THE UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

NATIONAL MULTI-SECTORAL STRATEGIC FRAMEWORK ON HIV AND AIDS 2021/22 - 2025/26

NOVEMBER 2022

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2021/22 – 2025/26

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ACRONYMS

ACT	Accelerating Children's HIV/AIDS treatment
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
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 Clinics
CTX	Cotrimoxazole
DBS	Dry Blood Spot
DSD	Differentiated Service Delivery
DNA-PCR	Deoxyribonucleic Acid-Polymerase Chain Reaction
EIMC	Early Infant Male Circumcision
eMTCT	Elimination of Mother to Child Transmission
FANC	Focus on Antenatal Care
FP	Family Planning
FBO	Faith-based Organisation
FSW	Female Sex Worker
GAS	Global AIDS Strategy
GF	Global Fund
GBV	Gender Based Violence
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
IBBS	Integrated Biomedical-Behavioural Survey
IEC	Information Education and Communication
IPT	Isoniazid Prophylaxis Treatment
IPV	Intimate Partner Violence
KP	Key Population
KVP	Key and Vulnerable Population
LTF	Lost To Follow
M&E	Monitoring and Evaluation

MAC	Multisectoral AIDS Committee
MDA	Ministries Departments and Agencies
MOCLA	Ministry of Constitution and Legal Affairs
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOCDGWPD	Ministry of Community Development, Gender, Women, and People with disability
MOEScT	Ministry of Education, Science, and Technology
MOFP	Ministry of Finance and Planning
MoICIT	Ministry of Information, Communication and Information Technology
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 Strategic Framework
OI	Opportunistic Infections
NSA	Non-state Actors
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PEPFAR	President's Emergency Fund for AIDS Relief
PLHIV	People Living with HIV
PMO-LYEPD	Prime Minister's Office – Labour, Youth, Employment and People with Disability
PMTCT	Prevention of Mother To Child Transmission
PORALG	President's Office Regional Administration and Local Government
PO-PSMGG	President's Office – Public Service Management and Good Governance
PSCM	Procurement and Supply Chain Management
PSI	Population Services International
PWID	People Who 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 and Reproductive Health
SRHR	Sexual and 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 and Health Service
T-MARC	Tanzania Marketing and Communication Company Limited
TOMSHA	Tanzania Output Monitoring System for HIV and AIDS
TPSF	Tanzania Private Sector Foundation
TTIs	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

FOREWORD

Prime Minister's Office, through the Tanzania Commission for AIDS (TACAIDS), has developed the fifth National Multisectoral Strategic Framework for HIV 2021/22 – 2025/26 (NMSF V). TACAIDS was formed in 2001 to coordinate a multisectoral national response by providing strategic leadership in HIV response. In its twenty years of existence, TACAIDS has spearheaded a robust response leading to significant progress towards halting the epidemic with a remarkable reduction in AIDS-related morbidity and mortality, but a slow decline in new HIV infection and mitigating the social impact related to AIDS are the remaining key challenges.

Lessons from the implementation of the NMSF IV call for more concrete efforts to prioritise and scale up tailored interventions to maintain the country's progress toward epidemic control. Tanzania commits to maintaining progress toward ending AIDS as a public health threat by 2030, in line with the global Sustainable Development Goals (SDGs), the 2021 UN High-level Political Declaration on HIV and AIDS, and the Global AIDS strategy CGAS) 2021-2026. We will build on the significant progress that has been made in the reduction of AIDS-related morbidity and mortality; and the encouraging strides in reducing new HIV infections to renew the multi-sectoral collaboration and actions with government sectors, non-state actors, and affected communities.

At the heart of this new framework is the strategy to "reduce inequality and break down barriers", especially among those left behind. While comprehensive prevention and care will be provided countrywide, intensified concentrated efforts will be made in councils that account for the highest disease burden. In each year of implementation, the country will review existing data to determine councils with more people living with HIV and those with the majority of new infections and focus on them. The purpose is to saturate these populations or geographical locations with high-impact prevention and treatment services and strengthened efforts to address the social and structural factors that increase vulnerability to infection.

With this understanding, we aim to scale up cost-effective and socially inclusive interventions for their successful implementation. NMSF V re-emphasises the need for maximizing equitable and equal access to HIV services and solutions and strengthened community engagement and leadership, to be achieved through effective prioritisation of interventions, populations, and geographical locations.

This framework promotes a gender transformative and right-based approach in service delivery to overcome barriers resulting from gender norms, different forms of discrimination, power imbalances, and persecution and ensure that interventions reach the most hard-to-reach populations. Tanzania will allocate resources preferentially to people who are most in need to enhance equity. The NMSF V is aligned with the country's Vision 2025, the third 5 years Development Plan, the National Universal Health Coverage (UHC) aspirations, the East African Community HIV and AIDS Prevention and Management Act (2012), and the African Union goals on HIV control.

One of the key priorities in implementing NMSF V is the need to focus on primary prevention and address social and structural drivers of HIV infection using a multi-sectoral approach. Based on the country's epidemiological profile, prevention programs will be intensified among adolescent girls and young women and on key and vulnerable populations, not forgetting adolescent boys and young men. Recognising that different people require different prevention approaches, differentiated care models will be scaled up to tailor interventions to each person's needs, including enhanced use of proven community-based services.

Tanzania will therefore continue to engage community actors, including PLHIV, to contribute to the HIV response. Community-based CSOs working with affected communities will continue to create awareness and mobilize community members to access services. PLHIV groups such as NACOPHA clusters will continue to provide peer support and support services delivery.

In implementing NMSF V, Tanzania will embark on developing and implementing an innovative sustainable HIV and AIDS Financing Strategy that will ensure adequate and sustained funding with an expanded diverse donor base and strengthen the scope of the Tanzanian AIDS Trust Fund. These strategies are intended to ensure a reduction in external funding dependency and a reduction of the national response financing gaps. The NMSF V hinges on the government's commitment, development, and implementing partners' continued support to scale up cost-effective and socially inclusive interventions for its successful implementation.

Tanzania will continue to mobilize resources to ensure adequate funds for investing in evidence-based interventions and sustain gains to achieve impact while devising and implementing interventions with efficiencies leveraging resources and existing multisectoral comparative advantage. Resource mobilisation will include strategies to increase domestic financing of the HIV programme amidst diminishing donor support. In order to sustain the national response to HIV, NMSF V calls for innovative approaches to secure and increase domestic resources. NMSF V will endeavor to roll down principles of the investment approach for LGAs to apply during the planning of HIV interventions. The country will continue to invest in systems for health, social protection, humanitarian settings, and pandemic responses in order to sustain gains and remain resilient to emergencies such as the COVID-19 pandemic. During the NMSF V period, the resource tracking mechanism will be strengthened to ensure all funding earmarked for HIV and AIDS, whether the funding goes through the government channels or directly from the donor to the implementing partners.

Tanzania will review the national response coordination model, including joint planning, implementation, participation, reviews, and reprioritise building on existing TNCM and PEPFAR mechanisms. NMSF will devise mechanisms to hold accountable all actors, including central and local governments, funding partners, and the communities served, regarding resource utilisation, service provision, and adherence to services to achieve the best health outcomes at all levels. 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.

Hon. Kassim Majaliwa Majaliwa

Prime Minister

Date: **25-11-2022**

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EXECUTIVE SUMMARY

For the past four decades, HIV and AIDS have continued to be a public health threat in Tanzania. The country has made significant progress towards halting the epidemic with a remarkable reduction in AIDS-related morbidity and mortality but a slow decline in new HIV infections. The slow decline in HIV incidence is attributed to limited access and low utilization of some combination of prevention practices and behavioural and social drivers that fuel risky behaviours.

The fifth National Multi-Sectoral Strategic Framework for HIV 2021/22 -2025/26 is pursuing and, with inspiration from the global 95-95-95 targets, has adopted the UNAIDS's investment case approach to ensure strategic targeting of key and vulnerable populations, including Men who have Sex with Men (MSM), Female Sex Workers (FSW), People who Inject Drugs (PWID) & People who Use Drugs (PWUD), adolescents girls and boy as well as prison inmates, miners, migrant workers and Fisherfolks with a clear focus on geographical locations with a high disease burden and the epidemic hotspots. This approach will optimise the use of resources through efficiency gains in the design and delivery of services.

The development of the NMSF V, which was carried out in 2021/22, has been based on the broad participation of all of the actors involved in addressing HIV and AIDS in Tanzania communities, civil society organizations, ministries, development partners and UN agencies. As a result, we are confident that the strategies identified in the framework are those that are the most likely to achieve the intended outcomes.

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

HIV mainstreaming will support all sectors to address the challenges of the epidemic. Internal mainstreaming will focus more on HIV workplace interventions 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 V will be on improving coordination efficiencies, accountability, 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 Multisectoral HIV M&E System.

This framework will address the variations in HIV burden across vulnerabilities, including age, sex, occupation, and geographic environments and revitalise HIV multisectoral coordination and linkages at all levels through formal national and sub-national coordination mechanisms while enhancing community health systems for the HIV epidemic.

As a precursor for a wider multisectoral involvement when the country is approaching the last mile in ending AIDS, NMSF V departs from the previous two predecessors, where an emphasis was to describe investment or technical areas that needed to be prioritized. NMSF V returns to the traditional description of broader thematic areas to allow and encourage all sectors to draw from and support country implementation. Uniquely, in each of the thematic descriptions, the NMSF V illustrates strategic interventions that will contribute to the attainment of the national goal.

HIV Care and treatment programme continues to be the cornerstone of HIV response during the implementation of NMSF V. Tanzania's achievement in scaling up prevention and treatment programmes will be complemented by an equivalent focus on improving the quality of service by ensuring quick adaptation and implementation of better treatment protocols, including differentiated HIV care services, prevention of TB among PLHIV and integration of HIV services using a person-centered approach. Priority is given to ensuring that treatment programmes are holistic and integrated, addressing each person's health needs, including co-morbidities. When feasible, the country will ensure that PLHIVs access comprehensive health services under one roof. Essential services such as TB screening and prevention, family planning, NCD screening, COVID-19 vaccination, and cervical cancer prevention will be offered at HIV Care and Treatment clinics.

The seven thematic areas of the NMSF V, described in chapter 3, aim to build on lessons learnt and achievements to date, close gaps that persist in the national response and build a strong foundation to end HIV as a public health threat.

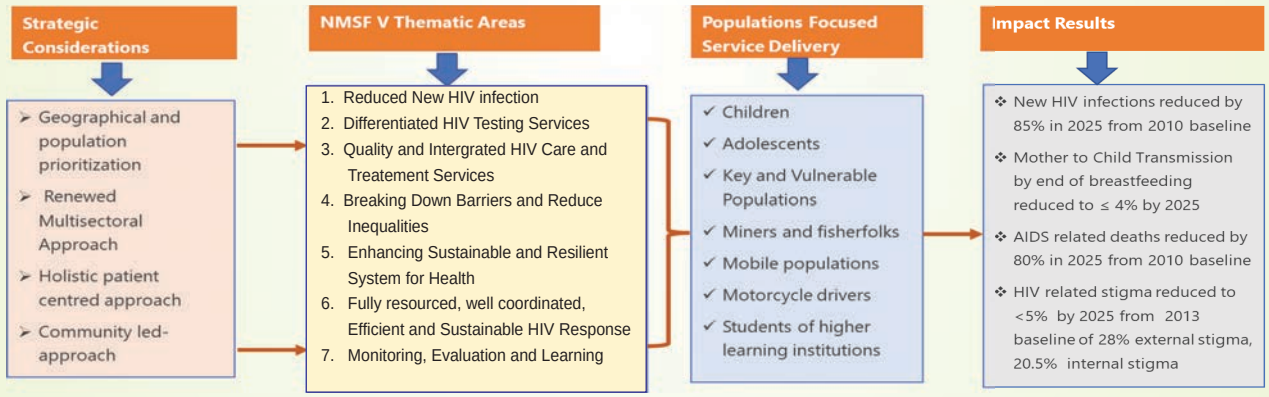


Figure 1: NSMF V Thematic Areas and Strategic Considerations

Sustainable epidemic control will require additional resources, improved resource allocation and efficiencies, and more effective monitoring to work towards an AIDS-free nation. The total cost for implementing NMSF V is US$ 3,828,668,652.17: the available funding from development partners is US $ 2,152,904,110.05 (56%) and domestic resource is US$ 408,979,132.31. (11%). The country will mobilize resources to invest in the priority interventions and sustain gains to achieve impact while improving efficiencies by leveraging resources and existing multisectoral comparative advantage. Resource mobilization will include strategies to increase domestic financing of the HIV programme amidst diminishing donor support.

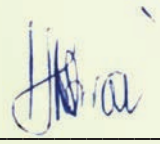
PREFACE

The NMSF V (2021/22-2025/26) marks a critical juncture of the country's response to HIV, following promising results against the 2020 UNAIDS Fast track targets. However, the new NMSF V is being introduced when the world is still experiencing the emergence of another global pandemic of COVID-19. COVID-19 has provided a lesson on how such unprecedented social, political, and economic challenges may affect anticipated results. In order to protect and sustain the momentum in the HIV response, the GoT is committed to continuing to lead the country's response and accelerate progress toward ending AIDS. NMSF V calls for strengthening resilient country-led AIDS responses (with increased domestic resources) that can withstand disruptions and manage uncertainties and unforeseen emergencies to secure these gains. One such response is using community systems to facilitate and support service delivery for those with chronic diseases.

The development of the NMSF V has been informed by the results of the NMSF IV Mid-Term Review; the Tanzania Investment Case; the UN Political Declaration on HIV and AIDS 2020; WHO Global HIV, STI and Viral Hepatitis Strategy 2022-2030, and the Global Fund (GFATM) which aims at investing to end the Malaria, AIDS and TB epidemics. The strategies and bold targets set out in this framework provide insight into surpassing 95-95-95 Global milestones by 2025.

A strategic information approach will be used to address HIV data and reporting, focusing on enhancing programmes using review data, lessons, and best practices to improve the quality of services and increase efficiencies. Therefore, there will be an increased emphasis on the quality and use of data from surveys, surveillance, evaluation, and reviews to measure and monitor progress towards outcomes.

Social Behaviour Change Communication and Advocacy remain a pivotal cross-cutting element in implementing NMSF V. The country will continue to use SBCC approaches to create demand for services and address norms using multiple communication channels and media, including the growing social media platforms. Tanzania plans to piggyback on its ever-present political will and GoT commitment to mobilize internal and external resources and communities. Tanzania will also revitalise informal and formal sector workplace interventions to include new proven interventions and tools such as access to condoms using dispensers, HIVST, and the use of technology and social media for HIV communication activities.



Dr. Hedigwa Swai

Chairperson

Tanzania Commission for AIDS (TACAIDS)

Acknowledgement

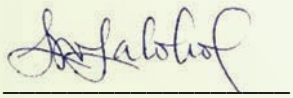
The successful development of the National Multisectoral Strategic Framework for HIV V (NMSF V) 2021/22 - 2025/26 has resulted from the tremendous contribution and active participation of several stakeholders. The NMSF V draws from recommendations based on evidence-based implementation experiences, epidemic analyses, and global and country guidance on HIV response. Key lessons learned from the implementation of the NMSF IV were considered.

Particularly, TACAIDS would like to thank its staff, partners, and stakeholders who contributed to the development of this framework. Incredible appreciation goes to members of the technical and thematic working groups, and the peer review team.

We are so thankful to the consulted representatives from Government Ministries, Agencies, and Departments (MDAs), Parastatals, Non-state Actors, representatives of Development Partners Group (DPG) supporting the national response, Non-Governmental Organizations (NGOs), and relevant private sector stakeholders. We also express our sincere gratitude to networks of People Living with HIV (PLHIV), Non-State Actors, including Civil Society Organisations and affected communities, including, Adolescent Girls, Boys and Young Women who made a significant contribution to the development of this framework.

We appreciate the financial and technical contributions of various partners during the development, review, and printing of this framework. Specifically, we thank the Global Fund to Fight AIDS, Tuberculosis, and Malaria, UN Joint Team on HIV led by UNAIDS, UNDP, WHO, ILO, UNICEF, and UNFPA; the US Government for its support through the President's Emergency Plan for AIDS Relief (PEPFAR) and its agencies (USAID, CDC, and DoD). TACAIDS remains committed to working with all stakeholders to implement NMSF V.

Finally, this acknowledgment would not be complete without expressing my deepest gratitude to the TACAIDS team and to the Consulting team led by Dr. Emmanuel Matechi, who was supported by Daudi Nasib (Multisectoral review), Mr. Mkingama Kapinga (M&E), Dr. Dereck Chitama (Costing) and Dr. Dunstan Bishanga, (Costing).



Dr. Leonard L. Maboko

Executive Director

Tanzania Commission for AIDS (TACAIDS)

1. INTRODUCTION

1.1 Background information

The United Republic of Tanzania is the largest East African country covering an area of 947,300 square kilometres and constitutes about 30% of the population in the region. Tanzania is an East African country bordering Kenya and Uganda to the North; Rwanda, Burundi, and the Democratic Republic of Congo to the West; Zambia, Malawi, and Mozambique to the South; and the Indian Ocean to the East. Nearly 44% of the population is below 15 years of age, while about 54% are between 15 and 64. The population is projected to rise to 63 million by 2023 based on an estimated average annual population growth of 3.1% and a total fertility rate of 5.0[1]. From 2007 to 2017, economic growth averaged 6.3% annually, contributing to a decline in the national poverty rate by 23% and extreme poverty by 33%. However, the absolute number of poor increased from 13.2 million in 2007 to 13.9 million in 2018 because of the high population growth rate[2]. The Mainland is divided administratively into 185 councils in 26 regions.

Tanzania attained lower-middle-income status in July 2020. The country's Gross Domestic Product (GDP) has continued to rise, reaching 7.1% in 2019. However, it went down to 5.5% in 2020, reflecting the impact of COVID-19 on some economic activities[3]. Major exports from Tanzania are mainly from agriculture, mining, and tourism. Approximately two-thirds (65.5%) of the population are employed in agriculture. Tanzania is expected to generate significant export earnings from her gas reserves in the long term. Other important economic sectors include tourism, construction, financial services, manufacturing, telecommunications, and utilities. The most recent figures on poverty levels in Mainland Tanzania indicate a decline to 25.7% (2020) from 26.4% (2018) of the population living below the basic poverty line. Food poverty has also decreased from 8.0% in 2017/18 to 7.3% in 2020[4].

The Tanzanian economy is largely dependent on a labor-intensive service provision sector in agriculture, manufacturing, mining, and construction industries.[5] Therefore, having a healthy and skilled human capital base is critical. It is anticipated that the Government of Tanzania (GoT) will continue to invest in health and other social sectors by making available the required resources to combat HIV and AIDS

1.2 The Situation of HIV in Tanzania

HIV prevalence

Tanzania is one of the high HIV burden countries in Africa. Although the prevalence of HIV among people aged 15-49 years has declined progressively from 7% in 2003/2004 to 5.7% in 2007/08 to 5.1% in 2011/2012 and 4.7% in 2016/2017, about 1.7 million people are living with HIV (PLHIV) which makes Tanzania one of five countries with the highest number of PLHIV in Africa.

