THE UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

TANZANIA COMMISSION FOR AIDS

National HIV Prevention Road Map 2023/24- 2026/27

MARCH 2024

'LAST MILE EFFORTS TO ENDING AIDS AS A PUBLIC HEALTH THREAT BY 2030'

FOREWORD

The Government of Tanzania, through support from multilateral and bilateral agencies, has, for nearly three decades, in multi-sectoral response efforts to control the AIDS epidemic nationwide. Significant progress has been registered to date, particularly in the reduction of AIDS-related morbidity and mortality. With regard to progress towards achieving global goals and targets, the recently released Tanzania HIV Impact Survey 2022-2023 (THIS 2022-2023) indicated that 82.7% of individuals aged 15 years and older living with HIV were aware of their HIV-positive status (84.8% of women and 78.4% of men); amongst those, 97.9% were on ART (98.4% of women and 96.7% of men); and out of these, were on ART, 94.3% had achieved viral load suppression (94.9% of women and 92.9% of men). However, despite this progress, the rate of decline of new infections remains persistently slow. The survey found that there were approximately 60,000 new cases of HIV among adults in Tanzania during the survey year (less than a 50% decline from the 2010 baseline of 110,000). This is far from the global goal to reduce new HIV infections by 75% by 2020 and makes Tanzania one of the 28 countries contributing to most of the global total of new HIV infections.

In October 2017, 50 like-minded organizations (UNAIDS Cosponsors, civil society, public and private sector funding partners, and UN Member States) formed the Global HIV Prevention Coalition (GPC, or the Coalition), co-convened by UNAIDS and UNFPA. They endorsed the 2020
Road Map as the strategy to achieve the 2016 Political Declaration on HIV prevention targets, initially focusing on 25 countries that were reporting most of the global total of new HIV infections. In 2018, three more countries and the Southern African Development Community (SADC) joined the coalition, totaling 34 members (including countries that have made significant progress in reducing new HIV infections). Tanzania adopted the HIV Prevention 2020 Road Map, including the 10-point actions. The adopted 2017 - 2020 Road Map was aligned with the NMSF IV and HSHSP IV and was built around five (5) prevention pillars – combination HIV prevention for key and priority populations, Combination HIV prevention for Adolescent Girls and Young Women (AGYW), Comprehensive Condom Program (CCP), Pre-Exposure Prophylaxis (PrEP), and Voluntary Medical Male Circumcision (VMMC).

In July 2022, the coalition released a new Road Map that charts a way forward for country-level actions to achieve an ambitious set of HIV prevention targets by 2025. Those targets emerged from the 2021 Political Declaration on HIV and AIDS, which the United Nations General Assembly adopted in June 2021 and are underpinned by the Global AIDS Strategy (2021–2026). The 2025 Road Map builds on the previous HIV Prevention 2020 Road Map and responds to the need for stronger action against the inequalities that hold back progress. It takes account of an evolving context that is marked by persistent pandemics and economic challenges.

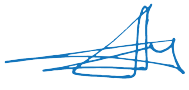
In alignment with the GPC guidance, under the leadership of TACAIDS and NASHCoP, the Government of Tanzania engaged in a multi-stakeholder consultative process to adopt and domesticate the global Road Map. Therefore, this National HIV Prevention Road Map 2023/24-2026/27 has been developed to reflect the local context and needs. The domesticated National Prevention 2025 Road Map is aligned with the Southern Africa Development Community (SADC) Road Map for Health and HIV and AIDS Sustained Responses, the East and Southern Africa (ESA) commitments, the fifth National Multi-Sectoral Framework (NMSF V) 2021/22-2025/26, the fifth Health Sector HIV and AIDS Strategic Plan (HSHSP V) 2021-2026, the fifth Health Sector Strategic Plan (HSSP V) 2021-2026, the third National Five Year Development

Plan (FYDP III) 2021/22 – 2025/26, and the Tanzania Development Vision 2025. Underpinning the Road Map is the Global AIDS Strategy goal to Ending Inequalities and Getting on Track to End AIDS by 2030.

The National HIV Prevention Road Map 2023/24-2026/27 sets an ambitious goal to reduce new HIV infections by 85% in 2025, using 2010 as the baseline. To achieve this, as emphasized in the NMSF V and HSHSP V, the Road Map acknowledges the importance of scaling up evidence-based prevention strategies across all population segments at risk, ensuring equitable reach. Special attention is given to effectively engaging with and providing comprehensive support to classical key and vulnerable populations (KVPs), including female sex workers, men who have sex with men, and people who inject drugs alongside adolescents and young adults. Additionally, the strategies recognize the need to extend these efforts to other previously underrepresented KVPs (e.g., fisherfolks, miners, long-distance truck drivers, plantation workers, and the sexual partners of KVPs) to ensure a more inclusive and effective response. 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. 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.

