIDS	• % Of sector employees accessed HIV and AIDS specific • # of housing projects that have conducted EIA that incorporates HIV and AIDS.

Information Communication and Technology	Ministry of Information, Culture, Arts and Sports	• Influence and exposure of social media to risky behaviours,	• To ensure efficient and effective use of technology to promote, communicate, inform, and create awareness of HIV and AIDS	• Establish PPP with ICT companies to support HIV response • Implement HIV workplace / wellness programme - minimum package	• % Of Sector employees accessed HIV and AIDS specific services • % Of ICT companies promoting HIV and AIDS response
Labour and Employment	Minister of State in the Prime Minister's Office: Parliamentary Affairs, Labour, Employment, Youth and the Disabled	• Staff mobility, migration, unemployment, poverty, casual and commercial sex	• To ensure compliance with national labour and employment policies and laws that protects the legal and human rights of workers and provides social justice.	• Enforce and ensure compliance with labour laws and policies that address HIV and AIDS • Advocate for HIV mainstreaming of HIV and AIDS in sector policies and management protocols • Undertake labour law and policy reviews to mainstream HIV and AIDS, gender and human rights • Implement HIV and AIDS workplace programmes	• % Of Sector employees accessed HIV and AIDS • % Of sectors and medium to large private companies that have functional HIV workplace programmes • % Of migrant workers reporting accessed basic HIV and AIDS services

Mining	Ministry of Minerals	Labour migration, casual and sex work, alcohol abuse, and inconsistent use of condoms, GBV / IPV	• Ensure that all mining development projects undertake ESIA and have mainstreaming HIV and AIDS response	• Monitor compliance with ESIA policies and guidelines for large energy projects. • Mainstream HIV and AIDS response strategies in all sector operational functions and service delivery	• # Of sector employees access HIV prevention and treatment services • % Of mining companies who undertake ESIA that incorporates HIV and AIDS
Energy	Ministry of Energy	• Staff mobility, exposure to casual and commercial sex, alcohol abuse, and informal settlements around capital projects (i.e. mines and dams etc.)	• Ensure that all energy development projects undertake ESIA and have mainstreaming HIV and AIDS response	• Monitor compliance with ESIA policies and guidelines for large energy projects. • Mainstream HIV and AIDS response strategies in all sector operational functions and service delivery	• % Of Sector employees accessing HIV and AIDS services- • % Of development projects that have conducted ESIA incorporating HIV and AIDS

Gender	MOHCDGEC (Ministry of Health, Community Development, Gender, Elderly and Children)	• Gender inequalities, GBV, negative social and cultural norms and practices	• Ensure gender equality, prevent GBV/IPV, and advocate for elimination of negative social practices and structural barriers	• Intensify advocacy for gender transformative and equality • Monitor compliance and enforcement with HIV related policies and legislation	• % of sectors that have mainstreamed gender HIV response strategies into their policies and programmes
Youth sports and culture development	Ministry of Information, Culture, Arts and Sports	• Low risk perceptions, risking taking behaviours, low comprehensive knowledge of HIV and AIDS, unemployment, casual and unprotected sex, MCP, alcohol and drug abuse, lack of knowledge of HIV status.	Mainstream HIV sensitive and responsive in cultural and sporting activities targeting youth.	• Mainstream HIV and AIDS response strategies in all sector functions, operations and service delivery • Collaborate with communities, sporting associations, and youth organisation to intensify community mobilisation and demand creation for HIV. • Incorporate social and behaviour change interventions in all sporting and cultural activities	• # Of sector employees and youth reached with HIV prevention and treatment programmes • # Of community members reached with HIV prevention programmes through sporting and cultural activities • % of sporting associations that have mainstreamed HIV, gender and human rights in their activities.