The prevalence of HIV varies geographically from 0.3% to 11.6%, with regions in the southern highlands having the highest prevalence. When compared to 2011-2012, HIV prevalence in 2016-2017 declined in 15 regions and increased in 10 regions. The absolute increase was by more than 1% (range, 1.3-3.0%) in 5 regions, namely, Dodoma, Kagera, Iringa, Mwanza, and Tanga, in increasing

1 National Bureau of Statistics, 'Population Projections for the Period of 2013 to 2035 at National Level', February 2018.
2 The World Bank, "Tanzania Mainland Poverty Assessment", 2018
3 Bank of Tanzania, 'Annual Report', 2020
4 National Bureau of Statistics, 'Tanzania in Figures',2020
5 World Bank, 'World Bank in Tanzania, Overview', April 2022 (https://www.worldbank.org/en/country/tanzania/overview#1,)

order.[6] The progressive decline in HIV prevalence is also seen among 15-34-year-old women and 15-39-year-old men but not in the older age groups (Figure 2). The reasons for this pattern are not clear, but it may be indicative of declining incidence rates in, at least, successive younger age cohorts. Program data also shows that the HIV positivity rate declined among females from 4.9% in 2015 to 2.9% in 2018 and among men from 4.6% in 2015 to 2.3% in 2018.

The prevalence of HIV also declined among female sex workers (FSW) from 31% in 2010 to 15% in 2017; among men who have sex with men (MSM) from 22.3% in 2013 to 8.3% in 2017, and among people who inject drugs (PWID) from 15.5% in 2014 to 8.7% in 2017.[7]

National HIV Response

Tanzania is making good progress toward ending AIDS. At the end of 2020, 88% of people living with HIV knew their HIV status, 97% of people living with HIV who knew their HIV status were accessing antiretroviral therapy, and 95% of people on treatment were virally suppressed, which helps to keep them healthy and prevents the further spread of the virus[8].

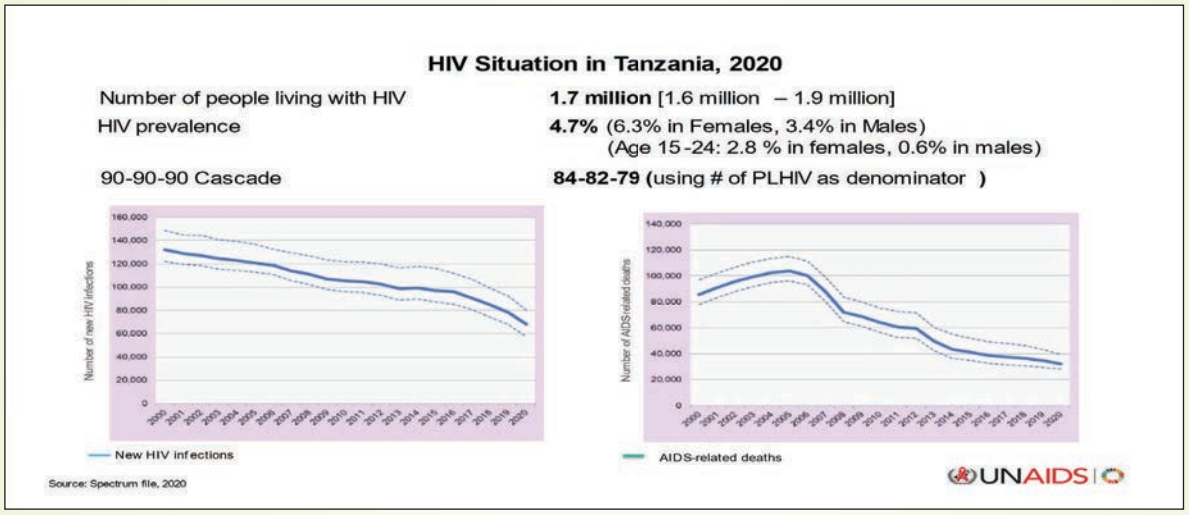


Figure 2: HIV Situation in Tanzania

However, new infections remain high despite the progress towards the 90-90-90 targets and recorded drop in HIV prevalence.

Table 1: Performance of Impact Indicators by 2020

Indicator Description	Baseline		Mid-Term Performance		Data source
	Value	Year	2020 targets	2020 results	
Number of new HIV infections	87,013	2017	27,500	61,281	Spectrum estimates
Number of AIDS-related deaths	39,3180	2017	32,000	32,639	Spectrum estimates
Mother to child transmission of HIV	7.6%	2017	<5%	7.9%	PMTC
HIV related stigma and discrimination	28%	2013	Zero	5%	Stigma Index.2.0

6 National Bureau of Statistics, 'Tanzania HIV Impact Survey,' 2018
7 NACP, MUHAS, 'Integrated Biological and Behavioural Surveillance Survey (IBBSS) Surveys in Dar Es Salaam.', 2017.
8 UNAIDS,'Global AIDS Update' 2021

HIV incidence

Even though the number of new HIV infections has been declining steadily over the years, UNAIDS Spectrum estimates show a decline from 110,000 new HIV infections in 2010 to 61,281, a 38% reduction against the target of 75% by 2020[4] despite the investments.

According to the THIS 2016/17, the annual incidence rate of HIV of infection among adults is 0.34% in women, 0.17% in men, and 0.24% overall, translating to 72,000 new infections among adults. The highest annual incidence rate of 0.7% occurred among women aged 25-34 years, followed by men aged 35-49 years (0.37%), women aged 35-49 years (0.24%), men aged 25-34 years (0.15%) and women aged 15-24 years (0.14%).

AIDS-Related Mortality

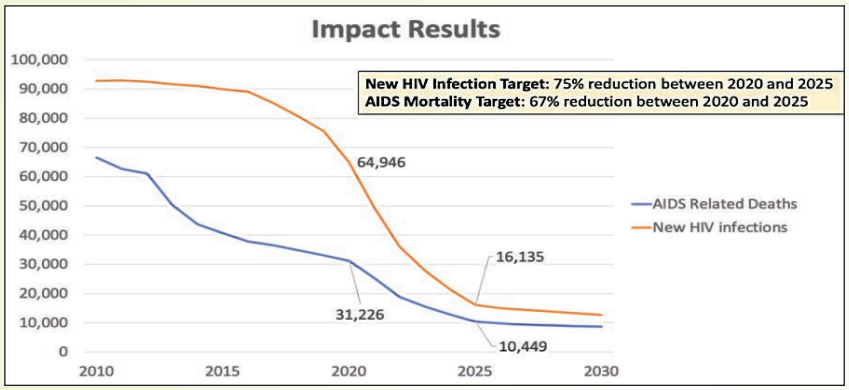


Figure 3:Trends and projections of impact indicators

AIDS-related deaths declined significantly from 72,6222 in 2010 to 32,639 in 2020, representing a 55.06% reduction. In 2020, 22% of all estimated AIDS-related deaths were among children aged below 15 years. AIDS-related deaths declined by 57.8% among adults and 53% among children from 2010 to 2020 (UNAIDS Data 2020). Slightly over half (54%) of all the AIDS-related deaths estimated to have occurred in 2020 were among adult men. The success in reducing HIV mortality is attributed to increased ART coverage, early detection of opportunistic infections among PLHIV with advanced HIV disease, and viral suppression. As of 2020, 88% of all Tanzanians with HIV were aware of their HIV status, which means that the 2020 target of achieving 90% across levels of health service delivery was nearly achieved.

Comprehensive knowledge of HIV and safe sex behaviour

Heterosexual transmission remains the main mode of transmission of HIV infections in Tanzania. Comprehensive knowledge of HIV has declined among adolescents and young people. Among women aged 15-19 years and 20-24 years, comprehensive knowledge declined progressively from 39% and 50% in 2003-2004 to 32% and 43%, respectively, in 2016-2017. Similarly, among men aged 15-19 years and 20-24 years, there was a decline from 43% and 57% in 2003-2004 to 33% and 41%, respectively, in 2016-2017. Comprehensive knowledge for other age groups was not reported in the THIS 2016/2017. Just as comprehensive knowledge has declined, unsafe sex behaviour has increased in all age groups for both women and men. Among people who had sex in the 12 months prior to the survey, 56% of men and 36% of women had sex with a non-cohabiting, non-marital partner in 2016-2017 compared to 46% and 23%, respectively in 2003-2004. Among women and men, the percentage was highest among teenagers and then declined with age. Over 96% of teenage men and 61% of teenage women had sex with a non-cohabiting, non-marital partner. Furthermore, condom use declined in those practicing high-risk sex from 50% to 35% in men and from 38% to 28% in

women. Women aged 30 years and above had the lowest rates of condom use for high-risk sex, while teenagers had the lowest rates among men.

The level of comprehensive knowledge of HIV among KVP is similarly low, with rates of 46% among Female Sex Workers (FSW), 41% for Men who have Sex with Men (MSM), and 36% for People Who Inject Drugs (PWID). About 71% of Female Sex Workers used a condom with their last client. In the month before the survey, 79% of MSM had been paid by other men to have anal sex, 63% of those who had anal sex with a non-paying male partner did so with two or more people, only 32% used a condom with their paying male partner and less than 10% had always used a condom with their non-paying partners. About 69% of PWID had received payment for sex, while 36% had paid someone for sex. Only 25% used a condom with their last non-paying partner; 46% used a condom the last time they paid for sex, and only 30% used a condom the last time they were paid for sex.

1.3 Mid Term Review of the NMSF IV

The Mid Term Review (MTR) of the NMSF IV was conducted between January and March 2022. The MTR showed that despite success in achieving 90-90-90 targets by 2020, new HIV infections are declining too slowly. Contributing factors, in general, include low comprehensive knowledge of HIV and low condom use during high-risk sex, and limited access to HIV and AIDS services among key and vulnerable populations. Among children, the contributing factors are gaps in the PMTCT programme related to ART coverage at non-PEPFAR sites, ART retention, especially among adolescents, and low rates of early infant diagnosis. Substantial progress has been made towards identifying PLHIV; however, earlier diagnosis among men and finding children living with HIV through testing strategies that increase yield are imperative given the disparity in mortality between women and men. Tanzania has demonstrated the capacity to identify implementation bottlenecks and deploy tailored interventions to address them with measurable results.

Key Gaps and Challenges

The NMSF IV review noted the following key gaps that need to be prioritized by the national response:

- Some population segments in Tanzania are left behind in achieving the 90-90-90 targets, such as fisherfolks and people along transport corridors whom only 52% to 73% of those living with HIV knew their status during a 2020 survey. The coverage of HIV services shows disparities across age groups, particularly children and adolescents, as well as men as only 66% of men and 70% of children, were enrolled in care in 2019, and children have low suppression , and limited coverage of the DSD model to cater for hard-to-reach communities such as fisherfolks, pastoralists, KVPs, small miners, and the disabled PLHIV. Also, high defaulter rate among PLHIV on ART (27%), especially adolescents, and late diagnosis as some new clients still present with Advanced HIV Disease;

- Inadequate capacity of health workers and caregivers for disclosure support to children and adolescents, which is further exacerbated by the inadequate involvement of parents and caregivers in the management and care of children and adolescents on ART services;

- Weak integration of HIV services with other disease programs, including NCD, child health and immunisation platforms, SRH, STIs, viral hepatitis, cervical cancer screening, nutrition, and mental health. Tanzania has low TPT coverage among PLHIV (Children <50%, 72% of adults) and a low completion rate (78%) despite high TB/HIV mortality (9800 PLHIV died in 2020 due to TB). HIV stigma remains an important factor affecting ART retention;

- Paucity of data, especially those related to measuring the implementation of prevention interventions, and

- The country has a notable funding gap in HIV prevention, including condom programming, social and behaviour change communication, and sexual and reproductive health education interventions.

Key Opportunities for NSMF V

The progress in HIV response in Tanzania is attributed to existing efforts that provide a favourable environment for success including the following:

- Active engagement of community-led organization and workforce, including PLHIV groups (HIV Clusters, NACOPHA) and influential leaders who, over time, have developed a strong capacity to design, implement, monitor, and report HIV service delivery at the community level;

- Favourable political and legal framework demonstrated through an active Parliamentary Standing Committee for HIV, TB, and Drugs and the presence of Tanzania HIV/AIDS Prevention and Control Act No. 28. The country's ruling party manifesto has prioritized the HIV/AIDS agenda;

- Financial and technical support from bilateral partners, including the USG, the PEPFAR, and the Global Fund ATM. NGOs, CSOs, and community groups also support the in-country implementation;

- Strong supply chain system for HIV commodities and a laboratory management system, making necessary HIV commodities, including HIV testing and monitoring reagents and ARVs, available. The country uses pooled procurement approach to drive down ARV and laboratory commodities;

- Existence of HIV electronic monitoring and evaluation (M&E) and electronic logistic and management systems (eLMIS) which are critical to monitoring of programmatic progress. Although not perfect, these systems enable near real-time data analysis and enable the national program and Implementing Partners to take necessary actions to mitigate challenges and improve programming, and

- Tanzania has expressed policy-level commitment toward universal health insurance by 2030. Efforts such as the Tanzania Social Action Fund (TASAF) flagship Productive Social Safety Net (PSSN) programme targeting the ultra-poor provides opportunities for vulnerable populations affected or at risk of HIV. A cash transfer initiative under this programme has recorded positive impacts of the intervention, including changes in knowledge about some aspects of HIV prevention and contraceptive use.

NMSF IV MTR Recommendations

The NMSF V will need to consider the distinct needs of sub-populations, especially those left behind Specifically, the MTR recommended the following priority actions:

- Delivery of comprehensive and client-centered, HIV prevention, care, and treatment interventions, embracing appropriate DSD models that have shown resilience during COVID-19;

- Conduct a holistic review and integrate HIV co-morbidities within a one-roof platform to ensure the well-being of PLHIVs;
- Strengthen the social and economic welfare of PLHIVs and their families by expanding the cluster-based engagement and participation in health, social and economic well-being;
- Support adolescents living with HIV to access peer-driven and adolescent-friendly health services, engaging them in their care and linking them with psychosocial interventions;
- Scale up innovations such as family-centred care for mother-baby follow-ups and offering children and adolescents attending boarding schools with additional support and follow-up appointments during their school holidays;
- Employ a multisectoral approach for adolescent health agenda based on the six pillars as stipulated in the National Accelerated Investment Agenda for Adolescent Health and Wellbeing ., and
- Strengthen community health systems and expand engagement of communities including affected populations in services delivery and quality improvement initiatives such as Community Led Monitoring (CLM).

1.4 Global, Regional, and Country Context

Globally, HIV remains a serious health problem affecting all regions, with the brunt of the disease affecting Sub-Saharan Africa. At the 2021 UN General Assembly, a political declaration on ending inequalities and getting on track to end AIDS by 2030 was reaffirmed. Regarding HIV prevention, an intermediate goal of an 80% reduction of new HIV infections by 2025 was developed . In 2020, almost 700,000 people died of AIDS-related causes despite the existence and availability of effective treatment; this implies that the HIV response should refocus on extending life-saving services to all PLHIV who need them in every country and community. Additionally, the impact of the COVID-19 pandemic is jeopardizing the gains from efforts in the fight against HIV and AIDS. More effort is needed to identify and address factors that prevented countries from reaching the 2020 targets.

Tanzania has made a formal commitment to ending the HIV epidemic set at the global level within the framework of the SDGs. The UNAIDS 95–95–95 targets provide a road map toward ending AIDS under the 2021 UN General Assembly Political Declaration, the Global AIDS Strategy (2021-2026), and WHO Global Strategy for HIV, Viral Hepatitis and STIs Strategy (2022-2030), all aiming at ending inequalities and getting on track to end AIDS by 2030. The new NMSF 2021/22–2025/26 guides the post-2015 agenda and alignment with the SDGs, principally Goals 3 and 5. The NMSF considers the cross-border dimensions of the epidemic at the regional level. It will contribute to the objectives of regional initiatives, including the East African Community and the African Union Commitment on HIV Control, and the ESA commitment on Education and Well-being for Adolescents and Young people.

In Tanzania, the NMSF V is aligned to the Third Five-Year National Development Plan, the Ruling Party Manifesto (2020-2025), and the Tanzania Investment Case 2.4, locating the fight against HIV within the struggle for economic and social development.

The NMSF V 2021/22–2025/26 will be implemented within the existing planning, policy, guidelines, and legal framework in Tanzania using the public health approach, which requires evidence-informed interventions that will be implemented to impact the epidemic to achieve critical levels sufficient

for epidemic control. The 2001 National HIV and AIDS Policy provides a broader framework for delivering HIV and AIDS services in the country and inspires national action in policy formulation, planning, programming, and service delivery. It also promotes a human rights-based, gender-transformative, and legal and policy environment to address HIV and AIDS in Tanzania. The NMSF 2021/22–2025/26 guides the multi-sectoral response in the country, coordinated by TACAIDS. From a gender and human rights perspective, this NMSF is well aligned with Tanzania's national, regional, and international commitments and obligations to protect and promote human rights and achieve gender and general equality for all.

1.5 The Purpose of the NMSF V

The NMSF V is intended 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, and practices (planning, services delivery, etc.), and advance knowledge within 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 deliver innovation and best practices necessary to drive the 95-95-95 ending AIDS milestone in 2025 and move towards ending AIDS by 2030.

1.6 The Process of Developing the Framework

The process of developing the NMSF V was participatory, involving stakeholders from the Government, Private Sector, Civil Society Organisations (CSO), Development Partners, and representatives of PLHIV, Adolescent Girls, Boys and Young Women, as well as Key and Vulnerable Populations (KVPs). The process used diverse approaches, including document review, data analysis, key informant interviews, focus group discussions (FGD), and stakeholder engagement. The process started with a comprehensive desk review of the performance of NMSF IV. This was complemented by stakeholder consultations based on key informant interviews and focus group discussions (FGDs). This was followed by data analysis and preparation of a technical review report in a stakeholders workshop. The findings informed the NMSF V development process.

The NMSF V development process started with conceptualizing and prioritizing high-impact interventions necessary to achieve the desired outcome and impact results. In this process; a multi-stakeholder consultation workshop was held in October 2021 to analyse the country's HIV response performance. The workshop brought together participants from the health sector and beyond, who conducted a Strength, Weakness, Opportunities, and Threat (SWOT) analysis and a Root Cause Analysis (RCA) of the gaps and challenges of the national response.

1.7 Reflecting the Global AIDS Strategy 2021-2026 and WHO 2022-2030 Strategy

The 2021 Political Declaration and new Global AIDS Strategy (GAS) 2021–2026 seek to reduce inequalities that drive the HIV epidemic and put people at the centre, in order to get the world on track to end AIDS as a public health threat by 2030. Inequalities exist not only between countries but also within countries. Even in countries that have achieved the 90–90–90 treatment targets, the averages conceal the reality that some people are still being left behind. The NMSF V reflects this reality, and it includes strategic consideration and thematic areas on maximising equitable and equal access to HIV services and solutions, breaking down barriers to achieving HIV outcomes, and fully resourcing and sustaining efficient HIV responses. Like the GAS, the NMSF

V has a thematic area on a fully funded, well-coordinated, efficient, and sustainable response . All the ten result areas of the GAS are reflected in the eight thematic areas of the NMSF V. The NMSF V has also adopted the bold 95-95-95 targets by 2025 as recommended by the GAS.

The WHO Strategy has emphasized the need to optimize systems and sectors, similar to the renewed multisectoral collaboration in the NMSF V. In addition, NMSF V embraces engagement of communities, innovations, and use of data for decisions as recommended in the WHO strategy.