As we stand at the precipice of a pivotal moment in our collective journey towards eradicating HIV/AIDS, it is both an honour and a duty to present the National HIV Prevention Road Map for Tanzania, covering the period from 2023/24 to 2026/27. This document is not just a testament to our resilience and dedication but also a beacon of hope for the future we are committed to creating—a future where HIV/AIDS no longer shadows our communities but is a challenge we have overcome together. Our journey has been long and fraught with challenges, yet it is the unwavering spirit of our people and the steadfast support of our global partners that have brought us to this juncture. The strides we have made in combating HIV/AIDS reflect a nation united against a common enemy, armed with compassion, innovation, and an indomitable will to protect the most vulnerable among us. This Road Map is a culmination of years of research, dialogue, and collaboration across various sectors. It draws upon the lessons we have learned, the successes we have celebrated, and the setbacks from which we have rebounded stronger and more determined. It is a strategic blueprint designed to guide our actions in the next crucial years as we strive to reduce new HIV infections, improve the quality of life for those living with HIV, and ultimately, achieve our goal of ending AIDS as a public health threat by 2030. This document delineates a comprehensive approach that addresses the multifaceted nature of the HIV/AIDS epidemic. Our strategies are inclusive, evidence-based, and tailored to meet the unique needs of our diverse population. From enhancing access to preventive services and expanding treatment and care services to integrating HIV prevention into broader health and social services, our approach is holistic and grounded in the principles of equity, dignity, and respect for all.

As we journey forward with the National HIV Prevention Road Map 2023/24-2026/27, we are called to strengthen our mutual commitment and work towards a future where Tanzania is free from HIV/AIDS. Our collective resolve and unity are crucial for overcoming significant challenges. This document is not just a strategy but a rallying cry for all to contribute towards turning the tide against HIV/AIDS, aiming to end it as a public health threat by 2030 through our combined efforts, compassion, and dedication.



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Dr. Jerome Kamwela
ACTING EXECUTIVE DIRECTOR
TANZANIA COMMISSION FOR AIDS

ACRONYMS

ABYM	Adolescent Boys and Young Men
ABC/M	Activity-Based Costing and Management
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ASM	Age Structured Model
ATE	Association of Tanzania Employers
AYAS	Adolescent and Young Adult Stakeholders
CABLA	Long-Acting Cabotegravir
CC	Constant Coverage
CCP	Comprehensive Condom Programming
CDC	Centers for Disease Control and Prevention
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organizations
DCEA	Drug Control Enforcement Agency
DHIS	District Health Information System
DoD	Department of Defense
DRMCH	Directorate of Reproductive, Maternal and Child Health
DPP	Directorate of Policy and Planning
DSDM	Differentiated Service Delivery Model
EIMC	Early Infant Male Circumcision
ESA	Eastern and Southern Africa
FBO	Faith-Based Organization
FCI	Faith-Based Community Initiatives
FHR	Female at High Risk
GBV	Gender-Based Violence
GC	Grant Cycle
GDP	Gross Domestic Product
GF	Global Fund
GPC	Global Prevention Coalition
HAPCA	HIV/AIDS Prevention and Control Act
HIV	Human Immunodeficiency Virus
HLI	Higher Learning Institution
HSHSP V	Health Sector Strategic Plan V
HTS	HIV Testing Services
IBBS	Integrated Biological and Behavioral Surveillance
IEC	Information, Education, and Communication
JTWG	Joint Technical Working Group
KP	Key Population
KVP	Key Vulnerable Population
MPT	Multipurpose Prevention Technology
MSD	Medical Stores Department
MTCT	Mother-To-Child Transmission
MoH	Ministry of Health
MOJCA	Ministry of Justice and Constitutional Affairs
MOEST	Ministry of Education, Science and Technology
MOT	Modes of Transmission
MHR	Men at High Risk

M-TEF	Medium-Term Expenditure Framework
NAC	National AIDS Council
NASHCoP	National AIDS, STI, and Hepatitis Control Program
NHIF	National Health Insurance Fund
NGO	Non-Governmental Organization
NMSF V	National Multisectoral Strategic Framework V
NSP	National Strategic Plan
O-CCF	Optimization- Constant Coverage Funding Scenario
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV/AIDS
PMO	Prime Minister's Office
PMTCT	Prevention of Mother-To-Child Transmission
PO-RALG	President's Office - Regional Administration and Local Government
POPSM GG	President’s Office Public Service Management and Good Governance
P-SAT	Prevention Self-Assessment Tool
PTWC	Prevention Technical Working Committee
PWID	People Who Inject Drugs
RCA	Root Cause Analysis
RLA	Research and Learning Agenda
RMNCAH	Reproductive, Maternal, Neonatal, Child, and Adolescent Health
RNM	Resource Needs Module
SBCC	Social and Behavioral Change Communication
SoP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRHS	Sexual and Reproductive Health Services
STIs	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities, Threats
TAC	Technical AIDS Committee
TasP	Treatment as Prevention
TMA	Total Market Approach
TWC	Technical Working Committee
U=U	Undetectable Equals Untransmittable
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VAM	Violence Against Men
VAWC	Violence Against Women and Children
VEO	Village Executive Officer
VMMC	Voluntary Medical Male Circumcision
VMAC	Village Multi-Sectoral AIDS Committee
WEO	Ward Executive Officer
WHO	World Health Organization
WLHIV	Women Living with HIV
WMAC	Ward Multi-Sectoral AIDS Committee
ZBTC	Zonal Blood Transfusion Centre

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1.0. INTRODUCTION

1.1. Background

The United Republic of Tanzania, a lower-middle-income country since July 2020, is the largest East African country, covering an area of 947,300 square kilometres and constituting about 30% of the population in the region.[1] The country borders Kenya and Uganda to the North, Rwanda, Burundi, and the Democratic Republic of Congo to the West, Zambia, Malawi, Mozambique to the South, and the Indian Ocean to the East. The 2022 National Population and Housing Census shows that the population of Tanzania is estimated at 62 million, an increase of 37% from 2012 (~60 million in Mainland and ~1.9 million in Zanzibar).[2] Nearly 44% of the population is below 15 years of age, while about 54% are between 15 and 64. In accordance with the country's vision 2025, Tanzania aims to achieve the following by 2025: a) High-quality livelihood; b) Peace, stability, and unity; c) Good governance; d) A well-educated and learning society; and e) A competitive economy capable of producing sustainable growth and shared benefits.