Trade and Commerce	Ministry of Industry, Trade and Investment	• Mobility, informal and cross border trade, migration to industrial sites and mushrooming of informal settlements around big development projects	Ensure trading and commerce practices mainstream HIV and AIDS interventions.	• Mainstream HIV and AIDS response strategies in all sector functions, operations and service delivery • Create awareness of HIV and AIDS services available • Implement HIV workplace programmes – provide the minimum package	• Sectors have mainstreamed HIV and AIDS • % Of sector employees accessing HIV and AIDS services
Roads and Transport	Ministry of Works Transport and Communication (TANROADS)	• Mobility, sex work, casual sex, alcohol, and drug abuse	Provide access to HIV and AIDS service within the transport industry	• Undertake external mainstreaming of HIV and AIDS, gender and human rights	• % of people accessing HIV and AIDS services from external and internal mainstreaming initiatives
Works and Construction	Ministry of Works Transport and Communication	• Staff mobility, exposure to casual and commercial sex, alcohol, GBV, long periods away from home, informal settlements	• Sustainable infrastructure development	• Strengthen a comprehensive sector-based wellness / HIV and AIDS programmes • Undertake both internal and external HIV mainstreaming • Ensure that all large public works projects and programmes integrate EIA that incorporates HIV and AIDS • Identify HIV/AIDS hotspots and provide basic services	• % Of public sector employees accessing HIV and AIDS • % Of large public works and transport project that have conducted EIA, and have a mainstreamed response strategies

Defence Forces / Uniform Services	Ministry of Defence and National Service	Mobility, casual and sex work, alcohol and drug abuse, GBV	Provide national security	• Strengthen a comprehensive HIV / wellness workplace programme • Mainstream HIV and AIDS response strategies in all sector operations • Strengthen civil-military / police collaboration with communities to address HIV and AIDS. • Train police services to deal with sexual violence, and GBV. • Provide of PrEP/ PEP security services for service providers	• % Of Sector employees accessing HIV and AIDS services • % Of service providers with comprehensive knowledge of HIV and AIDS
Social protection[2]	Minister of State: Public Service and Governance	• Poverty, gender inequality, Gender-based violence, unemployment	• Ensure social protection of vulnerable individuals, households, and communities	• Ensure availability protective, preventive and transformative policies and service delivery frameworks. • Provide the minimum package of HIV and AIDS services	• % Of vulnerable households that received external material and psychosocial support • % Of men and women accessing HIV/AIDS social protection services • % of KVPs enrolled on cash transfers

Civil society (FBOs, NGOs and CBOs)	MOHCDGEC (Ministry of Health, Community Development, Gender, Elderly and Children) Coordination of the NGO Act and Registrar of NGOs seats here	• Mobility, casual sex, sex work, MCP, low levels and inconsistent use of condoms, not knowing ones HIV status, vocational training, IGAs, job insecurity	• Support community-based interventions that address HIV and AIDS in partnership with respective communities	• Strengthen CSO- community partnerships • Support community-based demand creation for HIV/AIDS • Intensify advocacy on enforcement and compliance with HIV / AIDS related policies and legislation • Strengthen community capacities to address GBV, alcohol abuse, gender inequality etc. • Support interventions that target KVP – AGYW, FSW, MSM, PWIDs, etc.	• # Of communities reached with HIV prevention and treatment programmes • % Of community leaders trained in leadership and governance in the context of HIV and AIDS • % of CSOs implementing HIV interventions (CSO mapping, we have more than 4000 registered CSOs in TZ.)

[12] (it is under Public Social Safety Net which offers household livelihood enhancement and other poverty focus initiatives

Private sector Both format and informal?)	• Ministry of Industry, Trade and Investment • Networks • Formal - ATE, and TPSF • Informal – TIENAI • (Tanzania Informal Economy Networks in AIDS Initiatives)	Have money, mobility, casual sex, sex work, MCPs, low levels and inconsistent use of condoms, not knowing ones HIV status	Development and provision of HIV/AIDS and wellness programmes at the workplace.	• Strengthen a comprehensive sector-based wellness programme that integrates HIV and AIDS interventions • Mainstream HIV and AIDS response strategies in all sector operations • Strengthen the PPP arrangement with government, CSO and communities. • Support policy advocacy to strengthen a social, policy and legal environment for HIV and AIDS response at the workplace	• % Of private sector companies that have functional HIV and wellness programmes • % Of private sector employees accessing HIV and AIDS