2. NMSF V CONCEPTUAL FRAMEWORK

2.1 Introduction

This Chapter discusses the strategic direction that Tanzania will take in implementing the NSMF V. The concepts and considerations are based on implementation experience, evidence, and lessons learned at the country, regional and global levels. It is therefore noted that Tanzania is making good progress toward ending AIDS. At the end of 2020, 88% of people living with HIV knew their HIV status, 97% of people living with HIV who knew their HIV status were accessing antiretroviral therapy, and 95% of people on treatment were virally suppressed, which helps to keep them healthy and prevents the further spread of the virus. NMSF V is designed to ensure that Tanzania remains on the right course toward ending AIDS as a public health threat by 2030, in line with the global Sustainable Development Goals (SDGs) and Global AIDS Strategy 2021-2026.

Over the previous years, great progress has been made, leading to a significant reduction in AIDS-related morbidity and mortality; and encouraging progress toward reducing new HIV infections. Key success factors include swift translation of scientific evidence in programmes, implementation of robust policy and strategic frameworks, and a multisectoral approach that engages all levels of governance, different sectors of the economy, various stakeholders, communities, and partners.

2.2 Strategic Considerations

This NSMF V has eight thematic areas promoting multisectoral engagement in implementing priority strategies and interventions. A much more strategic and focused effort will be needed to successfully implement the interventions in these thematic areas, applying the detailed understanding and insights gained regarding epidemic dynamics to maximize the impact of available resources and efforts. Therefore, to ensure success in each of the thematic areas, the NMSF proposes four strategic considerations to increase the effectiveness of programming.

1. **Geographical and Populations Prioritization**

   In Tanzania, the burden of HIV infection varies across regions, councils, and when comparing rural and urban residents. The NMSF V calls for yearly country modelling using UNAIDS's Spectrum and Naomi model to estimate the burden of disease and inform programming. The modelling is informed by survey data, sentinel surveillance data, as well as routine programmes. Specific interventions will be tailored to regions with the highest incremental number of PLHIV including Dar es Salaam, Kagera, Mbeya, Mwanza, and Tabora, and those regions that show an increase in HIV incidence when compared to previous surveys.

   Meeting the needs of diverse populations and geographical variations requires DSD models on comprehensive HIV prevention, care, and support services. The NMSF V will scale up a multisectoral, comprehensive, and integrated HIV services package to prioritize sub-populations who are left behind along the 90-90-90 targets, such as children, AGYWs, men, KVPs, Men who have Sex with Men (MSM), Female Sex Worker (FSW), and their sexual partners, People Who Inject Drugs (PWID), fisherfolks, inmates, miners, and other vulnerable groups. Other at-risk populations such as motorcycle drivers and vulnerable girls in higher learning institutions will also be targeted.

2. **Renewed Multisectoral Approach**

NMSF V calls for the national and sub-national coordination bodies under TACAIDS and PORALG to hold stakeholders and implementers at all levels accountable. This will involve devising mechanisms to hold accountable all actors, including central and local governments, funding partners, and the communities served, regarding resource utilisation, service provision, and adherence to services in order to achieve the best health outcomes. Tanzania will continue to invest in a multisectoral HIV response and strengthen coordination and governance structures under the leadership of TACAIDS. Further, the NMSF V takes cognisance of the role of other Ministries, Departments, and Agencies to draw from the policy direction in the implementation of NMSF V.

3. **Holistic People-Centered Approach**

This framework has embraced the Global perspective to remove barriers and reduce inequalities and increase access to services. behind. The Care and treatment programme continues to be the cornerstone of HIV response. However, the maturing epidemic calls for an integrated, holistic facility and community-level HIV care, treatment, and support services delivered in a comprehensive and differentiated model to address each person's health needs. This will require integrating HIV services with TB, NCDs, family planning, cervical cancer screening, antenatal, and post-natal services, and other health services, including community-based and workplace interventions.

4. **Community-led response**

The NMSF V will build on the demonstrated capacity of NSAs and CSOs including PLHIV and affected communities as strategic partners in the response, both as beneficiaries and being part of the planning and service delivery. Communities will also, through the community-led monitoring tool, lead in monitoring the quality of HIV services and enable them to implement evidence-based advocacy for HIV quality improvements.

2.3 NMSF V Theory of Change (ToC)

The NMSF V 2021/2022–2025/2026 builds on a model based on the Investment Case Framework of Tanzania. It is rooted in implementing an evidence-based intervention to halt new infections and sustain gains in reducing HIV-related mortality.

The NMSF V ToC is built from the assumption that despite progress in the national HIV response, there are key barriers and inequalities limiting access to HIV services to sub-population and thus continue to fuel the HIV epidemic. The country's HIV landscape shows that despite the generalized HIV epidemic, recent evidence indicates that the HIV burden is higher in some population groups, the KVP, men, and children, as identified in the national routine data and surveys. These populations and groups have a greater vulnerability to infection and yet low access to the continuum of services to prevent HIV infection or access the needed care services. Tanzania will therefore build on existing in-country and external resources and experiences to increase momentum towards ending AIDS while upholding a right-based approach to ensure everyone can access the HIV information and services that they need for a healthy life. These values are fundamental to achieving the set goals. Engagement of communities including the affected populations will be key, believing that if people are empowered, they are able to make healthy choices, and they can access affordable, high-quality, person-centred interventions. These interventions include facility and community-based HIV combination prevention, testing, care, and treatment services. NMSF

V recognises that evidence-based approaches and interventions have been identified nationally and globally. An investment case model for the country informs which interventions to prioritize . When these interventions are implemented in a targeted setting at a moderate scenario with maximum efficiencies and differentiated according to populations at risk, they will contribute to the desired outcomes: By 2025, more than 95% of PLHIV will know their HIV status; more than 95% of those who know their status will be enrolled into ART, and more than 95% of those on ART will be virally suppressed. Ultimately, this reduces HIV incidence by 85% (2020 baseline) and AIDS-related mortality by 80% (2020 baseline)

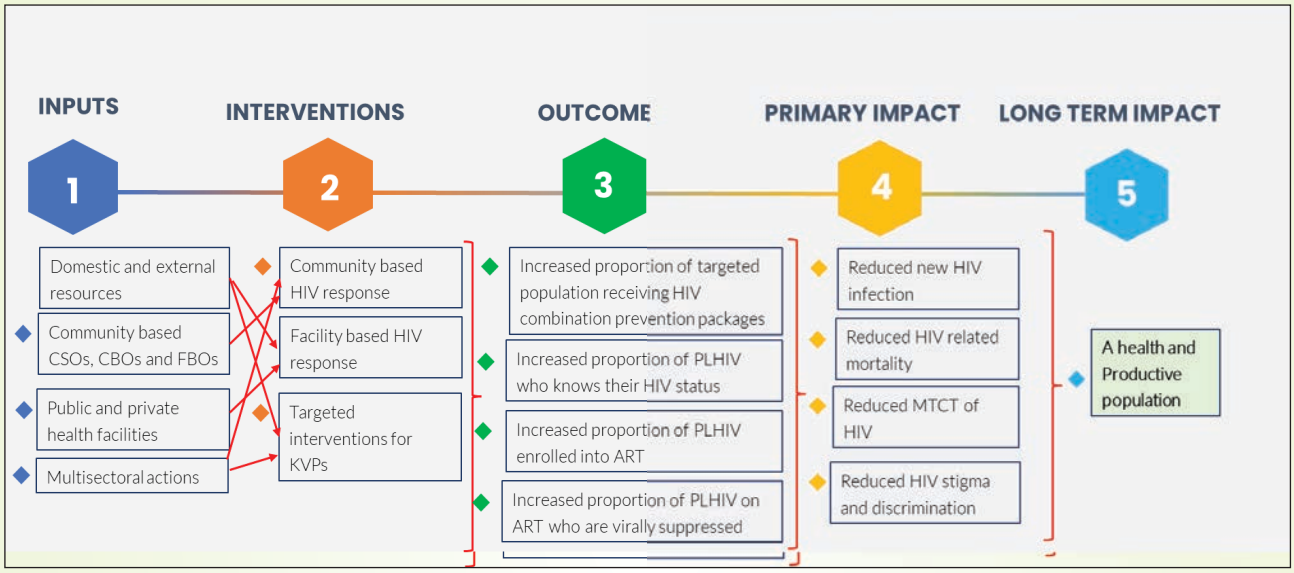


Figure 4: NMSF V Theory of Change

The prioritized intervention will be optimized and offered with sufficient standards of quality to ensure maximum levels of uptake and retention for all population groups, including key and priority populations. The interventions should also be technically sound and complemented to leverage available resources and build sustainability. Ultimately, by scaling up and sustaining the HIV response, Tanzania will maintain its momentum toward ending AIDS by 2030.

To achieve this, NMSF V assumes that:

- Providing integrated services (beyond HIV-only services) improves access and uptake of services and offers better value for money;
- People's health will improve as a result of community action, improved services, and strengthened health and community systems;
- Community-based service delivery mechanisms help people navigate through services, and
- People are involved in designing, delivering, prioritizing, and monitoring these services to meet their needs and are of high quality.

2.4 Vision, mission, and Guiding Principles

Vision

To have a healthy and AIDS-free society that contributes fully to the well-being of individuals and to national development

Mission

Providing sustainable quality HIV services that are integrated, people-centered, equitable, accessible, and free of financial constraints.

Expected Results

At the outcome level, the country aims to reach the global commitment by achieving 95-95-95 targets by 2025; furthermore, in line with the global commitments, the NMSF V aims to reduce the number of new infections from 110,000 in 2010 to less than 15,000 in 2025. This will translate to an 85% reduction from the 2010 baseline. During this period, the country intends to virtually eliminate the mother-to-child transmission of HIV. NMSF V interventions will also reduce HIV-related deaths by 80% by 2025. The number of AIDS-related death in 2010 was 65,000, the NMSF V sets a new target to reduce AIDS-related death to less than 15,000 by 2025. Tanzania also aims to eliminate HIV-related stigma and discrimination. By 2025, the proportion of PLHIV who report experiences of HIV-related discrimination in all settings should be less than 5%.

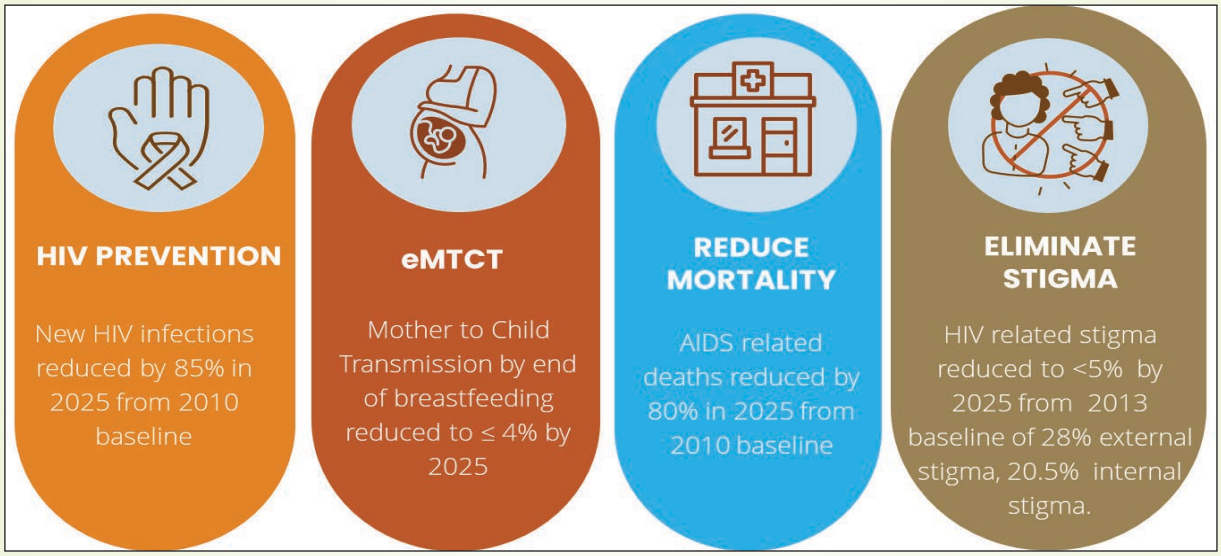


Figure 5: NMSF V Impact Results

Guiding Principles

The NMSF V recognizes the need for locally tailored responses within a framework that fosters local leadership and shared accountability. The framework aims to end inequalities and rapidly scale up effective HIV services, particularly for those left behind. The following key principles will guide this framework:

- A country-owned multisectoral approach;
- People-centred services;
- Commitment to promoting access quality, integrated HIV services, and
- Scaling up evidence-informed and result-driven planning.

Figure 6: NMSF V Guiding principles

3. NMSF V – THEMATIC AREAS

Introduction

The fifth National Multi-Sectoral Strategic Framework 2021/22 -2025/26 NMSF V focuses on seven thematic areas to achieve the 2025 ending AIDS milestones, in reflection of the Global and country targets. The thematic areas include 1) Prevention of new HIV infections, (2) Differentiated HIV Testing Services, (3) Quality Integrated HIV Care and Treatment Services, (4) Breaking Down Barriers and Reducing Inequalities, (5) Sustainable and Resilient Health and Community Systems, (6) HIV financing, and (7) Monitoring and Evaluation. This chapter provides an overview of each of the 7 thematic areas and describes the strategic approach that NSMF V will take. Furthermore, in each theme, there are strategic Interventions and results to measure the progress in the thematic area. At the outcome level, the country aims to reach global commitment by achieving 95-95-95 targets by 2026.

Table 2: Expected Outcomes and Impact

Indicator Description	Baseline		Target	Data source
	Value	Year	2026	
Number of new HIV infections	87,013	2017	<15,000	Spectrum estimates
Number of AIDS-related deaths	39,3180	2017	17,913	Spectrum estimates
Mother to child transmission of HIV	7.6%	2017	<4%	Spectrum estimates
HIV related stigma and discrimination	28%	2013	Zero	Stigma Index. 2.0

3.1. Thematic area 1: Prevention of new HIV Infection

The prevention thematic area prioritizes seven core intervention areas covering: Elimination of Mother to Child Transmission; Adolescent girls, boys and young women programming; KVP programming; Condom programming; Voluntary Medical Male Circumcision (VMMC), Pre-exposure Prophylaxis (PrEPs), and the general population programming. NMSF V will continue to advocate for scaling up HIV and AIDS-related interventions such as Blood Safety and Management of STIs.

3.2 Overview

Effort to implement HIV combination prevention interventions was the focus of NMSF IV. Progress was noted in condom programming as the country increased access to condoms through a total market approach. The VMMC programme continued to be scaled up in 17 priority regions, focusing on older men. By 2020, more than 6 million adolescent boys and men were circumcised. The Country initiated a PrEP programme targeting KVPs and discordant couples. By the end of 2020, at least 15,000 beneficiaries had started PrEP. There has been a notable improvement in the access and provision of KVP-friendly services with programmatic data in 2020 showing that HIV testing and treatment coverage in KVPs had steadily improved.

In Tanzania, despite the geographical disproportionality, the coverage of HIV tests at the first ANC visit has been consistently high (>95%) in the past 10 years. Most pregnant women receive their first HIV test during this visit, but the HIV re-testing among pregnant women found to be negative during

the initial test has remained low. By 2019, Tanzania enrolled 92% of estimated pregnant women living with HIV to prevent mother-to-child transmission (PMTCT) services. In 2020, a total of 75,719 pregnant women were identified with HIV at ANC; about 69% of them were already known to be HIV-infected during their Ante-natal Care (ANC) booking, and about 31% were newly diagnosed HIV-positive. The PMTCT programme provided ART to 97.7% of pregnant women living with HIV. Viral suppression among pregnant women in ART care was 91% in 2020, which is above the 90% 2020 fast-track milestone set by UNAIDS. This is in comparison to a viral suppression rate of 55.6% in 2016 during a period when viral load testing was not routine. However, the mother-to-child transmission of HIV infection rate in 2020 was still high (7.9%) above the global and performance national target of <5%.

Tanzania continued to scale up HIV Early Infant Diagnosis (EID) services by introducing Point of Care for HEID (POC-HEID) testing in 2019. By 2021, 100 (42%) gene expert machines were optimized for POC-HEID in all zones.

. HIV Early Infant Diagnosis (EID) coverage at two months is 68%

. The trend of HIV positivity among tested infants has been decreasing significantly over the past five years. The positivity among infants who tested first DNA-PCR regardless of their age decreased from 3.8% in 2015 to 2% in 2020. The positivity among exposed infants tested within 2 months of age decreased from 3.5% in 2015 to 1.4% in 2020.

Other gaps associated with the delay in achieving elimination of MTCT include; low coverage of maternal HIV re-testing services (27.7% in 2020) during the third trimester of pregnancy and breastfeeding (applies to those who were negative at the initial testing), and a high proportion of PMTCT clients drop out of care, highest drop out within the first twelve months (26%, 30% and 33% at 3, 6 and 12 months, respectively), a period in which they are transitioning from PMTCT to CTC clinic. Adolescents and young people remain affected by the negative attitudes of service providers in addition to the stigma associated with HIV as it is largely perceived to be a result of promiscuity. NMSF V will address the salient issues and barriers contributing to the dropping out of pregnant and lactating women. Access to HEID should be prioritized, taking advantage of existing POC technology and the sample referral systems. Innovative approaches to support women and their families, including peer support and community-based interventions for PMTCT and male involvement in RCH services must also be strengthened.

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 95-95-95 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 including prioritising innovative strategies that strengthen male involvement in eMTCT services uptake.

The major concern is the rate of decline in new HIV infections, which remains low with one-third of new infections contributed by adolescents and young women . Despite the scale-up of combination prevention campaign activities, this trend has been noted. This is perhaps due to the complex nature of HIV transmission and risk patterns explained by a myriad of barriers and drivers to HIV.

3.3 Strategic Approach

NMSF V focuses on evidence-based combination prevention interventions and tools, primary

prevention, and strategies that address the social and structural drivers of HIV infection in a multisectoral approach. The inequality lens approach points to the need to increase HIV prevention focus on adolescent girls and young women and key and vulnerable populations, not forgetting adolescent boys and young men. To achieve the NMSF V targets for reducing new HIV infections, the priority will be given to programs for preventing new, infection which entails a renewed momentum to address sexual risk reduction through biomedical interventions such as condoms, PreP, and VMMC coupled with SBCC. The country will also continue to strengthen safe blood transfusion. The NMSF V strategies will therefore aim to address a mix of evidence-based biomedical, behavioural and structural factors that fuel the epidemic. NMSF V intends to reduce the number of new infections from 110,000 in 2010 to less than 15,000 in 2026.

Expected Results:

95% of people at risk of HIV infection have access to and use appropriate, prioritized, person-centred and effective combination prevention options

Elimination of Mother-to-Child Transmission

Strategic Interventions.

- Enhance initiatives that increase access and provision of quality PMTCT services that are delivered under a differentiated service delivery model with a family approach;
- Facilitate the delivery of appropriate care for discordant couples, including PrEP and family planning;
- Promote strategic linkages between HIV, TB, RCH, NCDs, Family planning, Immunization, and Nutrition programs;
- Strengthen community involvement and enhanced participation of community structures in comprehensive eMTCT and paediatric care and support. This will include the engagement of trained peer mothers and other key community health volunteers;
- Promote programs that improve community knowledge, awareness, attitudes, perceptions, behaviours, and practices to support eMTCT and Paediatric HIV care and treatment through communication interventions, and
- Strengthen community-based OVC programs to support HIV testing among children and linkage to HIV care and treatment, and social services.