In this regard, investing in multi-faceted HIV response efforts to protect the health and well-being of the country's productive workforce is pivotal for the country's sustainable economic growth. HIV has a complex relationship with poverty.[3] Poverty can make people more vulnerable to HIV infection. Women and girls may find that, in the absence of other means to raise resources, they are in situations where they sell sex in order to pay for food, housing, or education. In their efforts to meet their most basic needs, vulnerable people are often unable to negotiate condom use or avoid intimate partner violence and are at risk of exposure to HIV. Households affected by HIV are more vulnerable to falling into and remaining in poverty. People living with or affected by HIV may be unwell or spend extended periods seeking health services. Consequently, they may be absent from their work, unable to produce food or feed themselves, or unable to maintain their homes. Parents may be forced to take their children out of school to work in the family home, business, or farm. These children are then denied a proper education and the opportunity to secure a higher-paying job or a brighter economic future.

At global, regional, national, and community levels, progress in HIV prevention and treatment is faltering around the world, putting millions of people in grave danger. Data shows that every day, 4000 people— including 1100 young people (aged 15 to 24 years)—become infected with HIV[4] . If current trends continue, 1.2 million people will be newly infected with HIV in 2025—three times more than the 2025 target of 370,000 new infections. The human impact of the stalling progress on HIV is chilling. In 2021, 650,000 [500 000–860 000] people died of AIDS-related causes—one every minute.[5] With the availability of cutting-edge antiretroviral medicines and effective tools to properly prevent, detect, and treat opportunistic infections such as cryptococcal meningitis and tuberculosis, these are preventable deaths. Without accelerated action to prevent people from

[1] mpo-tza.pdf (worldbank.org)
[2] matokeo.pdf (nbs.go.tz)
[3] HIV/AIDS and poverty - the critical connection (ilo.org)
[4] Full report — In Danger: UNAIDS Global AIDS Update 2022
[5] key-facts-hiv-2021-26july2022.pdf (who.int)

reaching advanced HIV disease, AIDS-related causes will remain a leading cause of death in many countries. In addition, continued rising new HIV infections in some regions could halt or even reverse progress made against AIDS-related deaths.

Countries need to capitalize on efforts to strengthen political leadership, enhance community engagement, employ rights-based and multisectoral approaches, and harness the consistent use of scientific evidence to guide concerted action. This is very important considering the global declining trends of developmental assistance for HIV (in 2021, international resources available for HIV were 6% lower than in 2010) coupled with falling domestic financing of HIV programming in low- and middle-income countries (in 2021, average domestic funding reduced by 2%). Global economic conditions and the vulnerabilities of developing countries—which are exacerbated by growing inequalities in access to health financing and commodities—threaten both the continued resilience of HIV responses and their ability to close HIV-related inequalities. High levels of indebtedness further undermine governments' capacity to increase HIV investments. Debt servicing for the world's poorest countries has reached 171% of all spending on health care, education, and social protection combined.[6] Increasingly, paying off the national debt is crowding out health and human capital investments that are essential to ending AIDS. Middle-income countries—home to 71% of people living with HIV and 71% of people newly infected with HIV—are in danger of being declared ineligible for HIV funding as donor countries redirect their resources to other newly emerging priorities (e.g., supporting refugees in countries experiencing wars and shifted focus to emerging pandemics).

Although new HIV infections globally continued to decline during the COVID-19 pandemic, the reduction in new infections in 2021 was the smallest annual decline since 2017. Based on current trends, 1.2 million people will be newly infected with HIV in 2025—almost three times higher than the 2025 target. Based on the modelling conducted on behalf of UNAIDS and the World Health Organization (WHO), results have shown that a six-month disruption to medical supplies could have resulted in an additional 500,000 AIDS-related deaths in sub-Saharan Africa alone by the end of 2021. Global pandemics can potentially reverse all the achievements gained over the years.