Annex 4: Glossary of terms used in the NMSF IV

Term	Definition
Baseline	A quantity, value or fact used as a standard for measuring other quantities and values. Represents the current status.
Coordination	The process of bringing together and supporting stakeholders to efficiently and effectively coordinate and plan their activities in a manner that enhances synergy, reduces duplication, increases skills and knowledge transfer
Critical enablers	These are activities that are necessary to support the effectiveness and efficiency of core programme activities.
Culture	Refers to people's inherited way of life and defined by cultural norms and attitudes.
Development synergy	These are investments in other sectors that have a positive and complementary effect in multiple HIV/AIDS contexts
Discordant couples	A case where one member of a couple is HIV positive and the other is not.
Duty bearer	The person or institution with a legal mandate to provide certain services to another person in need.
Effectiveness	The extent to which an intervention objective was achieved or is expected to be achieved
Efficiency	A measure of how economically resources / inputs are converted to results
Empowerment	Action taken to overcome obstacles arising from inequality between people and between gender – male and female.
Evidence Based	A process that allows planners to use available evidence to inform their choices and decisions on interventions and strategies to achieve specific desired results.
Family	A social unit by blood, marriage, and or adoption, defined by common line relationship of a paternal, maternal or parental nature.
Gender	Refers to the social conceptualization of males and female based on social differences and relations between them that are learnt, changeable over time, and have wide variations across cultures.
Gender empowerment	A composite index measuring gender inequality in three basic dimensions of socio-economic and political participation in decision-making and power over economic resources. Empowerment of women means development of their ability, collectively and individually to take control of their lives, to identify their needs, to determine interests that suit them.
Gender equality	Entails the concept that all human beings, both men and women are free to develop their personal abilities or make choices without limitations set by stereotypes, rigid gender roles and prejudices; so that their rights, responsibilities, and opportunities do not depend on whether they are born male or female.

Gender equity	It is fairness of treatment (distribution) of females and males according to their respective needs, rights, benefits, obligations and opportunities. Equity is the means to reach equality.
Gender-based violence	Gender-based violence is a form of violence derived from the unequal power relationship between men and women. It is the type of violence where either a man or a woman exerts his or her power over the other with the intention to harm, intimidate, and control the other person.
Human rights	The universally agreed upon rights with regard to the right to life, social and economic welfare, which should be enjoyed by all human beings irrespective of their sex, colour, or creed.
Human Rights Based Approach:	Entails consciously and systematically paying attention to human rights in all aspects of programme development. A HRBA is conceptual framework for the process of development that is normatively based on international standards and operationally directed to promoting and protecting human rights.
Impact Mitigation	Alleviating social and economic negative forces on the lives of people and society and contributes to lessening the burden of HIV and AIDS, poverty and income inequalities.
Impact result	Long-term positive changes in the lives of people, condition or organisation arising from an intervention.
Input	Pre-requisite resources (human, information, finance) required to support activity implementation to produce outputs.
Multiple and concurrent sexual partners:	Multiple partnerships is a situation where a man or woman has more than one sexual partner and overlapping, or a situation where the partners actively engaged the same time. Concurrent sexual partnerships refer to when a person has “overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner” (UNAIDS Reference Group on Estimates, Modelling, and Projections, 2009).
Outcome	A change in behaviour (values, attitudes, practices etc.) of, or the use of new capacities (laws, policies etc.) by target group (people and institutions).
Output:	Operational changes or new capacities (knowledge, skills and equipment, products and services), which result from the completion of activities within a specified intervention in a given time.
Poverty	Poverty is multi-dimensional including shortage of income and deprivation in access to basic social services (education, health and water), food security, shelter, credit and employment. It can be defined in absolute and relative terms. Absolute poverty refers to inability to attain a minimum standard of living.
Region	An administrative geographical area with clearly defined boundaries.
Result:	A measurable or describable change in the lives of people or organizations resulting from a cause and effect relationship or programme intervention.

Results based planning	A planning process that uses empirical evidence to inform planning and prioritising of interventions
Results chain	The causal sequence for an intervention to achieve impacts, moving from inputs and activities to outputs outcomes and impacts
Results Framework:	A diagrammatic illustration of the logical chain of results that will lead to strategic objectives being achieved.
Rights Holder	A person who has a human and or legal right to claim for services from another person or institution with the mandate to provide such services
Risks	The probability that a person may be affected negatively by a condition or behaviour i.e. acquiring HIV infection
Sector	A section of society that has common characteristics or interests.
Sex	A biological construct defining the physical differences that males and females are born with
Social protection	A set of interventions whose objective is to reduce social and economic risks and vulnerabilities with vulnerable children and households.
Three Ones principle	Three Ones principle means a country having one national coordinating authority, one national strategic framework and one national M&E framework.
Vulnerability	Results from a range of external factors that are often beyond the ability of a person to control that increases the possibilities of their exposure to HIV infection