Adolescent Girls, Boys, and Young People Programming:

Strategic Interventions

- Support scale-up of differentiated HIV combination prevention interventions in schools, out-of-school settings, facility-based youth-friendly services, and youth networks and clubs while involving parents and other community gatekeepers;
- Promote the scale-up of Interventions that address gender, economic and social inequalities, GBV and VAW. This will include advocating for reform of laws and compliance to protect the rights of AGYW;
- Advocate for the expansion of social safety net programming through the promotion of

livelihood initiatives and social transformation. Emphasis will be on skills building including vocational training, income generation, and employability readiness skills;

- Intensify efforts to increase a safe school environment and school retention, especially for adolescents girls and boys, in collaboration with relevant stakeholders;
- Promote public-private partnerships with appropriate stakeholders working with ABGYW, and
- Support strengthening and expansion of youth-friendly services and improved health seeking behaviour among ABGYW.

Key and Vulnerable Population programming:

In NMSF V, KVPs programming aims to reach the following groups; Miners, fisherfolks, long-distance truck drivers and helpers, prisons, motorcycle riders famous as "*boda boda*,", vulnerable girls in higher learning institutions, MSM, PWID and CSWs with their clients.

Strategic Interventions

- Enhance provision of high quality, comprehensive and client-centred HIV services to all identified key and vulnerable population groups;
- Promote supportive policy framework for expanding access and utilization of HIV services among KVP group members;
- Strengthen linkage with health and social services in delivering HIV services for all KVPs;
- Support strengthening of capacities of law enforcement officers, prison officers, and HCPs on respectful and inclusive HIV services for PLHIVs, free from stigma and discrimination;
- Strengthen the availability of comprehensive harm reduction services in a community-based approach to reach PWID, and
- Improve the mainstreaming of rehabilitation and reintegration of PWID into society through mapping and working with CSOs, FBOs, NGOs, and CBOs and trained KVPs.

Condom programming:

Strategic Interventions

- Accelerate the Total Market Approach (TMA) to increase access and utilization of condoms with a targeted approach to high-risk groups and hotspots;
- Support the improvement of the supply chain including condoms forecasting, procurement, and distribution at all levels;
- Support expanding distribution of public sector condoms using community outlets, workplaces, and hotspots;
- Strengthen a strong national M&E system for a condom to create evidence and inform condom programming, and
- Strengthen condom promotion activities including correct and consistence use of condom

through mass media and social media strategies.

Voluntary Medical Male Circumcision (VMMC),

Strategic Interventions

- Support expansion of quality VMMC and EIMC services in line with the National VMMC sustainability manual. Specific efforts should ensure sustainability, including encouraging community and family involvement in bearing the costs;
- Support demand creation effort for VMMC services in priority regions through age-appropriate messages and developing SBCC materials that address myths and misconceptions associated with VMMC and EIMC, and
- Support strengthened and continuous improvement of the quality VMMC and EIMC services, by ensuring the services are safe and culturally acceptable and tracking adverse events resulting from the procedures.

Pre-Exposure Prophylaxis

Strategic Interventions

- Support improved coordination and linkages to scale up provision of PreP to selected groups of key and vulnerable populations;
- Support programs that develop and disseminate literacy materials that promote uptake and appropriate use of PreP among the prioritized groups, and
- Enhance generation and utilization of quality data for decision making on to improve PreP program implementation.
- Coordinate with relevant stakeholders to explore the use of long-acting injectable Cabotegravir (CABLA) that may be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination prevention approaches in line with WHO recommendations.

General population:

- Enhance coordination and support for general population prevention programming agenda and stepping up advocacy for donors, private sector, community structures, and implementers to increase HIV prevention focus for this area;
- Employ data-driven approaches to segment and target the general population according to risk profiles;
- Support coordination for the scale-up of high impact, evidence-based, and risk-matched HIV prevention interventions to the general population, including SBCC campaigns;
- Coordinate resource mobilization and support improvement of accountability of various government and other entities in planning, budgeting, coordinating, and overseeing interventions targeting the general population;
- Support activities that leverage KVP programming and other investments and tools to enhance

the reach to the general population;

- Strengthen the current M&E system and the research and learning agenda (RLA) to cater to this group's needs, and
- Working with NSAs, facilitate and support community mobilization activities to create demand for services using enhanced SBCC, including mainstream and social media.

3.4 Differentiated HIV Testing Services

Strategic Context

Between 2017 and 2020, Tanzania scaled up targeted HIV testing strategies that have increased the proportion of PLHIV who know their status from 61% in 2017 to 88% in 2020. The country also amended the HIV & AIDS Prevention and Control Act (HAPCA) 2008 (approved in November 2019); by lowering the age of consent for voluntary HIV testing from 18 years to 15 years, and including HIV self-testing as an additional testing approach for 18 years and above (by Law). As a result of targeted testing, HTS yield (positivity) has increased from 2.6% in 2018 to 5.5% in 2021.

In order to sustain achievements in the 2nd 90, the country continued to implement effective referral and linkage strategies, including escorted referrals, linkage case management (LCM) using expert clients, and post-test club activities. This resulted in a significant increase in newly initiated PLHIV from 86.3% in 2017 to 97% in 2020. Additionally, subsequent initiation of ART within 7 days of diagnosis has also increased from 89% in 2017 to 95% in 2021.

However, there is still low HTS uptake among some population groups such as; men, adolescents, children, and people who are at risk for HIV infection and do not interact with routine HIV testing (e.g., FSW, MSM, PWID, fisherfolks, miners, mobile population, and clients of KVP). Because of random errors caused by the inadequate quality of HIV testing, misclassifications of HIV status have been reported. In 2019, 74% of those who tested HIV positive were verified, and 6% of those verified had final discordant results between event one and event two.

Expected Results:

95% of people within sub populations who live with HIV know their status and ALL ARE linked to ART services

Strategic Approach

The HIV testing strategies in Tanzania are working, and the country is on track to achieve the 1st 95 earlier than the year 2025. In collaboration with partners, the government will make deliberate efforts to reach populations and geographical segments that are lagging, using differentiated HIV testing approaches and promoting HIVST. Quality improvement strategies such as verification of HIV-positive status and a three-test strategy will be rolled out countrywide. Success in linking HIV-positive clients will be maintained through a proven approach such as escorted referral and same-day ART initiation.

Strategic interventions

- Support access to quality differentiated HIV testing services to targeted groups including children, men, KVP, and other at-risk population groups with a focus on geographical locations and hotspots. This will include supporting linkages with HIV care and treatment services;

- Facilitate scale-up of evidence-based differentiated HIV testing approaches in both health facilities and Communities. This will include integrating HTC services with TB, RCH, and family planning;

- Promote workplace HIV testing campaigns. Attention will be paid to integration with other appropriate health services including campaigns for non-communicable diseases (NCDs) and cervical cancer screening, and

- Promote the availability of HIV self-testing through the social market, and commercial markets by promoting community, CSOs, private sector, and FBO engagement.

3.5 Quality and integrated HIV Care and Treatment Services

Strategic Context

By 2020, Tanzania was on track to achieving the PLHIV enrolment and viral suppression UNAIDS Fast Track targets, estimation data showed that 88% of PLHIV were aware of their HIV status, of whom 97% were on HIV treatment, of whom 95% were virally suppressed. This has been achieved through the "Treat All" approach while paying attention to the improvement of quality of services, effective monitoring, adherence and retention in care, and viral suppression. The country has adopted service delivery models that have enhanced client-centered, comprehensive, and quality care for population segments; children, adolescents, pregnant women, and adults. This success is attributed to the implementation of the DSD Model and Community Based ART services since 2018. The models help to facilitate the uptake and continuity of the ART services, such as 3/6 months Multi monthly ART prescriptions. As of September 2021, 918,000 PLHIV (90.92%) were on 3/6 multi-month ART. The scale-up of DSD models has contributed to improved uptake and retention to care, especially during the COVID-19 pandemic. The coverage of community-based health services for HIV and AIDS (CBHS) has increased from 739,914 clients (52.7%) at the end of 2018 to 955,654 clients (74.3%) in 2019.

Expected Results:

95% treatment targets (enrolment and viral suppression) are achieved within all subpopulations, age groups and geographic settings, including children living with HIV

Despite this success, some population segments are left behind in achieving the 90-90-90 targets, such as fisherfolks and people along transport corridors, whom only 52% to 73% of those living with HIV knew their status during the 2020 survey. Coverage of HIV services also shows disparities across age groups, particularly children and adolescents as well as men; as only 66% of men and 70% of children were enrolled in care in 2019, children had low viral suppression.

Strategic Approach

NMSF V will consider the distinct needs of sub-populations, especially those who are left behind. Care and treatment interventions should be comprehensive, integrated, and client-centered, embracing appropriate DSD models that have successfully increased enrolment and retention, especially in the COVID-19 context. As the Care and Treatment programme continues to mature, the country needs to holistically review and integrate HIV co-morbidities within a one-roof platform to ensure the well-being of PLHIV. The Social and economic welfare of PLHIV and their families will be strengthened by expanding the cluster-based engagement and participation in health, social and economic initiatives. Community-led organizations and the workforce, including PLHIV groups (Clusters under NACOPHA), will be instrumental in this engagement. A multi-sectoral approach will ensure that adolescents

living with HIV will require support to access peer-driven and adolescent-friendly health services, engaging them in their care and linking with psychosocial interventions; while supporting those in schools.

Tanzania's achievement in scaling up prevention and treatment programmes will complement an equivalent focus on improving service quality and reducing loss to follow-up among people who initiate care while simultaneously implementing the new differentiated HIV testing and HIV care policies. Recognizing that different people require different prevention approaches, differentiated care models will be scaled up to tailor interventions to each person's needs, including enhanced use of proven community-based services. The country's priority is to ensure that treatment programmes are holistic, addressing each person's health needs, including co-morbidities.

HIV care and treatment for children below the age of 15 will be expanded further with a differentiated approach to reach out, especially to those below the age of 5 years (about two-thirds (63%) of children living with HIV are on ART). Specifically, comprehensive care for children living with HIV will include essential, quality health services, from health promotion to prevention, treatment and support while addressing other common causes of child morbidity and mortality. Integrated Management of Childhood Illnesses (IMCI) and Integrated Management of Adult Illnesses (IMAI) approaches will be used to identify infants and children at peripheral sites and refer them for HIV services, while strengthening the use of community health volunteers including peer mothers to identify possible cases of HIV and refer for testing and provide follow-up care support for infants and children who have HIV.

Strategic Interventions:

- Support the availability of quality ART services delivered under a differentiated service delivery model to all with special emphasis to reach more children and youth;
- In collaboration with relevant sectors, adopt strategies to increase access to and utilisation of quality ART services in the country;
- Support strengthening of operational linkages between HIV programmes, TB, NCDs, nutrition, and community support initiatives;
- Support implementation of community-led HIV programme through involvement and engagement of affected communities, including PLHIV clusters in service delivery, and
- Coordinate strengthening of a supportive environment for children and adolescents living with HIV who are on ART in boarding schools and tertiary institutions.

3.6 Breaking Down Barriers and Reducing Inequalities

Strategic Context

Tanzania has a robust legal framework that protects the rights of PLHIV and those at a high risk of HIV exposure. The Constitution of the United Republic of Tanzania 1977 has a comprehensive bill of rights that encompasses rights to be enjoyed by all people without any discrimination under Part III.

Stigma and discrimination have multifaceted effects on HIV-related interventions. Key and vulnerable populations (KVPs) who have a higher prevalence of HIV than the general population, continue to face stigma and discrimination, impacting their abilities to access vital prevention, treatment, care and

support services. The recently concluded National Stigma Index 2.0 Survey shows that internalized and enacted stigma have dramatically decreased within the last eight years. Internal stigma was (20.5%) in 2013 as compared to 6.4% in 2021. On the other hand, external stigma decreased from 28% (2013) to 5.5% in 2021.

Gender inequalities, and other intersecting socioeconomic, political and environmental factors, inherently characterize and shape the HIV epidemic and the disproportionate burden of disease borne by women and girls. There are 18.8 million girls living with HIV, accounting for more than half of the approximate 37.9 million people living with HIV worldwide . In Tanzania, there has been a decline in HIV prevalence from 6.3% in 2000 to 4.3% in 2018 among adults (15-49 years) with women being the more affected group (6.12) compared to men 3.98. Adolescent girls and young women (AGYW) face a heightened vulnerability to HIV and account for a quarter of all new HIV infections in the country. Cervical cancer for example is an AIDS-defining illness that puts women living with HIV at a 6 times greater risk of progressing to invasive cervical cancer faster at a younger age than non-immunocompromised women. Currently, Cervical cancer ranks as the first, most frequent cancer among women in Tanzania.

The socio-cultural norms, specifically unequal gender norms and stereotypes are the root causes of the disparities that characterise the HIV epidemic in Tanzania. Entrenched gender norms mean that Tanzanian women bear the burden of taking care of their families and in the process do not find time to utilize care services when they need . Also, the balance of power in relationships makes women more likely to accept violence or unable to make decisions about their own healthcare. The social construction of gender roles also adversely affects men's health-seeking behaviour, as men who subscribe to the traditional cultural script about masculinity were less likely to seek preventive care . This is evidenced by the higher AIDS-related mortality and lower testing, and treatment-seeking behaviour for men.

Gender-Based Violence (GBV) in all its forms can be explained by the multiplex of factors and accepted gender norms described in the previous paragraph. These norms result in increased risky behaviour and harmful practices including; FGM, 'widow cleansing', and women accepting violence which all substantially predispose women, men, AGYW, ABYM, and KVP vulnerability to HIV. The 2015-16 Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) reported that 4 of 10 ever-married women had experienced spousal violence, either physical or sexual (3 in 1 experienced spousal violence in the past year). The report further showed that about one-third (31%) of Tanzanian girls are married before their 18th birthday and that 27% of girls between 15-19 years have begun childbearing. Evidence from locations with high HIV prevalence suggests that Intimate Partner Violence (IPV) increases susceptibility to HIV (by 50%) and that violence (or the fear of violence) is associated with lower treatment access, treatment adherence, and viral suppression among women and girls.

Strategic Approach

Going forward, the key components of the national response will include the reduction of stigma and discrimination; monitoring and reforming laws, regulations, and policies; improving legal literacy; making legal services available and accessible; sensitisation of law-makers and enforcers; training healthcare providers on human rights and medical ethics, and reducing harmful gender norms and violence against women and children. Some of these interventions are already being implemented and should be scaled up. Together, these actions are expected to address both internalised and external stigma, facilitate access to justice, and promote an environment that enables and protects human and legal rights and prevents HIV-related stigma and discrimination.

NMSF V will promote human rights-based, gender-responsive programming so that the different needs and vulnerabilities of women, girls, men, boys, children, and people with disabilities are identified and addressed in accordance with the National Policy Guidelines for Health Sector Prevention and Response to GBV. CSOs will lead the provision of gender-responsive, patient rights, and human rights literacy to the affected populations to know and expect respectful treatment in health and social services facilities. Strategies to address gender inequalities in accessing health services and GBV will include capacity building for CSOs and service providers to identify and address gender determinants of health and manage related GBV cases, deliver integrated youth-friendly HIV and SRH services, and address stigma. The ultimate goal is to ensure the implementation of gender-transformative HIV interventions at all levels. NMSF V will also promote a human rights-based, gender-sensitive legal and policy environment to address HIV and AIDS to ensure equitable access to HIV services without being stigmatised or discriminated against.

A multi-sectoral approach will also increase social protection by addressing income poverty due to the increasing vulnerability of many communities, including those already affected by HIV and AIDS. NMSF V will mobilize all actors to expand social protection and other socio-economic interventions to reduce social and economic vulnerability and mainstream psychosocial support for people living with HIV and other vulnerable groups at higher risk of HIV.

Expected Results:

Less than 10% of women, girls, people living with HIV and key and vulnerable populations experience gender based inequalities and all forms of gender-based violence.

Stigma and discrimination

Strategic Interventions

- Advocate for integration of stigma and discrimination programming in to comprehensive HIV services and promote strategies that reduce HIV related stigma and discrimination;
- Support capacity building of health care providers, CHW, community religious leaders, law enforcers, and PLHIV networks to identify root caused and address stigma and discrimination practices in facilities and communities;
- Create an enabling policy environment for HIV prevention, care, and treatment for all PLHIV, GBV survivors and Key and Vulnerable Populations that is free of stigma and discrimination;
- Enhance meaningful engagement of media and high-level Government leaders, Champions, Religious leaders, and PLHIV testimonies to address stigma and discrimination, gender and age-related barriers to access HIV services, and
- Promote meaningful engagement of PLHIV including young PLHIVs in planning and delivering HIV services and build capacity of their association and networks to strengthen their voice and influence.

Gender Inequalities

Strategic Interventions

- Promote mainstreaming of gender into comprehensive HIV strategies, programmes, and services including social protection to vulnerable groups;
- Strengthen the capacity of HCP to identify and address socially constructed norms and practices

that fuel gender-related barriers to access and utilization of HIV services and address unequal gender inequalities in health outcomes;

- Support CSOs Coalitions, FBOs, private sectors and government MDAs to design, innovate and improve interventions addressing societal norms, GBV, stigma, and other barriers to health services, and
- Enhance health information systems to support collection and utilization of gender-related data to support evidence-based decision making and interventions.

GBV and Violence against women and children

Strategic Interventions

- Promote knowledge about GBV/VAWC/VAM among healthcare workers and strengthen its integration into comprehensive HIV and social services;
- Support scale-up of gender-transformative interventions to address root causes of GBV;
- Mainstream HIV and specifically GBV/VAWC in inter and cross-sectoral national policies, guidelines and programs;
- Advocate for increased investment in comprehensive combination prevention programs that integrate GBV for all populations, and
- Promote engagement of other sectors CSOs, coalitions, and FBOs to design, innovate and improve interventions addressing post-GBV, stigma, and other barriers to services.

3.7 Enhancing Sustainable and Resilient Health and Community Systems

Strategic Context

Robust and resilient health systems are essential for an effective response to HIV and other health outcomes. These systems are often affected by: Supply chain management and pharmacovigilance; Laboratory management and technology, Human resources for health; Community Systems; Service quality improvements; and HIV services delivery during emergencies. Throughout the implementation of the NMSF IV, the country made significant progress in scaling up HIV Testing, Care, and Treatment services which largely depended on the availability of HIV commodities. Health commodity availability was maintained at above 90%. The country implemented interventions to strengthen supply chain management, leading to improved management of HIV and related health commodities, including guidelines and SOPs on commodities quantification, forecasting, rational use of medicine, and pharmacovigilance.

The Ministry of Health is implementing Laboratory Management Systems (LMS) to optimize Diagnostic Networks by strengthening Laboratory Information Systems (LIS), Planned Preventive Maintenance (PPM), Quality Management Systems (QMS), and Sample transportation systems. The QMS is implemented through External Quality Assessment (EQA)/Proficiency Testing (PT) schemes for TB, HIV RDT, CD4, malaria microscopy, Blood Transfusion Services (BTS), and haematology with in-country production of some of the PT schemes. Tanzania has also established a network of accredited laboratories under the National Public Health Laboratory (NPHL) with the capacity and systems to process HVL, HEID, CD4 count, chemistry, and haematology. The MoH has established a functionally integrated sample referral system for routine, research, and forensics investigation

samples supported by a government agency as the main courier' . POC HIV Viral load and HEID test were also scaled throughout the country.