The United Republic of Tanzania joins other countries globally in applying evidence-based interventions to achieve set global and regional targets and goals. This is why, in 2021, following the development of the new Political Declaration on HIV and AIDS (2021) and the Global AIDS Strategy – End Inequalities. End AIDS (2021-2026), the Government of Tanzania engaged multiple stakeholders to revise its two blueprint HIV/AIDS strategies (i.e., the Fifth National Multi-Sectoral Framework [NMSF V] – 2021/22 -2025/26, and the Fifth Health Sector HIV and AIDS Strategic Plan [HSHSP V] – 2021- 2026) in order to align with the new global guidance. As part of this process, the national HIV prevention targets were adjusted to "New HIV infections reduced by 85% in 2025 from the 2010 baseline". Both the NMSF V and HSHSP V strongly emphasize 'amplifying' evidence-based prevention strategies at scale by targeting all population segments at risk 'equitably'. This includes 'effectively reaching' and 'saturating' the classical key and vulnerable populations (KVP) such as female sex workers, men who have sex

[6] https://unctad.org/publication/world-investment-report-2022

with men, people who inject drugs, adolescent girls/boys, and young women/men as well as other unreached KVP, which include fisherfolks, miners, long-distance truck drivers, plantation workers and sex partners of KVP, among others. Additionally, the strategies call for an increased focus on reaching segments of the underserved general population (for whom there have not been concerted efforts to target them in an impactful manner) with the 'right mix and dose' of HIV prevention interventions. The HIV Prevention Road Map 2023/24 – 2026/27 developed is meant to guide all stakeholders seeking to reduce new HIV infections in Tanzania.

Triggered by the slow progress towards ending AIDS as a public health threat by 2030, in the 2016 Political Declaration on Ending AIDS of the United Nations General Assembly, Member States committed to reducing the annual number of people newly infected with HIV globally to fewer than 500 000 by 2020 (a 75% reduction from the 2010 baseline). In tandem with this endeavour, the Global HIV Prevention Coalition (GPC) was launched in October 2017 to help reboot HIV prevention. The initial GPC's priorities were to map a clear path toward these 2020 prevention targets, marshal more substantial commitment, and generate greater investment for prevention programs. At the coalition's first meeting, the GPC endorsed an HIV 2020 Prevention Road Map featuring a 10-point action plan for countries and supplementary actions for development partners and civil society organizations.[7]

1.2. Tanzania's First National HIV Prevention Road Map 2017-2020

Tanzania constitutes one of the 34 focus countries that adopted the Prevention 2020 Road Map and has been monitoring the progress of implementing the 10-point actions and reporting them to GPC as required. The adopted 2017 - 2020 Road Map was aligned with the NMSF IV and HSHSP IV and was built around five (5) prevention pillars – combination HIV prevention for key and priority populations, Combination HIV prevention for Adolescent Girls and Young Women (AGYW), Comprehensive Condom Program (CCP), Pre-exposure Prophylaxis (PrEP), and Voluntary Medical Male Circumcision (VMMC). While the most accurate metric for gauging the impact of HIV primary prevention efforts is through measuring HIV incidence, the implementation status of the 10 HIV Prevention Road Map Action Points serves as a credible process indicator for measuring prevention efforts. This is why, in tandem with periodic HIV impact surveys and statistical modelling, countries implementing the HIV Prevention Road Map also conduct annual self-assessments of the action points and report the findings to the GPC secretariat. Table 1 provides an illustrative summary of the annual progress in implementing the 10-point actions for Mainland Tanzania from 2017-2020.

Table 1: Progress in implementing the 10-point Road Map actions, 2017–2020

Action Number	10 Point Road Map 2020 Actions	2017 Baseline	2018	2019	2020
1	Needs Assessment				

7 HIV Prevention 2020 Road Map (https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/03/JC2909_INCLUSION-GAP_013_En-2.pdf)

Action Number	10 Point Road Map 2020 Actions	2017 Baseline	2018	2019	2020
2	Prevention Targets				
3	Prevention Strategy				
4	Policy Reform				
5a	Key Population Size Estimates				
5b	Defined Key Population Package				
5c	Young Women Size Estimates				
5d	Young Women Package				
6	Capacity and Technical Assistance Plan				
7	Social Contracting				
8	Financial Gap Analysis				
9	Strengthen Monitoring				
10	Performance Review				

Key

Done | In Progress | Not Done | Progress Not Submitted

Based on the assessment findings illustrated above, from adopting the Road Map in 2017-2020, Tanzania has made remarkable steps in strengthening the leadership, oversight, accountability, and coordination of HIV prevention response at the national level.

2.0. CURRENT SITUATION OF PREVENTION IN MAINLAND TANZANIA

2.1. Tanzania's HIV Epidemiological Profile

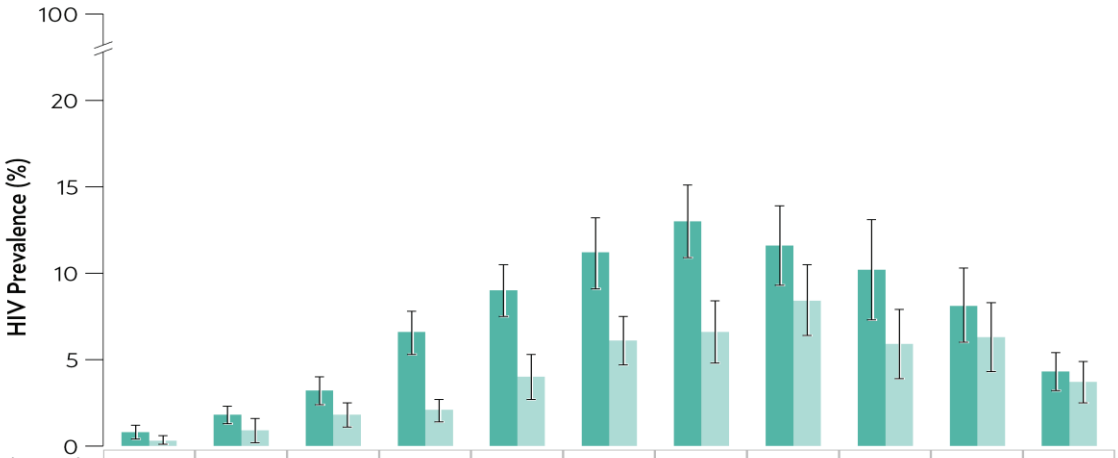
HIV prevalence

Tanzania is one of the highest 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, 4.7% in 2016/2017and 4.4% in 2022/23, 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.[8] The prevalence of HIV varies geographically from 0.4% to 12.7%, with regions in the southern highlands having the highest prevalence (i.e., Iringa, Njombe, and Mbeya). 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. The reasons for this pattern are