Communities, including PLHIVs and KVPs, are 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. In implementing NMSF V, strategic partnerships between communities and other stakeholders will be strengthened, particularly with health facilities. Communities and specifically affected communities' role in enhancing ownership through demand creation, service delivery, and advocacy is paramount to the sustainability of interventions. Peer-to-peer and other community outreaches remain the backbone of reaching all populations, especially those hard to reach.

Strategic Approach

This NMSF V aspires for ready, uninterrupted access to essential prevention, diagnostic and treatment commodities. While Tanzania's procurement and supply chain system has largely functioned well in the response, the gaps that have sometimes occurred have undermined the effective use of essential health commodities and adherence to prescribed prevention and treatment regimens.

In 2021–2026, Tanzania will take additional steps to strengthen procurement, supply chain, and associated information systems and ensure quality throughout. The country will further strengthen its stock monitoring system at national and local levels, supported by a rapid response system for shortages to ensure consistent and adequate supplies of medicines, testing kits, female and male condoms, and service delivery sites. Steps will be taken to strengthen and enhance efforts to reduce the occurrence of medicine stock-outs, including improved case and stock management at health facilities.

Under the NMSF V, community-based responses will be strengthened by implementing a core package of multi-sectoral services to address the social, physical, educational, and emotional needs of affected communities, including PLHIV and KVPs. NMSF V promotes effective community systems that underpin community-led and community-based HIV responses and which can complement and link with formal health systems. Communities will also participate in community-led monitoring to improve the quality of services. NMSF V encourages implementers to engage different types of formal and informal community groups, organizations and networks, and other civil society organizations in HIV programming. The country will continue to support CSOs to access needed resources and contribute to stronger health systems and ensure a seamless continuum of care from the health to the community system.

Another key community role will be to catalyse and influence local responses to change risk environments at the community level and address negative social and cultural practices that fuel the spread of HIV. Furthermore, intensified community models will support the delivery of HIV services at the community level. This will be done within the context of the Community Health Workers (CHWs) cadre and peer-based outreach services that have successfully supported adherence and retention, especially among KVP groups. 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, deliver, and sustain community-driven solutions.

Expected Results:

100% of health facilities report no stock out of HIV commodities

30% of HIV services are delivered by community based organisations

Human resource needs will be addressed through innovative means, including task shifting, enhanced differentiated care, community ART, and multi-month prescription, which have significantly contributed to reducing congestion at health facilities.

Strategic Interventions

- Strengthen service delivery mechanisms within the context of health and community systems including human resources for health focusing on adequacy, skills, and competencies;
- Strengthen health information and logistics management systems to capture real-time data and support decision-making at all levels;
- Promote active involvement of community, religious and political leaders and private sector for effective engagement in the national multisectoral response;
- Enhance community networks, linkage, partnerships, and coordination, and
- Facilitate adoption of emerging appropriate technologies that support the national HIV response.

3.8 Fully Resourced, well-coordinated, Efficient, and Sustainable HIV Response

Strategic Context

In Tanzania, a multisectoral and decentralised approach was adopted to coordinate the national HIV and AIDS response in 2001. The National HIV/AIDS policy 2001, the TACAIDS Act 2001, and the three principles of having one national coordinating agency, one national strategic framework, and one national M&E Plan informs the coordination framework. After a decade of implementation, multisectoral coordination has become complex and dynamic, thus creating new opportunities and challenges. The number and diversity of stakeholders have increased with different mandates, comparative advantages, roles and responsibilities, and different and complex governance structures, accountability, and reporting lines. Coordinating structures have been established at national, regional, community, and sector levels. In most cases, these structures are functional; however, their potential in ensuring equitable distributions of services, good governance, transparency, efficiency, accountability, and meaningful participation and involvement by all stakeholders, particularly communities, has not been fully realised.

Over-dependence on external funding for HIV response and inefficiencies are two of the vulnerabilities that need to be urgently addressed. With the potential for declining donor resources that may jeopardize Tanzania's HIV response, the government's ability to mobilize increased domestic funding for HIV would become critical to safeguard past progress and enable the country to advance toward its longer-term goals. Domestic funding is unlikely to replace external funding immediately, but gradual increases may have to occur over time to sustain gains and safeguard the national response. It will be important to explore innovative financing mechanisms for securing and sustaining funding for HIV response which requires resources beyond the national budget. Expanding health insurance services could be one of the options. To achieve this objective, Tanzania will need to develop a long-term strategy for sustainable financing of the response. Some efforts toward this goal have already started with the establishment of the Tanzanian AIDS Trust Fund; however, concerted investment will have to be made by the government and stakeholders, to realize its potential.

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 ensuring that development sectors mainstream HIV in both the internal and external responses. Although the core of the financial sustainability strategy is to finance, reviewing and strengthening other areas necessary to support sustainability will also be required. The two critical areas include organizational systems development and human resources for health.

Strategic Approach

In implementing the fifth framework, Tanzania will look into the national response coordination model, including joint planning, implementation, participation, and reviews, and reprioritise building on the existing structures including the TNCM and PEPFAR mechanisms. NMSF V will devise mechanisms to hold accountable all actors, including central and local governments, funding partners, and the communities served, regarding resource mobilisation, utilization, service provision, and adherence to services to achieve the best health outcomes.

The country needs to mobilise resources to invest in the priority interventions and sustain gains to achieve impact while devising and implementing interventions with efficiencies and leveraging resources and existing multisectoral comparative advantage. Resource mobilisation will include strategies to increase domestic financing of the HIV programme amidst diminishing donor support. Importantly, there is a dire need for innovative new funding sources. To sustain the national response to HIV, NMSF V outlines the need for innovative approaches to secure domestic resources. One such opportunity is to increase the domestic resource envelope in line with the Universal Health Coverage agenda.

NMSF V highlights the importance of investing in strategies that improve the resilience of the national response against pandemics, epidemics, and disasters. The country needs to recognize the plight of PLHIVs in the face of the COVID-19 pandemic by coordinating with responsible MDAs to provide differentiated interventions with a focus on PLHIVs who are at a higher risk of severe COVID-19 illness and death. NMSF V assumes that the Government at all levels of the health system will develop "All hazard" Emergency Preparedness and Response Plans and hazard-specific plans that will guide implementation during emergencies and build the capacity of healthcare providers at all levels to deal with the effects of various disasters.

Expected Results:

30% increase in domestic contribution of HIV response by 2025

Strategic Interventions

- Review and update the resource mobilization strategy to strengthen ATF's ability to effectively spearhead resource mobilization for a well-funded response;
- Review, update and disseminate the ATF advocacy and information strategy in order to expand the involvement of stakeholders in resource mobilization for the national HIV response;
- Advocate for inclusion of HIV services into national health insurance schemes;
- Intensify advocacy to increase domestic funding from government, private and other sectors. This will include implementation of the national resource mobilization strategy including coordination of the construction sector's contribution to the national HIV response;
- Intensify advocacy to retain the current donors and maintain funding levels, while aggressively expanding the donor base including bilateral, multilateral and private foundations;

- Advocate for the integration of the District Multi-sectoral AIDS response into District Development Planning and Implementation funding, and

- Facilitate community-led HIV Financing through the economic strengthening of PLHIV Groups and individuals to finance social protection schemes and eventually finance medications, including ARV.

3.9 Strengthen Monitoring, Evaluation, and Learning

Strategic Context

The NMSF V Monitoring and Evaluation (M&E) plan provides a monitoring framework for the national multisectoral response and ensures that TACAIDS efficiently leads stakeholders to capture and generate strategic information necessary for informing the national response.

Data sources that provided values for the NMSF IV performance indicators include; Health Management Information System (HMIS); the Local Government Monitoring Database (LGMD), the Tanzania Output Monitoring System for non-medical HIV and AIDS interventions(TOMSHA); the Management Information System (MIS) for the National Council for People Living with HIV and AIDS (NACOPHA); The Education Management Information System (EMIS); Ministry of Labour (MOL) MIS; and various surveys such as Tanzania HIV Impact Assessment (THIS) and Stigma Index conducted in collaboration between TACAIDS, National Bureau of Statistics (NBS), MOL, NACOPHA, and National AIDS Control Programme (NACP). These systems have enabled the Country to undertake Multisectoral monitoring and evaluation of the national epidemic response through innovation and technology introduced in some sectors like health, education, and at the council level. Data are directly captured and retrieved at district levels through information systems like TOMSHA (For TACAIDS), DHIS2 (For NACP), and EMIS (for education).

Despite these gains, more effort and or investment is required to address gaps in collecting community data and strengthening the linkage between CSOs implementing at the community level with LGAs. Furthermore, some of the electronic systems and software installed are outdated and need updating. There is an inadequate Human resource base for M&E capable of generating, storing, and using routine monitoring and periodic data sources functional in generating the required strategic information.

Strategic Approach

The NMSF V will strengthen strategic information activities to create validated evidence for innovation, improved efficiency, and enhanced impact. Strategic information, research, and innovation are key to strengthening evidence-based decision-making and policy formulation for the HIV response.

A separate Monitoring and Evaluation Framework has been developed alongside NSMF V to support its implementation. The NMSF V M&E framework will focus on monitoring progress towards outcome and impact indicators through the use of detailed data to guide programme design and targeting by using survey, surveillance, and programme data to model and triangulate in order to identify high-burden geographical spots where implementation will be intensified. When feasible and needed, geospatial mapping and profiling will be used to optimise decision-making at local levels. The monitoring and evaluation results framework and ongoing surveillance will use more disaggregated refined data to improve the information available for decision-making. The framework also aims to embrace partnerships with the information technology community to use the potential of digital and social innovations to connect people, share experiences through social media, access information, and deliver services.

Expected Results:

100% of health facilities and community based implementers complete and submit quarterly reports on time by 2025

NMSF V will promote innovations and integrate lessons in implementing novel interventions such as differentiated HIV testing, male involvement in HIV prevention, and community peer engagement models. This NMSF encourages the roll-out of innovative approaches to tracking prevention interventions, increased treatment uptake, services to manage adolescents and children; increased use of information technologies; tracking of expansion of services to at-risk groups and vulnerable communities beyond the static service provision facilities. Modelling Techniques and Implementation research will be undertaken to guide implementation in line with the available evidence.

Strategic Interventions

- Collaborate with relevant sectors to increase access to pre and in-service training to increase M&E related skills and reduce the M&E Human resource gap;
- Support strengthening of program data generation and management systems across sector and where possible ensure their interoperability;
- Collaborate with sectors to strengthen data quality assurance mechanisms at each level of data generation and use;
- Enhance availability of periodical and representative data on Key and Vulnerable Populations to track the epidemic in hidden populations;
- Advocate for resources and strengthen local capacity for planning and implementation of national surveys;
- In collaboration with other sectors identify and pilot innovative information technologies that will reduce data capture burden and enhance data security for community based services;
- Establish forums for broad dissemination of Strategic Information based on programmatic routine data, disease surveillance, Modelling and operational research results, and
- Collaborate with other sectors to strengthen HIV and AIDS Data and information use for decision making by policymakers, data use for frontline workers at the subnational level.

4. FINANCING NMSF V

4.1 Introduction

This chapter presents an analysis of the estimated resource needs, projected future funding, and resource gaps. It highlights key financing strategies for achieving NMSF V targets, its operationalization, and its implementation. The costing and financing analysis for the NMSF V builds on a similar analysis conducted for the Fifth Health Sector HIV Strategic Plan V (HSHSP V 2022-2026) and Condom Needs and Resource Requirement Estimation Tool (The Condom Tool) 2019-2023 and the Fifth Health Sector Strategic Plan (HSSP V 2021/22-2025/26), considering estimated resource needs, projected future funding, and the resource gap pertaining to HIV and AIDS response over the given period i.e. 2022–2026. The costing analysis was done and presented in line with thematic areas identified for the NMSF V including prevention of new HIV infection, increasing access to differentiated HIV testing services, ensuring quality HIV care and treatment services, breaking down barriers and reducing inequalities, enhancing sustainable and resilient systems for health, fully resourced, well-coordinated, efficient and sustainable HIV response, and strengthening monitoring, evaluation and learning. The chapter further describes the sources of data used and the data collection, analysis, and validation process with stakeholders.

4.2 Methodology

The costing approach

The costing of the NMSF V took a multisectoral collaboration approach in determining the resource needs for its implementation. The multisectoral approach is defined as the joint financing of a programme or intervention by two or more budget holders that have different sectoral objectives to jointly achieve their separate goals more efficiently[9]. In theory, this could mean increasing the resource envelope for the HIV response spending by pooling funds with health and non-health sectors and thus leveraging additional investment, as well as more efficient purchasing of health-producing interventions beyond the health system. The multipurpose perspective was chosen because firstly, multiple 'sectors' contribute to the production of HIV response, and secondly, some of the goods and services produced by the 'health or HIV sector' have multiple benefits besides health. Sectors and institutions responsible for each thematic area were identified and validated during the consultative meetings with HIV response stakeholders.

Data source, collection, and assumptions

Costing data and assumptions as inputs for the costing were collected from national documents, literature, published and unpublished reports, and through a consultative process at workshops and meetings, including TACAIDS staff, development partners, HIV/AIDS implementing partners, health managers, clinicians, and other stakeholders working in the HIV response from various sectors. Data sources to inform costing of the NMSF V included HSHSP V 2021- 2026 costing files, costed sub-sector strategic plans, the Medium-Term Expenditure Framework (MTEF), Condom Needs and Resource Requirement Estimation Tool (The Condom Tool) 2019-2023 files, GF application, Investment case 2.0 and PEPFAR COP 21 and other published and unpublished costing studies. Expert opinion was used in case of missing or incomplete data. Government circular and group consensus were used to standardize prices for common costing inputs such as conference packages, perdiem rates, transport costs, etc. Costs were collected in both TZS and U.S. dollars using an exchange rate of TZS 2309[10] to

9 McGuire, F., Vijayasingham, L., Vassall, A. et al. Financing intersectoral action for health: a systematic review of co-financing models. Global Health 15, 86 (2019)

10 BOT.2022. Monthly Economic Review April 2022

1 USD. Cost data from the Non-Health sector was collected using the Willingness to Pay Interview guide.

The costing

A mix of approaches has been used to estimate the HIV response costs for different sectors including the health sector (the MoH) and non-health sectors (Other relevant ministries and MDAs).

The One health tool (OHT)

The OneHealth Tool (OHT) was used to estimate the HIV response in the Health Sector. The OHT is a medium to long-term (3 to 10 years) strategic planning model in the health sector, created by an international consortium comprised of the World Health Organization, several United Nations agencies, and Avenir Health. The OHT estimates the costs of an entire health system, including service delivery and cross-cutting health system requirements. It is a dynamic model integrated within the spectrum suite of models, which allows for the linking of cost assumptions with health outcome models (Catherine et al., 2018; Stenberg and Rajan, 2012; and Perales et al., 2016)[11,12,13]. The OHT uses an ingredients-based cost approach where the costs are based on unit prices and the quantity of the inputs required to carry out the activities. Also, it allows the use of unit cost where the total commodity costs are estimated by multiplying the average unit cost per intervention by the number of cases per year. The general costing formulae applied in the OHT are; **∑ (Targeted Population size X % of Population In Need (PIN) X %Coverage target X Unit cost).**

Where:

- Relevant target population size estimate for the priority populations # (data preloaded);
- PIN refers to the prevalence;
- Coverage targets (%) reach of the intervention. Obtained from national and international targets or experts' opinions, and
- Unit cost; computed or adapted from the literature

For consistency, The NMSF has adopted unit costs from existing studies and other recent cost estimations done in various HIV/AIDS applications such as GF application, COP 16-21, and the ABC/M study[14] done by Health Policy + (see appendices 1).

The Co-financing models

Co-financing is an innovative financing approach whereby two or more sectors or budget holders, each with different development objectives, co-fund an intervention or broader investment area which advances their respective objectives simultaneously[15].

In the real world, co-financing models can nonetheless vary in their execution[16], especially where

11 Cantelmo, Catherine & Takeuchi, Momoe & Stenberg, Karin & Veasnakiry, Lo & Eang, Ros & Mai, Mo & Murakoshi, Eijiro. (2018). Estimating health plan costs with the OneHealth tool, Cambodia. Bulletin of the World Health Organization. 96. 462-470. 10.2471/BLT.17.203737

12 Perales N, Dutta A, Maina T. Resource needs for the Kenya health sector strategic and investment plan: analysis using the OneHealth tool. Washington, DC: Health Policy Project; 2015. Available from: http://www.avenirhealth.org/download/OHTCountryApplications/PDF/161_OneHealthKenya ReportFORMATTEDEC.pdf [cited 2021 December 26.

13 Stenberg K, Rajan D. Estimating cost implications of a national health policy, strategy or plan. In: Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016. Available from: http://apps.who.int/iris/bitstream/handle/10665/250221/9789241549745-chapter7- eng.pdf;jsessionid=0F700AEEA831EECE88335AD7DEDF1669?sequence=18 [cited 2018 May 21]

14 Lee, B., H. Pan, G. Ruhago, M. Mizinduko, D. Peter, C. Mann, and S. Forsythe. 2021. Applying Activity-based Costing and Management (ABC/M) to HIV Services in Tanzania. Washington, DC: Palladium, Health Policy Plus

15 UNDP, Financing across sectors for sustainable development, Guidance Note 2019

16 UNDP, Financing across sectors for sustainable development, Guidance Note 2019 pg 48-58)

there is a lack of data on multiple outcomes. One approach is for budget holders to determine how much they would be willing to contribute towards the intervention, assuming that other sectors (the health sector) cover the remaining implementation costs. This approach would rely on a sector perceiving an intervention outside of its traditional jurisdiction to provide sufficient benefits to its core objectives to be worth financing. Hence elicitation of the contribution uses a direct question ….how much is the sector willing to contribute to the HIV response? Answers to this question were further guided by the MTEF estimates. The Co-financing model was used to estimate costs from non-Health sectors. The non-Health sector included all non-health ministries and MDAs.

Scenario's development

Three coverage-driven scenarios were developed in estimating the fund needs; the status quo/ baseline, Moderate or prioritized/accelerated, and the ambitious scenario in estimating the resource needs for NMSF V 2021-2025 implementation.

- Status quo/Baseline scenario: This scenario implies maintenance of current coverage of services. The baseline scenario extends current targets and coverage of specific interventions for the baseline year (2021) through 2025, without any changes. It serves both as a useful counterfactual to examine additional costs and health gains, as well as an understanding of how much resources would be required simply to maintain current coverage as the population grows and inflation is applied.

- NMSF V Scenario (Moderate): The NMSF V scenario reflects the new costed strategic plan 2022-2026. This is where interventions are scaled up to attain the coverage level set in the NMSF V targets as per prioritized strategies.

- Ambitious scenario: The ambitious scenario represents the full expansion of intervention contemplated in the various impact areas, right from the first year of the strategic plan.

4.3. Total Fund Needs for implementing the NMSF V 2021-2025

The NMSF V Moderate Scenario

As reported in table 10 the cost for the entire planning timeframe of the activities reported in the NMSF V is around **US$ 3,828,668,652.17**. The estimated total cost under the NMSF V Moderate scenario will be 14% higher than the estimated implementation cost under the status quo scenario but lower by 33% than the ambitious scenario. The cost of implementing the NMSF V will continue to grow in the next five years from USD 631.4 Million in 2023 to USD 986.66 million by 2026. There is a sharp increase in resource needs for year five (a 25.6% increase from year four) matching the endline targets in the final year of the NMSF.

Table 10: Total Fund Needed to implement NMSF V 2021-2025

THEMATIC AREAS	Estimated cost (USD)					TOTAL(USD)	%
	2021	2022	2023	2024	2025		
	150,639,862	191,818,234	234,733,915.63	290,126,733	494,349,930	1,361,668,675	35.57
Reducing New HIV Infection	3,170,876	3,251,569	3,332,944.00	3,414,431	3,495,867	16,665,687	0.44
Ensure Quality HIV Care and Treatment Services	414,583,654	427,541,317	438,555,017	449,225,657	459,164,861	2,189,070,504	57.18

Elimination of Mother to Child Transmission of HIV	17,015,018	18,870,565	18,547,883	18,159,815	17,743,978	90,337,2578	2.36
Breaking Down Barriers and Reducing Inequalities	31,732,786	23,316,987	16,153,067	9,245,670	1,989,284	82,437,793	2.15
Enhancing Sustainable and Resilient Systems for health	6,035,003	20,924,169	19,861,290	6,178,894	6,400,095	59,399,451	1.55
Fully Resourced, well-coordinated, Efficient and Sustainable HIV Response	3,777,959	4,360,480	3,361,259	3,659,727	3,329,250	18,488,673	0.48
Strengthen Monitoring, Evaluation, and Learning	4,512,801	2,698,820	2,265,179	978,614	145,197	10,600,610	0.28
Total (USD)	**631,467,959**	**692,782,140**	**736,810,554**	**780,989,541**	**986,618,461**	**3,828,668,652**	**100**

NMSF V multisectoral collaboration costs

Table 11 -19 shows the costs for multisectoral collaboration in HIV response per thematic area. eMTCT is separated from other prevention strategies due to the uniqueness and organization of its interventions. The Ministry of Health(MoH) is considered the core sector in HIV response, henceforth, the largest budget bearer in almost all thematic areas.

Table 11 Total cost for Multisectoral collaboration in reducing New HIV Infection

Institution/ Sector	Estimated cost (USD)					Total (USD)
	2021	2022	2023	2024	2025	
Ministry of Health (MoH)	130,402,991	177,908,567	231,836,861	284,768,120	480,319,163	1,305,235,702
PORALG	30,641	31,795	32,097	31,826	31,786	158,145
TACAIDS	20,059,286	13,728,259	2,714,742	5,177,115	13,849,386	55,528,789
Ministry of Education	17,406	18,168	18,341	18,186	18,163	90,264
Ministry of Home Affairs	43,516	45,422	45,853	45,466	45,409	225,665
Other MDAs (Mineral, Transport, Livestock, fisheries, Agriculture)	86,022	86,022	86,022	86,022	86,022	430,110
TOTAL(USD)	**150,639,862**	**191,818,234**	**234,733,916**	**290,126,734**	**494,349,930**	**1,361,668,675**

Table 12 Total costs for Multisectoral collaboration in Increasing Access to Differentiated HIV Testing Services

Institution/ sector	Estimated cost (USD)					Total (USD)
	2021	2022	2023	2024	2025	
Ministry of Health (MoH)	3,110,415.00	3,188,460.00	3,269,236.00	3,351,261.00	3,432,776.00	**16,352,148.00**
PORALG	60,461.00	63,109.00	63,708.00	63,170.00	63,091.00	313,539.00
TOTAL (USD)	**3,170,876.00**	**3,251,569.00**	**3,332,944.00**	**3,414,431.00**	**3,495,867.00**	**16,665,687.00**

Table 13: Total costs for Multisectoral collaboration in Ensuring Quality HIV Care and Treatment Services

Institution/ sector	Estimated cost (USD)					TOTAL(USD)
	2021	2022	2023	2024	2025	
Ministry of Health (MoH)	414,551,017	427,507,250	438,520,627	449,191,558	459,130,804	**2,188,901,255**
PORALG	32,637	34,067	34,390	34,099	34,057	169,249
TOTAL(USD)	**414,583,654**	**427,541,317**	**438,555,017**	**449,225,657**	**459,164,861**	**2,189,070,504**

Table 14: Total costs for Multisectoral collaboration in Elimination of Mother to Child Transmission of HIV

Institution/ sector	Estimated cost (USD)					TOTAL(USD)
	2021	2022	2023	2024	2025	
Ministry of Health (MoH)	16,982,381.00	18,836,498.00	18,513,493.00	18,125,716.00	17,709,921.00	**90,168,009.00**
PORALG	32,637.00	34,066.50	34,389.61	34,099.14	34,056.71	169,248.96
TOTAL(USD)	**17,015,018.00**	**18,870,564.50**	**18,547,882.61**	**18,159,815.14**	**17,743,977.71**	**90,337,257.96**

Table 15: Total costs for Multisectoral collaboration in Breaking Down Barriers and Reducing Inequalities

Institution/ sector	Estimated cost (USD)					TOTAL(USD)
	2021	2022	2023	2024	2025	
TACAIDS	2,059,049.68	278,599.49	237,173.64	963,601.77	1,874,539.79	5,412,964.37
Ministry of Health (MoH)	29,630,220.00	22,994,872.00	15,872,377.00	8,238,552.00	71,228.00	**76,807,249.00**
The Ministry of Community Development, Gender and Women Empowerment	43,516.00	43,516.00	43,516.00	43,516.00	43,516.00	217,580.00
NSA						
TOTAL(USD)	**31,732,785.68**	**23,316,987.49**	**16,153,066.64**	**9,245,669.77**	**1,989,283.79**	**82,437,793.37**

Table 16:Total costs for Multisectoral collaboration in Enhancing Sustainable and Resilient Systems for health

Institution/ sector	Estimated cost (USD)					TOTAL(USD)
	2021	2022	2023	2024	2025	
Ministry of Health (MoH)	6,035,003.00	20,924,169.00	19,861,290.00	6,178,894.00	6,400,095.00	**59,399,451.00**
PORALG	-	-	-	-	-	-
MoEScT	-	-	-	-	-	-
TOTAL(USD)	**6,035,003.00**	**20,924,169.00**	**19,861,290.00**	**6,178,894.00**	**6,400,095.00**	**59,399,451.00**

Table 17: Total costs for Multisectoral collaboration in ensuring a Fully Resourced, well-coordinated, Efficient and Sustainable HIV Response

Institution/ sector	Estimated cost (USD)					TOTAL(USD)
	2021	2022	2023	2024	2025	
TACAIDS	2,152,004.74	2,872,979.01	1,986,926.94	2,172,225.77	2,089,686.87	11,273,823.33
Ministry of Health (MoH)	1,625,954.00	1,487,501.00	1,374,332.00	1,487,501.00	1,239,563.00	7,214,850.00
TOTAL(USD)	**3,777,958.74**	**4,360,480.01**	**3,361,258.94**	**3,659,726.77**	**3,329,249.87**	**18,488,673.33**

Table 18:Total costs for Multisectoral collaboration in Strengthening Monitoring, Evaluation, and Learning

Institution/sector	Estimated cost (USD)					TOTAL(USD)
	2021	2022	2023	2024	2025	
TACAIDS	4,455,113.29	2,698,819.78	2,265,179.11	949,769.88	145,197.21	10,514,079.28
Ministry of Health (MoH)	57,687.31	-	-	28,843.66	-	86,530.97
TOTAL(USD)	**4,512,800.60**	**2,698,819.78**	**2,265,179.11**	**978,613.54**	**145,197.21**	**10,600,610.24**

Funding Gap Analysis

To successfully advocate for funding for thr NMSF V, it is important to know how much the plan costs (i.e. it's budget), and the available funding (commitments from the HIV response stakeholders) and to identify the financial gaps of the plan. The financial gap analysis is a key tool for preparing resource mobilisation events and for planning and administering the financing to come. The details for the required financing and available funding (i.e, commitments) are discussed next.

Required financing (costed NMSF V)

Table 10 presents the total funds needed to implement NMSF V per thematic area for each year of implementation. The total cost ranges from TZS 631,467,959.00 in the year 2022/2023 to TZS 986,618,461.00 in the year 2025/2026.

Available Funding

Four funding sources for HIV programming were considered in the forecast calculations: The GoT, Global Fund (GF), PEPFAR, and other external funding, including UNAIDS, UNICEF, WHO, the International Labour Organisation (ILO), the United Nations Development Fund for Women (UNIFEM), United Kingdom, Sweden, Norway, German, Switzerland. Historical data from the aforementioned funding sources were collected for the funding projection covering the entire period of the NMSF V implementation.

- Government funding is based on the Global Fund 2021–2023 request information provided for the funding gap analysis in the Funding Request Application for 2021–2023. Based on past Government funding, polynomial regression was applied to project funding for the years 2024–2025.

- GFATM funding is based on recent allocations covering the year 2016-2023. The polynomial

regression was applied to the past GFATM funding to project funding for the years 2024–2025.

- PEPFAR's funding is based on its funding allocation for FY 2016-2021. Polynomial regression was applied to past PEPFAR funding to project funding for the years 2022–2025.
- Historical data from other external sources17 for HIV/AIDS funding were not available. Hence, they were not included in the funding projections.
- Projected future funding of the HIV response from the Government, Global Fund, and PEPFAR is presented in Table 10

Table 20: Projected future funding for the HIV response in Tanzania 2021-2025

	2021	2022	2023	2024	2025
Domestic: Government of Tanzania	41,071,701.21	80,379,090.00	88,416,999.00	95,822,692.01	103,288,650.09
Global Fund	139,116,336.79	124,520,604.92	116,103,481.30	118,617,598.64	86,088,810.04
PEPFAR	450,500,000.00	310,457,974.91	277,598,018.50	281,380,620.68	248,520,664.27
Total (USS) (EXPECTED)	**630,688,038.00**	**515,357,669.83**	**482,118,498.80**	**495,820,911.33**	**437,898,124.40**

Funding Gap

Comparing the estimated total fund needs for the implementation of the NMSF V 2021–2025 under a moderate scenario which the country has selected and the projected funding for this period reveals a potential total resource gap of USD 1,234,785,411 (Table 11). The funding gap is estimated to increase from USD 779,920 in 2022 to USD 548,720,336 in 2025.

Table 21: NMSF V Funding gap (US$)

	2021	2022	2023	2024	2025	Total (USD)
Projected Funding	630,688,038	515,357,6702	482,118,499	495,820,911	437,898,124	2,593,883,241
Total Resource need	631,467,958	692,782,140	736,810,553	780,989,540	986,618,460	3,828,668,652
Funding gap	**(779,920)**	**(139,205,438)**	**(254,692,054)**	**(285,168,629)**	**(548,720,336)**	**(1,234,785,411)**

4.5 Resource mobilization and sustainability consideration

The development of a National Domestic Resource Mobilization and Sustainability Strategy (DRMS Strategy) will be a critical first step toward ensuring that the estimated NMSF V financing gap is covered. The following strategic initiatives are proposed for consideration.

Domestic Public Resource Mobilization

- Increase public sector budgetary allocation and execution for the HIV response. Public allocation can be increased by strengthening advocacy and negotiation efforts to secure an increase in budget allocations for the HIV program from the Ministry of Finance. The advocacy and negotiation effort should at minimum, consider:
    - ATF Unit advocate through government channels to MOF and Parliament to increase the current ATF funding to reach the 300,000,000,000 TSHS per year promised, and
    - Advocate and negotiate with MoF to allocate to ATF 5% of the collections from mobile money transfer fees.

17 Other sources of external funding included: the United Kingdom, Sweden, Norway, Denmark, Switzerland, German, UNAIDS, ILO, UNIFEM, UNICEF and WHO

- Increasing Efficiency and Effectiveness of the HIV Response to reduce Waste through improved management and targeting of funds mainstreamed for HIV within priority interventions and sectors, and

- Implement an earmarked tax on the profits of large public and private enterprises.

Prepayment and Private Sector Financing

The private sector and pre-payment schemes have not been adequately explored as a source of domestic funds for the HIV response. Thus, it is proposed.

- Strengthen private sector engagement in providing HIV testing, counseling, and treatment services, and

- Explore the potential for the eventual integration of HIV services into social- and community-based health insurance benefits packages.

Sustainability and Capacity Building

- Ensure evidence-based decision-making for appropriate allocation and efficient use of HIV resources across sectors;

- Promote transparency and accountability in the collection, allocation, and execution of HIV funding by improving resource tracking and monitoring;

- Promote Value for Money (VFM) in the HIV Response. There is a need to ensure that existing and new resources are better leveraged to provide improved Value for Money (VFM) i.e. to maximize the available resources. Developing a VFM framework as part of the national HIV national response will be critical to maximising the use of the limited resources available;

- Local Manufacturing of HIV Commodities (Test Kits and ARV drugs). Local production of HIV commodities, including test kits and ARV drugs, has been recognized as part of the strategy for sustainable financing of the HIV programme, and

- Improvement of governance of HIV response at all Levels by strengthening multisectoral governance structures for the HIV response, strengthening institutional capacity at national and sub-national levels, and encouraging multisectoral collaboration.

5. COORDINATION, GOVERNANCE AND LEADERSHIP

5.1 Introduction

This chapter presents the coordination and management framework of the NSMF V. In Tanzania, a multisectoral and decentralized approach was adopted to coordinate the national HIV and AIDS response in 2001. The National HIV/AIDS policy 2001, the TACAIDS Act 2001, and the three principles of having one national coordinating agency, one national strategic Framework, and one national M&E Plan inform the coordination framework for the national HIV and AIDS response. After a decade of implementation, multisectoral coordination has become complex and dynamic, creating new opportunities and challenges. The number and diversity of stakeholders have increased with different mandates, comparative advantages, roles and responsibilities, and different and complex governance structures, accountability, and reporting lines[18]. Through this dynamic process, communities are increasingly recognized as strategic partners in ensuring ownership, sustainability, demand, adherence, and retention of clients (HIV positive and negative) on services. To guide this complex and dynamic process, Tanzania has developed a coherent system of government legislation, policies, strategies, and programmes that guide the country's National HIV and AIDS response. Increasingly the national strategies and policies and sectoral strategies and guidelines are harmonized to provide clarity and coherent partnerships.

5.2 Sector Mandates, Roles, and Responsibilities

In order to ensure "no one is left behind", the coordination of the national HIV and AIDS response ensures that there is clarity of service provider mandates, roles and responsibilities, good governance, and a supportive environment that promotes strategic partnerships and alliances, and participation of all people. It should ensure better linkages and coordination between communities and other stakeholders, especially community-based health facilities. Coordinating structures have been established at the national, sector, regional, council, and community levels as described in the Multisectoral Coordination Framework in figure 7.

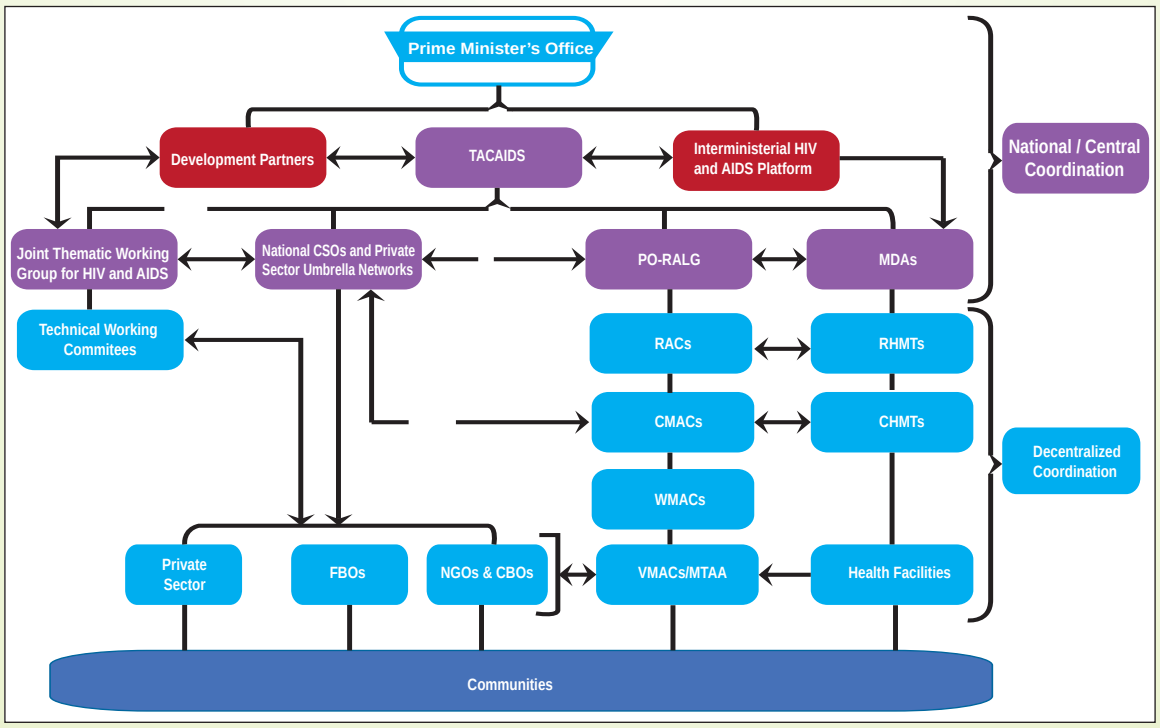


Figure 7: Multisectoral Coordination Framework

18 The National Multisectoral Strategic Framework for HIV and AIDS (NMSF) IV 2018/19 – 2022/23

Governance

The NMSF Multisectoral coordination framework informs the governance structure of the National HIV Response. The overall leadership of the response lies with the Prime Minister's Office (PMO) whose Permanent Secretary coordinates inter-ministerial meetings/discussions regarding the National HIV response. During such meetings, various reports are presented and issues are brought up for attention and response from specific ministries. This meeting is designed to ensure accountability for responsible ministries and MDAs. HIV and AIDS agenda is also presented to the meeting of permanent secretaries from all ministries which is chaired by the Chief Secretary, thus saving the purpose of the inter-ministerial meeting. As the main coordinator of the National Response, TACAIDS works under and reports to the PMO. Through the HIV and AIDS Joint Thermatic Working group, chaired by PMO Permanent Secretary, Partners, IPs, and other Stakeholders discuss pertinent issues brought up through TWCs reports. During NMSF V implementation, the JTWG meetings will include reports from PEPFAR and GF as well as CMACs to ensure improved accountability.

NMSF V in the following sections lists key mandates of all sectors in the implementation of the national response. This will enable easier follow-up and accountability for each player from government ministries, MDAs, partners, and non-state actors.

The Prime Minister's Office (PMO).