[8] THIS2022-2023_Summary_Sheet.pdf (nbs.go.tz)

unclear, but it may indicate declining incidence rates in at least successive younger age cohorts. Among women, HIV prevalence ranged from 0.8% in those aged 15-19 years to 13.0% in those aged 45-49 years. HIV prevalence was also over 10% among women in the age groups from 40-59 years, markedly higher than HIV prevalence among those in the age groups from 15-34 years (mostly targeted by HIV prevention interventions). Among men, HIV prevalence varied from 0.3% among those aged 15-19 years to 8.4% among those aged 50-54 years. It was close to or over 6% in age groups from 40-64 years. HIV prevalence was markedly higher among women than among men in the age groups between 30-49 years. This is an interesting observation because, programming-wise, there are no specific interventions targeting this segment of the female population. Figure 1 illustrates the observation described above.

Figure 1: HIV Prevalence by Gender and Age



Ages (years)	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Women	0.8%	1.8%	3.2%	6.6%	9.0%	11.2%	13.0%	11.6%	10.2%	8.1%	4.3%
Men	0.3%	0.9%	1.8%	2.1%	4.0%	6.1%	6.6%	8.4%	5.9%	6.3%	3.7%

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. In terms of PLHIV's awareness about their status, THIS 2022/23 shows that 82.7% of adults (aged 15 years and older) living with HIV are aware of their HIV-positive status (84.8% among women and 78.4% among men). Individuals were classified as aware if they reported their HIV-positive status or had a detectable antiretroviral (ARV) in their blood. However, disparities are observed in knowledge of HIV status among adolescents and youth. Program data shows that as of the end of December 2022, only 66% of the 10-19-year-olds and 73% of 20-24-year-olds were aware of their HIV status. This is of significance because the infected individual poses a high risk of onward transmission of HIV to their sexual partners.

Besides the variability in HIV prevalence by age and geography, the earlier conducted modes of transmission (MOT) studies showed a disproportionately high burden among key and vulnerable populations (KVP). These populations are defined groups that, due to specific high-risk behaviours, are at an increased risk of acquiring HIV, irrespective of the epidemic type or context. KVP often face legal and social issues related to their behaviour that increase their

vulnerability to HIV and limit their access to services. The WHO guidelines focus on five key populations: 1) men who have sex with men, 2) people who inject drugs, 3) people in prison and other closed settings, 4) sex workers, and 5) transgender people. On the other hand, vulnerable populations include groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls and young women in sub-Saharan Africa), orphans, street children, people with disabilities, and migrant and mobile workers. In the Tanzanian context, mobile populations include long-distance truckers, fisher folks, miners, specifically small-scale miners, construction workers, and displaced people, to mention a few. Collectively, KVP are pivotal to the epidemic because of the risk of onward HIV transmission. However, with increased efforts to reach this group using public health approaches, downward trends in HIV prevalence have been observed. Program data shows that the prevalence of HIV in Tanzania declined among Female at High Risk (FHR) from 31% in 2010 to 15.3% in 2017; among men at High Risk (MHR) from 22.3% in 2014 to 8.3% in 2017, and among people who inject drugs (PWID) from 15.5% in 2014 to 8.7% in 2017. [9, 10, 11]

HIV incidence

Even though the number of new HIV infections has been declining steadily over the years, UNAIDS Spectrum estimates showed a decline from 110,000 new HIV infections in 2010 to 61,281, a 38% reduction against the target of 75% by 2020 despite the investments. Tanzania HIV Impact Survey (THIS) 2016/17 showed an annual incidence rate of HIV infection among adults of 0.34% in women, 0.17% in men, and 0.24% overall. 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%). On the other hand, THIS 2022/23 shows an annual incidence of HIV among adults (aged 15 years and older) in Tanzania of 0.18%, which corresponds to approximately 60,000 new cases of HIV per year among adults. Similarly, variation by sex is observed, whereby HIV incidence is 0.24% among women and 0.11% among men. Therefore, in terms of trends of new HIV infections, compared to the progress registered as of 2022 (i.e., 38% reduction), there is a remarkable decline of close to half (45%) in comparison with the 2010 baseline. Of significance to note is that spectrum data shows that over 34.3% of new HIV infections occur among adolescent young people, and out of these, nearly three-quarters (74.1%) are contributed by adolescent girls and young women.

Vertical Transmission of HIV Infection

Mother-to-child transmission (MTCT) rates of HIV in Tanzania remain a challenge, contributing towards a mother-to-child transmission of HIV infection rate of 6.91% in 2022 against the global and national target of <5%. The timely identification and provision of ARV medication to HIV-infected pregnant and breastfeeding women is the most vital intervention to prevent MTCT of

[9] HIV prevalence among men who have sex with men following the implementation of the HIV preventive guideline in Tanzania: respondent-driven sampling survey | BMJ Open

Prevalence and risk factors associated with HIV-1 infection among people who inject drugs in Dar es Salaam, Tanzania: a sign of successful intervention? - PMC (nih.gov)

[11] HIV prevalence and associated risk factors among female sex workers in Dar es Salaam, Tanzania: tracking the epidemic - PubMed (nih.gov)

HIV among exposed infants during pregnancy, labour and delivery, and breastfeeding. The proportion of pregnant women enrolled in PMTCT services reached 92% in 2019. However, there are poor retention rates (67% and 83%) among pregnant and lactating mothers. Generally, in 2020, a total of 75,719 pregnant women were identified with HIV at Ante-natal Care (ANC); about 69% of them were already known to be HIV-infected during their ANC booking, and about 31% were newly diagnosed HIV positive. The PMTCT program provided ART to 97.7% of pregnant women living with HIV. Forty-eight per cent of pregnant and lactating women had a viral load test in 2019, and the majority (93%) of those tested attained viral suppression. Despite the geographical disproportionality, the coverage of HIV testing 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. Maternal HIV retesting during the third trimester of pregnancy was only 27.7% in 2020 and has never exceeded 30% in the past three years. Furthermore, a high proportion of PMTCT clients drop out of care, the highest dropout being within the first twelve months (26%, 30%, and 33% at 3, 6, and 12 months respectively), a period at which they are transitioning from PMTCT to CTC. This drop may be attributable to stigma and discrimination. The elimination of Mother-to-Child Transmission of HIV highly depends on timely ANC attendance and quality care. The utilization of antenatal care services in Tanzania has been almost universal for many years. However, early ANC attendance (before 12 weeks of gestational age) has been low due to several factors, which include, but are not limited to, cultural perceptions.

About one-third (30%) of newly identified women living with HIV (WLHIV) and one-quarter (24%) of all women living with HIV receive ANC services in non-supported HFs. The lack of support for these health facilities has affected the program's overall performance. For instance, the 2020 annual PMTCT report showed a disproportionate HIV prevalence among young women 25 years old attending ANC clinics. About 81% of HIV-infected pregnant women at ANC clinics (known and newly diagnosed as HIV positive) in 2020 were aged >25 years and above. The report further shows that despite the decreased trend of HIV incidence among pregnant and breastfeeding women from 2.09% (2015) to 1% (2020), among the newly diagnosed HIV-infected pregnant women, young women (<25 years old) contributed the most (60% and 61% in 2019 and 2020, respectively). This further justifies the importance of tailoring eMTCT interventions according to specific vulnerabilities of the population segments.

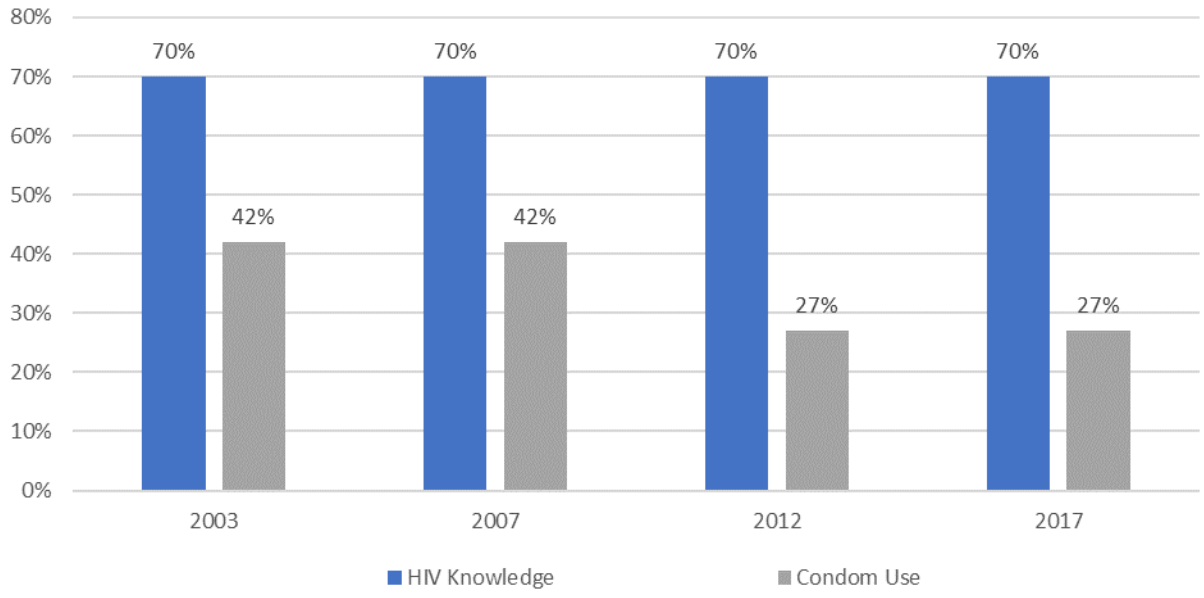
Comprehensive Knowledge of HIV and High-Risk Sex Behavior

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 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 practising 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.