The Prime Minister's Office is at top of the coordination and management structure of the National Multisectoral HIV and AIDS response in Tanzania. The PMO provides national leadership, commitment, and guidance for good governance necessary to ensure effective and efficient national coordination of the national HIV response. Other roles include providing support for sustainable financing for the national response, providing high-level political leadership, and ensuring effective implementation and enforcement of existing policies and laws. The PMO coordinates the multisectoral response across Ministries, Department and Agencies' (MDAs') through the Inter-Ministerial meetings of the Permanent Secretaries from all sector ministries involved in the HIV and AIDS response. The Permanent Secretary, Policy and parliament coordination at PMO chairs the National HIV and AIDS Joint Thematic Working Group, a forum that coordinates Government, development partners, and implementers of HIV and AIDS programs. Specifically, the PMO will deliver on the following mandate:

- Coordinate periodic meetings of Permanent Secretaries on HIV and AIDS, previously the Inter-Ministerial Technical Committee (IMTC) on HIV and AIDS, part of the PMO's mandate for coordinating the multisectoral response across Ministries, Department, and Agencies (MDAs');

- Coordinate the National HIV and AIDS Joint Thematic Working Group (JTWG) twice a year, with one meeting to be organized during World AIDS Day Commemoration. This forum is expected to bring together HIV and AIDS stakeholders from government MDAs, Development, and Implementing Partners (including PEPFAR and Global Fund), Academia, the Private sector, FBOs, and NGOs, and

- Provide leadership, oversite, and support to TACAIDS to ensure effective coordination of the National HIV and AIDS Response.

The Tanzania Commission for AIDS (TACAIDS)

The TACAIDS is a Presidential Commission established by the Act of Parliament No. 22 in 2001, with the overall legal mandate of coordinating the national multisectoral HIV and AIDS response. The Tanzania Commission for AIDS (TACAIDS) operates under the Prime Minister's Office. Thus, the

PMO supports and facilitates the activities of TACAIDS and, through TACAIDS, the overall National Response to the HIV and AIDS epidemic. TACAIDS coordinates all HIV and AIDS activities under PMO (including Technical Working Committees, and Joint Thematic Working Group meetings, provides coordination support to the Inter-Ministerial meetings on HIV and AIDS, and ensures that plans and reports are timely shared with PS PMO. In 2020 TWCs were reduced to four from the previous six, in order to improve their functionality and efficiency. The four technical working committees are 1) Prevention which includes three sub-committees, (i) Adolescents and young adult stakeholders, (ii) Comprehensive condom programming, and (iii) Key and vulnerable Populations, (2) Care, Treatment, and Support, (3) Monitoring, Evaluation & Research (4) Finance and Audit.

TACAIDS is also responsible for developing, reviewing, and coordinating the National HIV and AIDS Policy and translating it into a National Multisectoral HIV and AIDS framework that guides all stakeholders involved in the national response. Specifically, TACAIDS coordinates World AIDS Day and other associated national forums for sharing technical and other leanings. On behalf of PMO, TACAIDS facilitates all government ministries, departments, agencies, local governments, and the private sector to mainstream HIV and AIDS in their core functions and supports the integration of NMSF priorities in their investment plans and reports accordingly. As the country's multisectoral response leader, TACAIDS leads the coordination, resource mobilization, supervision, monitoring, evaluation, and learning of the national HIV response. TACAIDS hosts and facilitates the Tanzania AIDS Fund (ATF)

Ministry of Health (MoH)

The MOH coordinates the health sector-based HIV and AIDS response through the National AIDS Control Programme (NACP). NACP collaborates with TACAIDS in managing specific health sector-based committees and subcommittees on Prevention, Paediatric ART, eMTCT, Treatment, Care, Support, Community HIV Response, Medicines and Technology (Procurement and Logistics), and Monitoring, Evaluation, and Research. It is also responsible for HIV surveillance and epidemiological research, HIV and AIDS reporting, and STI surveillance in collaboration with other stakeholders. Additionally, the Ministry provides the necessary health-specific technical support to MDA, NSA, implementing partners, and other organizations.

The MoH also ensures the availability of harmonized and integrated health management information systems and adherence to updated guidelines, standards, and regulations. In addition, it promotes and oversees operational research on health sector HIV prevention, care, treatment, and support services. The MoH, through NACP, is also responsible for developing and disseminating national guidelines and policies governing HIV and AIDS interventions. The MoH coordinates a dialogue structure that guides the *Sector Wide Planning Approach (SWAp)* for the health sector. The SWAp provides an opportunity for the participation of all key stakeholders, including development partners and civil society, in health sector reforms and interventions. At the top of the dialogue, the structure is the Joint Annual Health Sector Review (JAHSR), which brings together all key stakeholders to review progress made in the health sector and set priorities for the following year. The MOH is also responsible for implementing health sector-based interventions to prevent sexual, blood-borne, and vertical transmission of HIV. In summary, MOH will have the following mandate:

- Lead the development of policy framework, strategies, and guidelines for the delivery of high-quality combination prevention services;
- Ensure availability of quality HIV and AIDS prevention, HIV testing, care, and treatment services delivered under a differentiated service delivery model;

- In collaboration with relevant partners, adopt strategies to increase access to and utilization of quality HIV and AIDS services in the country;
- Establish and strengthen operational linkages between HIV programs, TB, NCDs, nutrition, and community support initiatives;
- Develop policy, guidelines, and operational plans, and
- Coordinate a dialogue structure that guides the Sector Wide Planning Approach (SWAp) for the health sector and ensures it supports the HIV and AIDS response.

President's Office-Regional Administration and Local Governments (PO-RALG)

The PO-RALG is a key player in rolling out the implementation of the National HIV/AIDS Strategic Framework from the national to the decentralized level at regional, local government, and community levels. PO-RALG, through a division of Local Government under the Local Governance and Community Development Section, is responsible for managing, coordinating, and facilitating the implementation of the National HIV and AIDS response through local government authorities at the council, ward, and village levels. The Health, Social Welfare, and Nutrition Services division under the Health Service Section of the ministry is responsible for managing all government health facilities. At PO-RALG, there are three levels of governance to oversee the implementation of this framework; National, Regional, and Local Government Authorities (LGAs). PO-RALG is also responsible for facilitating effective recruitment and deployment of skilled workers in collaboration with POPSMGG and related ministries and designing and developing planning guidelines (MTEF) for the national AIDS response.

Consequently, the PO-RALG is mainly responsible for sustaining the management and coordination of regional and council-level responses to the HIV/AIDS epidemic through the Council Multisectoral AIDS Committees (CMACS), Ward level through the Ward Multisectoral AIDS Committees (WMAC) and at the community or local government level through Village in rural and Mitaa in Urban Multisectoral AIDS Committees (VMAC). This responsibility is exercised by integrating HIV and AIDS into the district development planning process, district-level performance management, and oversight of HIV and AIDS implementation accountability.

PO-RALG takes the lead in executing the following mandate:

- Providing overall leadership in interpreting and implementing policies and guidelines to guide the HIV and AIDS response, including drawing bylaws and ordinances to regulate activities that promote the prevention of HIV and the uptake of HIV and AIDS services;
- Planning, budgeting, coordinating, and monitoring all HIV and AIDS activities in the local government. Ensure that networks of people living with HIV, civil society organizations, and faith-based organizations' activities align with the NMSF and district plans, appraise officers' performance against targets and ensure that the disbursement of funds is tied to progress in meeting targets;
- Ensuring that resources are mobilized, allocated, utilized, and accounted for in addressing local government HIV and AIDS activities including facilitating the process of annual budget for HIV and AIDS from RS and LGAs for submission to the MoF;
- Supervising and coordinating all implementing partners at the local government level and appraising community HIV and AIDS programs and projects for quality assurance and

accountability including to ensure that the HIV coordination structures are functional and supported, including CMACs, WMACS, and VMAC;

- Guiding HIV and AIDS mainstreaming in local government programs, ensuring that all NMSF priorities are integrated appropriately;
- In partnership with Implementing partners and CSOs, ensure quality HIV combination prevention services for KVP, at-risk groups, and the general population;
- Ensure readily accessibility and utilisation of HIV prevention services such as condoms, VMMC, PreP throughout the Country, and
- Working with NSAs, facilitate and support community mobilization activities to create demand for services using enhanced SBCC, including mainstream and social media

Ministry of Finance and Planning (MoFP)

The MoFP's primary responsibilities include integrating HIV and AIDS into the National budgeting and planning process. The MoFP works with TACAIDS, MoH, and PO-RALG to ensure that adequate resources are made available to the various MDAs and councils for HIV and AIDS activities through mobilization, allocation, and disbursement. MoFP, in collaboration with recipient line ministries and TACAIDS, will coordinate development partners' financial contributions to HIV and AIDS prevention, care, treatment, and support. The Ministry will also use routine or research-generated epidemiological and other data provided by TACAIDS and its partners to make projections of the epidemics' economic and human resource development impact and incorporate this into manpower and economic planning. Overall the MoFP will have the following mandate:

- Facilitate and support the central and local governments, ministries, departments, and agencies to mobilize adequate financial resources for the implementation of the NMSF;
- Ensure that local government, ministries, departments, and agencies provide for and disburse funds for NMSF implementation;
- Ring fence funds allocated for HIV and AIDS and ensure they are thoroughly audited;
- Oversee prudent financial management, procurement, accountability, and periodic tracking of HIV-related resources, and
- Ensure that all national development initiatives integrate HIV as envisaged in the NMSF.

President's Office Public Service Management and Good Governance (PO-PSMGG)

The PO-PSMGG has an overall mandate to coordinate and facilitate HIV and AIDS prevention, treatment, and support services to the civil public service workforce. PO-PSMGG works with TACAIDS, MOH, and PO-RALG to develop and implement policy guidelines and protocols that address barriers to the utilization of HIV and AIDS services by public servants and their families, including stigma and discrimination. To do that, the ministry will have the following mandate:

- Ensure all ministries, departments, agencies, and local governments have HIV and AIDS-related workplace programs that prioritize relevant NMSF V interventions;

- Facilitate mainstreaming of HIV and AIDS into General Standing Orders, Guidelines, job descriptions, employee appraisals, etc., as well as into the Performance Management System;
- In co-operation with MOFP, use human resource information to make human resource planning projections for HIV and AIDS response coordination across government and ensure that targets are met;
- Collaborate with TACAIDS on monitoring the implementation of the Workplace Code of Conduct across sectors, and
- Ensure appropriate workplace policies are in place and enforced.

Ministry of Education, Science, and Technology.

The Ministry of Education, Science and Technology will ensure that HIV and AIDS response is mainstreamed in all aspects of the education system from the setting of educational policy, teachers' training, and student teaching. Ongoing programs, including updating the national curriculum and establishing counseling services, should be maintained and strengthened. Specifically, the ministry will:

- Ensure that the pre-service curriculum in training and learning institutions integrates HIV and AIDS;
- Ensure implementation of workplace interventions in all institutions under the ministry, including design, planning, and implement appropriate NMSF V activities for learners, educators, and school communities;
- Develop guidelines for the care and support for students living with HIV in boarding schools and tertiary institutions. Provide peer counseling and support, including AIDS clubs and directives that address HIV and AIDS-related stigma and discrimination;
- Collaborate with CSOs to implement HIV prevention interventions on campuses including education about condoms and HIVST;
- Address HIV and AIDS-related issues such as coercion, rape and other forms of sexual abuse, human rights, and predatory sex, and
- Ensure there is a supportive environment for utilization of HIV and AIDS services among students and staff and a specific focus on vulnerable groups, including but not limited to young women and persons with disabilities.

Prime Minister's Office - Labor, Youth, Employment, and Persons with Disability

The Ministry of Labor, Youth, Employment, and Persons with Disabilities comprises many diverse departments, each with its individual mandate and specific roles. The Ministry will work with the private sector and the Occupational Safety and Health Authority (OSHA) to support the development of workplace HIV/AIDS programs and policies, including labor benefits. Additionally, the ministry will ensure the rights of people living with HIV to employment, social welfare, and compensation where relevant. A further key responsibility is to assess and address the needs of out-of-school youth and

provide among others, sports, and recreational opportunities to minimize engagement in high-risk activities like alcohol abuse and unsafe sex. Specifically, the ministry will:

- Strengthen PPP arrangement with the private sector, CSO, and communities to coordinate the involvement of special groups including, persons with disabilities and youth especially out of school, and improve access to HIV and AIDS services;
- Support policy advocacy to strengthen a social, policy and legal environment for HIV and AIDS response at the workplace, and
- Work with MOH and TACAIDS to develop guidelines and directives that address barriers to HIV services for persons with disabilities.

Ministry of Home Affairs

The Ministry of Home Affairs is made up of diverse departments, such as Prisons, Police, and Immigration, each with specific needs for HIV and AIDS services. This ministry will coordinate and facilitate the provision of HIV and AIDS to communities of people that are highly exposed to HIV infection and need support, including prison and police offers, prisoners, and other groups of people who interact with these forces and their surrounding communities. Specifically, the ministry will:

- Work with relevant partners to provide prevention, care, and support services within the prison community as part of the response to HIV and AIDS through the Department of Prisons Services;
- Work with relevant partners to provide prevention, care, and support services within the police community as part of the response to HIV and AIDS through the Tanzania Police Force;
- Integrate HIV/AIDS behavior change interventions into the training programme for police and prison officers;
- As part of community policing initiatives, conduct orientations to address HIV and AIDS-related issues such as rape and other forms of sexual abuse, human rights, domestic violence, and the relation between alcohol and HIV infection;
- Build the capacity of law enforcement officers to address HIV/AIDS-related issues such as rape and other forms of sexual abuse, human rights, and domestic violence;
- Orient police and prison officers to support HIV prevention, especially among KVP groups;
- Integrate HIV/AIDS behaviour change, condom programming, and VMMC among police, prison officers, immigration, fire brigade and armed forces, and
- Orient police and prison officers to facilitate HIV prevention, especially among KVP groups and others that face social and legal barriers.

Ministry of Constitution and Legal Affairs

One of the key responsibilities of the Ministry of Constitution and Legal Affairs is to develop a

supportive legal framework for the implementation of the National HIV and AIDS response. The ministry ensures an inclusive legal system that supports and protects vulnerable populations. Specifically, the ministry will:

- Review and mainstream HIV and AIDS in all national and sector policies, legislation, agreements, and conventions;
- Create awareness and provide support on HIV and AIDS-related human and legal rights to the general public. This includes coordinating and facilitating the provision of legal assistance and advice to PLHIV, other vulnerable groups, and the general public to ensure that human rights are upheld and that there is equitable access and provision of HIV and AIDS services;
- Ensure that appropriate legislations and policies support the national response, and facilitate review of legislations and policies as well as monitoring and evaluation;
- Address rights violation-related drivers of HIV infection to the general public and specific groups, and
- Enforce regulations against sexual and gender-based violence, stigma and discrimination, good governance, and accountability.

Ministry of Community Development, Gender, Women and Special Groups.

This Ministry is responsible for coordinating and facilitating gender mainstreaming into the national HIV and AIDS response. As such, the ministry will ensure that the promotion of gender equality and advancement of women and girls, from education to employment, is prioritized as it contributes to curbing the spread of the epidemic. Further, the ministry works with other ministries and MDAS to ensure that HIV and AIDS services barriers among vulnerable groups, PLHIVs, young women, and people with disabilities, are addressed or highlighted in programs. Therefore, the ministry will:

- Facilitate programs that engage communities, with specific reach to young people, including young women and adolescent boys and girls, women and men that address socio-cultural and economic barriers to services;
- Facilitate and support mainstreaming of gender in HIV-related policies, programs, and budgets in public and private entities, and
- Enhance the engagement of cultural and religious institutions, special populations, and orphans and vulnerable children in implementing the NMSF.

Ministry of Information, Communication, and Information Technology

This ministry is responsible for both internal and external mainstreaming of HIV and AIDS into their communication strategies. The ministry is responsible for coordinating media houses and outlets, both print and digital, to contribute effectively to the realization of the National HIV and AIDS response objectives. The digital revolution era has made information transfer extremely powerful, faster, broader, and hard to monitor or control, making this ministry an important partner in the implementation and monitoring of information to ensure it contributes to the national response. Specifically, the ministry will:

- Develop guidelines to ensure media houses and outlets support the national response by disseminating and covering key HIV and AIDS information;

- Work with media partners to cover campaigns that reduce barriers to services among vulnerable communities by addressing barriers to HIV services uptake including gender violence, stigma and discrimination, persecution, and exploitation;

- Create a supportive environment for innovation and creativity in the context of utilisation of ICT for effective digital transmission of correct HIV and AIDS information, including social media;

- Facilitate a supportive environment for stakeholders to access and utilize key information, including affordable internet services and coverage of strategic HIV and AIDS services and forums, including but not limited to the annual WAD commemoration symposiums and events, and

- Ensure appropriate storage and security of HIV data.

Other MDAs and Parastatals

This section covers other Ministries, Departments, and Parastatals including those responsible for mining and fisheries with communities that are vulnerable to HIV infections that were not listed above. MDAs in this section will be responsible for coordinating and facilitating the provision and uptake of HIV and AIDS services for their workers, stakeholders, and surrounding communities.

Based on comparative advantages, MDAs and parastatals in this section will have the following mandate and responsibilities in implementing the NMSF V.

- Ensure that the National HIV and AIDS Response priority activities are mainstreamed in all MDAs and Parastatals, especially agriculture, Mining, Livestock, fisheries, transport, works, tourism, energy, sports, and arts sectors;

- Ensure that appropriate interventions addressing the HIV and AIDS disease burden on fishing, mining, transport, and other vulnerable communities are included in major programs within the sectors;

- Provide leadership in integrating HIV and AIDS in livelihood programs, agricultural research, and extension services and

- Disseminate HIV and AIDS messages and services to staff families, and surrounding communities.

Development Partners (DPs)

The DPs play a vital role in supporting the GoT to achieve its commitment to end the HIV/AIDS epidemic by 2030. The major donor partners include the U.S. Government through PEPFAR, Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), The United Nations Agencies, and the World Bank. PEPFAR and the Global Fund accounted for 90% of financing from 2015 -2017[19]. During the implementation of NMSF V, the DPs are expected to maintain and protect the gains made over the past decade to ensure Tanzania is on track to achieve epidemic control. The role of development

19 Tanzania Investment case 2.0, 2020

partners specifically in the areas of financial support where they play a significant role is covered in the previous chapter on financing the NMSF. The roles of the two largest NMSF supporters are listed in the following paragraph.

PEPFAR

PEPFAR in collaboration with the Government of Tanzania and civil society of Tanzania, will work to support the country's progress towards controlling the pandemic and maintaining control, through the following priority areas:

- Continue to build on strong population-specific case identification efforts, with an enhanced focus on safe and ethical index testing services as a primary priority for the program in COP22;
- Support the implementation of tailored linkage and treatment continuity interventions by client/population through real-time data analysis, targeted case management approaches, and population-specific health education/literacy;
- Support the implementation of short and long-term strategies to eliminate HVL and DBS sample backlogs, including completion of lab diagnostic network optimization by the start of COP22;
- Support operationalization of revised maternal retesting tools and include maternal re-testing as part of a comprehensive prevention package including PrEP and family planning for high risk pregnant and breastfeeding women to reduce new child infections. Also, Improve mother-baby cohort monitoring, EID 2-month testing coverage through the use of novel EID assays and scale the rollout of DTG 10mg (3kg infants) across all service delivery sites;
- Ensure PrEP is reaching priority subpopulations, including KP (FSW, MSM, PWID), AGYW, serodiscordant couples, and pregnant/breastfeeding women and that uptake/coverage by subpopulations is being tracked and monitored.

GLOBAL FUND

The Global Fund to Fight AIDS, Tuberculosis, and Malaria is Tanzania's second largest donor for the National HIV and AIDS response. Global Fund also supports HIV/TB integration programs as well as malaria response. During the implementation of NMSF V, the Global Fund is expected to support the following areas of the national response;

- Treatment care and support of the HIV-positive people;
- HIV testing and counselling;
- Support Key Population HIV and AIDS services,
- Support TB /HIV integration services, and
- Support systems strengthening.