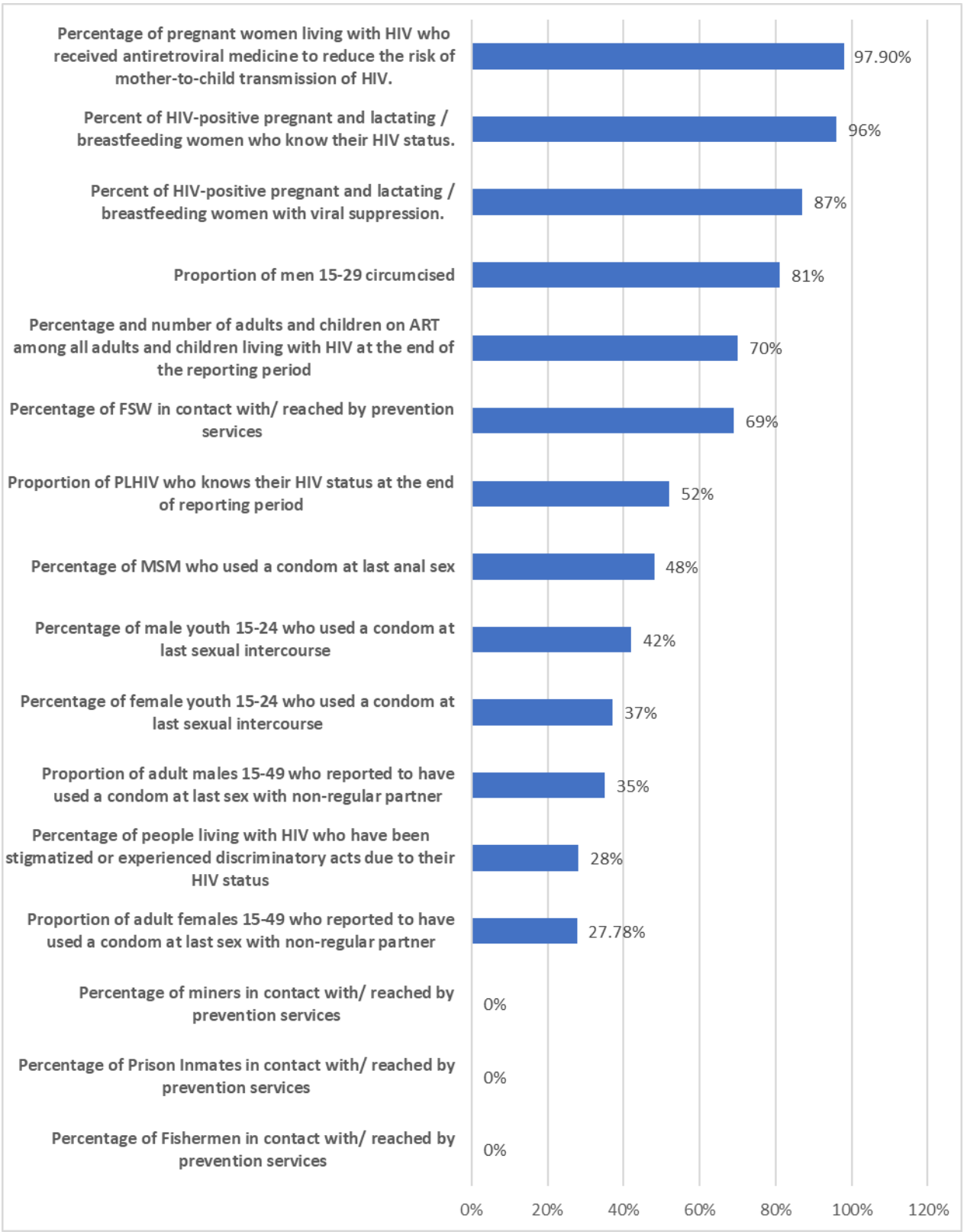
The level of comprehensive knowledge of HIV among KVP is similarly low, with rates of 46% among FHR, 41% for MHR, and 36% for PWID. About 71% of FHR used a condom with their last client. In the month before the survey, 79% of MHR had been paid by other men to have anal sex, 63% of those who had anal 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. Based on this trend, it is unsurprising that comprehensive condom use is also remarkably low and has been declining over the years. Data show that about a third of individuals are practicing condom less sex, and also, about a third of the population do not have comprehensive knowledge of HIV and AIDS. Figure 2 below provides an illustrative summary.

Figure 2: HIV Knowledge and Condom Use



This observation may partially explain the reported high rates of STIs in Tanzania. This is important because the literature suggests that untreated STIs can enhance both the risk of acquisition and onward transmission of HIV and viral hepatitis up to 10-fold. Figure 3 provides an illustrative summary of other parameters associated with HIV risk in Mainland Tanzania.

Figure 3: Other HIV Risk Parameters



Note: For details regarding the data source and year of the data in this figure, refer to NMSF V.

AIDS-Related Mortality

AIDS-related deaths declined significantly from 72,622 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.