Generally, Donor Partners support the government of Tanzania and other stakeholders by building capacity for external and domestic resource mobilization and technical and allocative efficiencies so that Tanzania can adequately generate the necessary financial resources for HIV response. This should be complemented by transparency and accountability of investments made in HIV response

and advocacy with the GoT and stakeholders for increased data sharing on performance, including financial information through resource alignment initiatives for effective decision-making. DPs will collaborate with stakeholders, the Government of Tanzania (GoT), and implementing partners to tailor effective strategies to close results gaps and ensure that systems, including policies, support programmatic best practices.

In line with the health sector and other development strategies, DPs are expected to continue to collaborate and coordinate with GoT to address key human resources for health gaps that stand as key barriers to the full implementation of activities required for epidemic control. Specifically, support will be needed to target allocative efficiency and improved performance of community health workers using evidence-based approaches to estimate the site-level needs and client-centered approaches.

CSO Coalition and FBOs

Civil society participation in the national response to HIV is dual-track in that CSOs including FBOs are providers and consumers of HIV prevention and AIDS care services. Civil society networks and networks of persons living or affected by HIV play a key role in ensuring access to disease prevention and care services for women, men, youth, and key population groups in whom HIV prevalence and the likelihood of new HIV infections, and the risk of transmission is particularly high. Communities of practice, communities of purpose, communities of circumstances, and communities of interest also play key roles in mobilization, monitoring, advocacy, and direct service delivery or providing support in service delivery. In general, however, it is anticipated that CSOs and FBOs will play a leading role in the following areas:

- Actively participate in the processes of establishing and reviewing HIV and AIDS policies on prevention, treatment, and support services, programme financing and ensure they address structural challenges such as stigma and discrimination and gender-based inequalities) that constitute barriers to an effective response to HIV and AIDS;
- Apply community-led solutions, including digital technologies, to enhance data utilization from community scorecards for quality improvement;
- Conduct evidence-informed advocacy at the local and national levels aimed at holding duty bearers accountable for HIV prevention services, AIDS treatment, social support, and protection for the most vulnerable communities (such as PWD, KPs, women, men, youths and others);
- Collaborate with other stakeholders to conduct social mobilization for improved service uptake by building effective linkages with other actors in public and private sectors to reduce vulnerabilities and promoting equity;
- Spearhead efforts to build the capacity of lower-level community-based organizations to fulfill their roles in social mobilization, education, and resource mobilization;
- Bridge resource gap (financial and human resource mobilization) to complement government investment in programme interventions that support the implementation of the NMSF V;
- Work with partners to engineer changes in social cultural beliefs, knowledge, behavior and attitudes at local level as factors that influence norms and practices which fuel HIV transmission, GBV and VAC;

- Develop and implement target behavioral change information communication in the community to support relevant interventions, especially HTS, and
- Coordinate and facilitate the provision of psychosocial support services.

The Private Sector

The government of Tanzania has steadily leveraged the private health sector's capacity to strengthen the Tanzanian HIV and AIDS response and other health services; first by removing the ban on private practice in 1991 and then by emphasizing PPPs in its national health policies, HIV and AIDS policy and strategic plans[20]. In response, the private health sector has grown and organized into several umbrellas and network organizations, such as the Christian Social Services Commission (CSSC), the National Muslim Council of Tanzania (BAKWATA), the Association of Private Health Facilities in Tanzania (APHFTA), the National CSO Coalition, Tanzania Private Sector Foundation (TPSF) and The Association of Tanzania Employers (ATE).

Through the PPP framework, the Councils contract services from FBOs through service level agreements, which lay out the services provided and remunerations. In many places, the service level agreements are implemented but not adequately monitored due to a lack of key performance indicators agreed upon between them. Collaboration between MOH and the Association of Private Health Facilities in Tanzania (APHFTA) is improving. More and more private facilities join the association and provide reports to the government. APHFTA distributes guidelines and instructions among its members and runs capacity-building programs that enable them to participate in the national health system framework. The health insurance schemes run by the government have benefited private providers, and the highly anticipated SNHI will offer more opportunities to serve a wider range of clients. Currently, private insurance schemes that exist reach only a handful of clients.

Tanzania embraced a total market approach to expand the provision of condoms in both the public and private sectors, a strategy that was stipulated in the National Multi-sectoral Condom Strategy that was developed in 2016. One of its key strategies is to expand the distribution of public sector condoms using individual distributors beyond public healthcare facilities, community-based outlets, workplaces, and others, and support social marketing & private condoms distribution systems.

Public-private partnership is an essential tool in response to HIV. The private sector's knowledge, resources, capacity, and contacts are valuable resources that can contribute to an effective response to AIDS. By using their corporate communications and marketing skills, businesses can help raise AIDS awareness and promote behavioral change among employees, families, and communities. Companies can incorporate prevention messages that promote gender equality in existing communication platforms as well as instate zero-tolerance policies to eliminate stigma and discrimination. Two out of three people living with HIV go to work each day, according to UNAIDS. The workplace has a vital role to play in mitigating the impact of the AIDS epidemic and facilitating access to HIV prevention, treatment, care, and support.

NMSF V underscores innovative financing approaches that may catalyze private investment for the HIV response using tools such as credit guarantees or subsidies that reduce risk and provide additional incentives for private financial institutions to lend to the health sector. This approach to structuring capital enables diverse investors to combine funds for financial and development impact and promotes the long-term sustainability of HIV programs. In Tanzania, the private sector is envisaged to become a full partner in the national response with the coordination of the Association of Tanzania Employers (ATE) and Tanzania Private sector Foundation (TPSF). Specifically, the private sector will:

20 SHOPS Project. 2013. Tanzania Private Health Sector Assessment

- Develop a strategy to guide the private sector effectively contribute to the attainment of the national HIV and AIDS response goals;
- Use market-based approaches to increase access to patient-centered HIV services and products in private outlets, promote access to private financing for local private health organizations, and introduce innovative and emerging technologies to improve patient outcomes;
- Engage in high-level advocacy by using their weight to promote accountability and transparency by reporting on money spent on social welfare programs. They can break the upward trajectory of costs of drugs, supplies, and delivery and participate in innovative public-private partnerships on research and development;
- Establish and support workplace AIDS committees to oversee education and condom distribution campaigns, information sessions for people living with HIV, and awareness events around World AIDS Day;
- Promote healthy workplaces by defining roles and responsibilities at all levels of policy and decision-making processes, implementing and evaluating HIV programs in the workplace in adherence to national and ILO Standard on HIV/AIDS and the world of work;
- Promote and support private HIV and AIDS service delivery and market development;
- Support blended financing of the response;
- Support supply chain modernization; and
- Support social enterprise development and public-private partnership in HIV response.

5.3 Internal and External Mainstreaming

NMSF V considers HIV mainstreaming to mean, firstly, an analysis of how HIV and AIDS impact various sectors now and in the future, both internally and externally, and secondly, determining how each sector should respond based on its comparative advantages. Mainstreaming HIV and AIDS, therefore, enables the public and private sectors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace environment.

NMSF V recommends a minimum package of services for internal (workplace) mainstreaming and key external mainstreaming initiatives that include families of workers and surrounding communities as well as a requirement for HIV social assessment as part of environmental impact assessments (EIA) on all infrastructural projects.

Minimum Package (MP)

This minimum Package for HIV mainstreaming will guide MDAs, parastatals, and non-state actors, including the private sector with regard to how they can plan and mainstream HIV services in their routine operations. Broadly, stakeholders will be responsible for developing annual HIV and AIDS Action Plans that address both the internal or workplace domain and external domain which includes families, stakeholders, and surrounding communities. The internal elements of the plan will be built upon the foundation of a minimum package to be implemented by each sector across the board. Additional activities can, of course, be planned and implemented based on each sector's capabilities

and needs. MDAs, parastatals, NSAs, and the private sector will be responsible for developing and implementing appropriate activities based on the key areas outlined in the Minimum Package below:

- Promote HTS, including HIVST, and link staff to HTS by establishing institutional partnerships with HTS providers;
- Ensure condom availability and accessibility in all offices and intensively promote their use;
- Promote staff awareness about all relevant HIV services (e.g., HIVST, PMTCT, ART/TB, etc.) and facilitate linkages with programs to increase access by staff, families, and surrounding communities;
- Develop and implement targeted Behavior Change Communication with all staff, families and surrounding communities to support relevant interventions as appropriate;
- Integrate HIV and AIDS strategic in all operational plans, including annual action plans and mainstream HIV and AIDS into the organization's overall strategic plan;
- Ensure appropriate workplace policies are in place and enforced, and
- Establish a budget line for HIV/ AIDS programs (internal and external activities).

5.4 Strategic partnerships

NMSF V construes strategic partnerships, also referred to as an alliance, as relationships between two entities with overlapping or complementary products or services that aim to achieve a mutually beneficial result. In NMSF V, the multisectoral and decentralized approach to the national response implementation demands the collaboration of different stakeholders based on their mandates, technical expertise, and comparative advantages. Strategic partnerships and alliances are expected to leverage resources and expand access to technical assistance and strategic information. They are also expected to support skills transfer, knowledge, and best practices sharing, increase coverage, improve access, and utilization of services, and increase retention of clients on services.

For the above purpose, existing partnerships and alliances will be consolidated and new ones established where the need arises. Tanzania will build from long-standing relationships and collaboration with international funding agencies and development partners. Particular emphasis will aim on improving partnerships and linkages between communities and service providers by involving community-based health facilities and community health workers.

Tanzania will strengthen and expand the Public-Private Partnerships (PPP) scope to support HIV and AIDS response. The expansion of the PPP modality is strategic in increasing 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), and shared risks and benefits. A well-managed strategic partnership arrangement will have great potential to promote and strengthen country and community ownership and long-term services sustainability.

5.5 Regional and International Partnership

Tanzania is a member of regional and international bodies, including the East African Community, SADC, African Union, and the United Nations. The government of Tanzania has signed international and regional declarations and has committed to ending AIDS as a public health threat in Tanzania

by 2030. Country efforts have always embraced global and in-country best practices and evidence.

The fifth NMSF is therefore informed by the UNAIDS Fast-Track Commitments to End AIDS by 2030, and the country is working to achieve 95-95-95 targets by 2025; The WHO Global Health Strategy for HIV, viral hepatitis and the Global Fund (GFATM). The Framework has also addressed Tanzanian's commitment to implementing the UN Political Declaration on HIV and AIDS in 2015, Sustainable Development Goals (SDGs), and the Africa Union Agenda 2063.

5.6 Leadership and Shared Accountability

Leadership, mutual accountability, and commitment remain the key ingredients for the successful national HIV response. The NMSF V will strengthen a decentralized approach that places districts/ councils at the hub of quality services across all sectors and departments. Through the existing multisectoral, intergovernmental relationships and PPM, including multisectoral coordination at the regional, district, and ward levels, leadership at the ward level will be mobilized. Involvement of the formal and non-formal private sectors will be deepened, and civil society sectors and community networks will be capacitated. The vision of leadership reflected in the NMSF requires the transparent sharing of essential information on the epidemic and the response and inclusive national and local dialogue on performance.

Annex 1: NMSF V Result Framework

By 2026

- New HIV infections reduced by 85% in 2026 from the 2010 baseline (110,000);
- Mother to Child Transmission by the end of breastfeeding reduced to ≤4% by 2025;
- AIDS-related deaths reduced by 80% in 2026 from the 2010 baseline (64,000);
- HIV-related stigma, reduced to <5% by 2026 from the 2013 baseline of 28% for external stigma and 20.5% for internal stigma.

S/N	THEMATIC AREA	INTERVENTIONS	RESULTS	
			OUTPUTS	OUTCOMES
1.	Reduction of New HIV Infection	0.1 Condom programming	▪ Increased supply of condoms ▪ Efficient condom logistics ▪ Effective social + commercial marketing	Increased use of condoms among target KVP groups members
		1.2 VMMC and EIMC	▪ Accessible VMMC and EIMC services	Increased uptake of VMMC and EIMC services
		1.3 PrEP	▪ Differentiated PrEP services available	Increased uptake of PrEP services among targeted group
		1.4 KVP	▪ HIV prevention sources provided to KVP and at-risk groups	Increased use of prevention measures
		1.5 AGYW and adolescents boys	▪ HIV prevention knowledge and tools are accessed and used	Increase use of prevention measures
2.	HIV Testing Services	2.1 Differential HIV testing	▪ HIVST testing services are available ▪ Three–test strategy services provide.	Increased proportion of PLHIV who knows their HIV status (disaggregated by sub-populations)
3.	Quality and intergrated HIV care and treatment services	3.1 Roll-out DSD	▪ Comprehensive and differentiated HIV services are available for all population groups at communities and health facilities	Increased proportion of PLHIV enrolled and retained into ART Increased proportion of PLHIV who are virally suppressed Increased proportion of health facilities that intergrate HIV care and treatment services with other reproductive health services dissegragated by type of services e.g. FP, cervical cancer,TB

4	Elimination of mother to child transmission of HIV	4.1 ARV during ANC, Labor, and breastfeeding	▪ Barriers contributing to dropping out of pregnant women and lactating mothers removed ▪ Differentiated PMTCT services scaled-up	Increased proportion of pregnant and lactating women enrolled and retained into ART Care Increased proportion of pregnant and lactating women who are virally suppressed
5	Breaking down barriers and reducing inequality	5.1 Operationalize the revised laws and policies	▪ Revised laws operationalized	Increased number of adolescents below 18 accessing HIV testing
		5.2 Elimination of stigma and discrimination	▪ Facility staff and the community, in general, are sensitized to avoid stigmatizing PLHIV, especially KVP ▪ Sensitize and or empower individuals and, in particular, PLHIV and KVPs to be confident and open up	Increased proportion of PLHIV access services feely and at convenient times Increased proportion of KVPs access services feely and at convenient times
		5.3 Reduction or elimination & gender inequality and GVB.	▪ Community sensitized/ engaged in the transformative process for repressive gender norms and vehicles	Reduced proportion of women who report GBV incidences Increase the proportion of women who report easy access to HIV services and equal participation in decision making
6.	Enhancing sustainable and resilient health and community systems	6.1 Uninterrupted access to essential prevention diagnostic and treatment commodities and services.	▪ Logistics systems for prevention, diagnostic care, and treatment commodities strengthened	The availability of HIV commodities in all facilities without interruptions

7	Full, resourced, well-coordinated, efficient, and sustainable HIV response.	7.1. Develop and implement a mechanism that will hold accountable all actors	▪ Memorandum of understanding developed and signed by key stakeholders (MDAs, DPs, CSOs, and private sector) with accompanied TOR defining the modus operandi	HIV Response coordination mechanisms and structures operating efficiently at all levels
		7.2. Mobilise local resources	▪ Mobilize the private sector to contribute towards ATF; ▪ Facilitate LGAs to increase or establish funds for HIV response from their own sources. ▪ Hold special fund-raising events for HIV response ▪ Economic strengthening of PLHIV Groups and individuals	Increased funding to the ATF Domestic resources for HIV response increased; The welfare of PLHIV increased, and they are capable of self-purchasing of social protection schemes/insurance.
		7.3. Ensure efficient resource allocation and usage	▪ MDAs, LGAs, and IPs oriented sensitized to use the Investment case model in programming and budgeting for HIV ▪ Budgeting for HIV harmonized at all levels, i.e., MDAs, LGAs, and IPs, to reduce and or eliminate overlaps and or wastage	Resources are efficiently allocated using the investment case; Overlaps eliminated by harmonized HIV programming

8.	Strengthening monitoring, evaluation, and learning for the HIV response (including Research)	8.1. Rollout data Collection storage and analytics beyond council levels downwards to community level	▪ TOMSHA rolled down to community levels ▪ Community-Led Monitoring is scaled up ▪ LGAs should go a step further in analysing the data collected in order to discover progress and success stories, new insights into the HIV response, and any challenges	Community-level HIV Response data is collected and analyzed at the LGA level. Through CLM, communities, and beneficiaries are able to contribute toward HIV services quality improvement
		8.2. Evidence-generating research	▪ Budgetary allocations for evidence-generating and operational research on topical HIV response issues/themes	Research on topical HIV themes/issues conducted
		8.3. Monitoring, evaluation, and research products (reports) disseminated	▪ Publications and bulletins are made public using appropriate media. ▪ Organization of national and or international level symposia ▪ Use public meetings to publicize findings from research, monitor and evaluation products	Analysis and research findings known and or used by stakeholders in the HIV response

Annex 2: Glossary of terms used in the NMSF IV

Term	Definition
Baseline	A quantity, value, or fact is 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 and 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 is 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 economic resources/inputs are converted to results
Empowerment	Action taken to overcome obstacles arising from inequality between people and gender-based, between 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 a common line relationship of a paternal, maternal or parental nature.
Gender	Refers to the social conceptualization of males and females based on social differences and relations between them that are learned, 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 the development of their ability, collectively and individually to take control of their lives, to identify their needs, and 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 the 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, and social and economic welfare, which should be enjoyed by all human beings irrespective of their sex, colour, or creed.

Human Rights-Based Approach:	This entails consciously and systematically paying attention to human rights in all aspects of programme development. HRBA is a 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 contributes to lessening the burden of HIV and AIDS, poverty, and income inequalities.
Impact result	Long-term positive changes in the lives of people, conditions, or organisations arise from an intervention.
Input	Pre-requisite resources (human, information, finance) required to support activity implementation to produce outputs.
Multiple and concurrent sexual partners	Multiple partnership is a situation where a man or woman has more than one sexual partner and overlapping or a situation where the partners are actively engaged at 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 behavior (values, attitudes, practices, etc.) of, or the use of new capacities (laws, policies, etc.) by the target group (people and institutions).
Output:	Operational changes or new capacities (knowledge, skills, 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 a 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 the 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 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	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 increase the possibilities of their exposure to HIV infection

Annex 3: Selected Indicators

Indicator Description	Baseline		Targets	Data source
	Value	Year	2026	
Percent of HIV-positive pregnant and lactating / breastfeeding women who know their HIV status.	96%	2016	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%	THIS
Percent of HIV-positive pregnant and lactating / breastfeeding women with viral suppression.	87%	2017	100%	HMIS-DHIS-2
Percentage of MSM who used a condom at last anal sex	48	2012	68%	IBBSS
Percentage of FSW in contact with/ reached by prevention services	69%	2017	70%	LGMD
Percentage of Fishermen in contact with/ reached by prevention services	0	2018	70%	LGMD
Percentage of Prison Inmates in contact with/ reached by prevention services	0	2018	70%	LGMD
Percentage of miners in contact with/ reached by prevention services	0	2018	85%	LGMD
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	95%	THIS
Percentage of youth 15-24 who used a condom at last sexual intercourse	M: 42% F: 37%	2016	80%	TDHS
Proportion of men 15-29 circumcised	81%		95%	THIS
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	95%	HMIS-DHIS-2
Number of individuals who test for HIV and received their results (by age and gender and category (if they are key populations))	7m	2016	9m	HMIS/DHIS
Proportion of PLHIV who knows their HIV status at the end of reporting period	52%	2017	95%	THIS
Percentage of people living with HIV who have been stigmatized or experienced discriminatory acts due to their HIV status	28%	2013	0%	Stigma Index
Domestic and international HIV expenditure by programme categories and financing sources	US$ 485,296,049	NASA 2014/15	US$ 1,548 million	NASA

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