Despite this tremendous progress, several barriers remain to ending AIDS as a public health threat by 2030. Box 1 provides an illustrative summary of current gaps as informed by HIV prevention scorecard findings, GPC's prevention self-assessment (P-SAT) results, the mid-term review of the HSHSP IV and NMSF IV, and other program review data available,

Box 1: Current Barriers / Challenges to Meeting HIV Prevention Goals by 2030

- Low coverage and saturation of key and vulnerable populations (classic and non-classic), including vulnerable girls and young women
- Insufficient focus on mature and middle-aged women
- Low and declining comprehensive knowledge of HIV and AIDS
- Persistently low access and use of condoms by at-risk groups
- Low pace of scale-up of new prevention policies and tools
- Low awareness and scale-up of PrEP
- Dwindling investments in VMMC maintenance and sustainability *(data shows that large populations graduate into VMMC eligible population due to a large younger population base)*

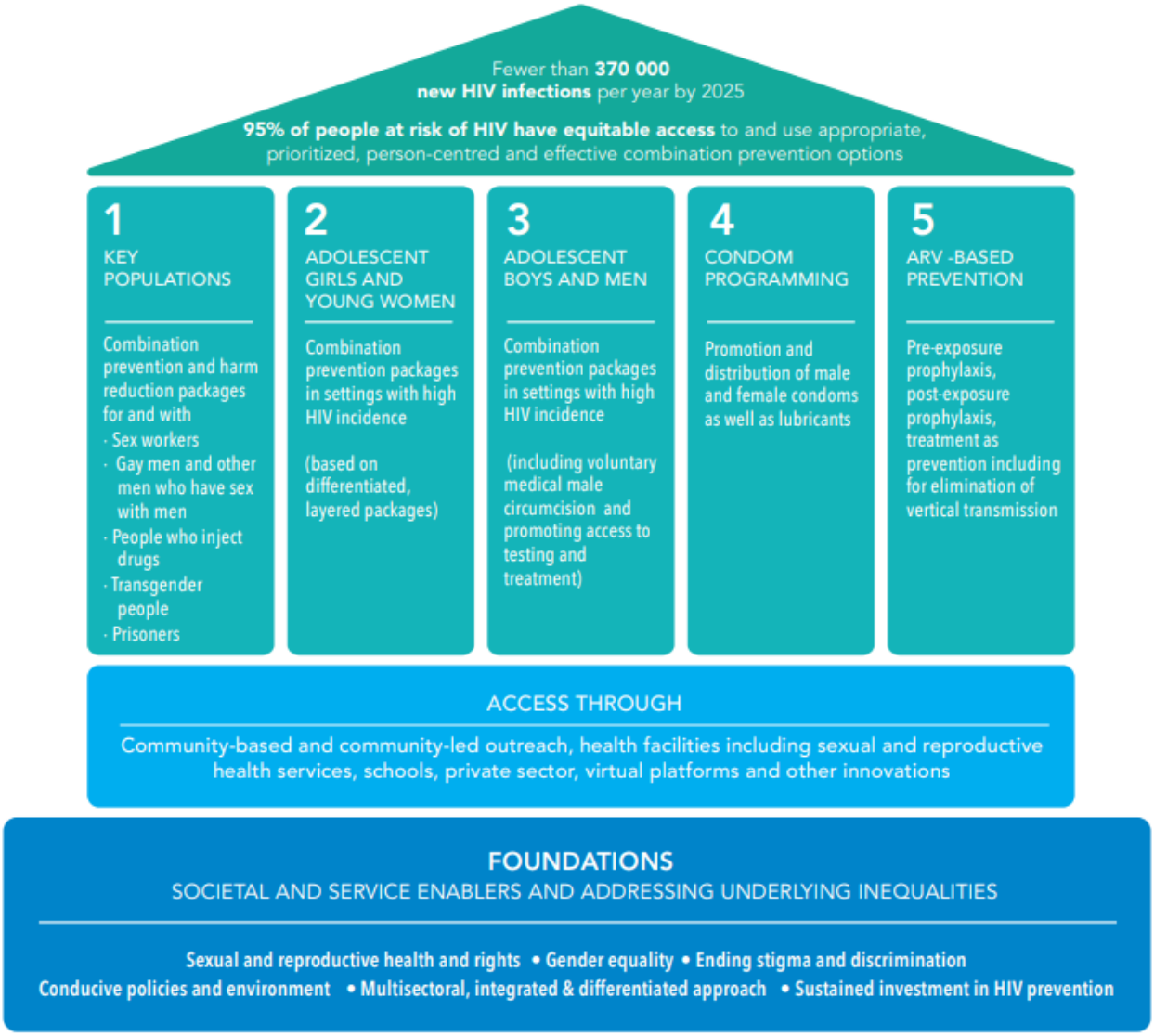
2.2. Status of the Implementation of HIV Primary Prevention Interventions

Alongside other HIV interventions (i.e., HIV testing and antiretroviral treatment scale-up), combination HIV prevention interventions that encompass biomedical, behavioural, and structural interventions remain key for controlling the epidemic. The National HIV Prevention Road Map 2023/24 – 2026/27 has adopted the five prevention pillars described in the Global HIV Prevention 2025 Road Map. These pillars reflect the emphasis in the Global AIDS Strategy (2021–2026) and the demands of an evolving epidemic. Pillars 1–3 describe people-centred combination prevention packages for key populations everywhere and for adolescents and young adults in geographical areas with high HIV incidence. Programs in these pillars include population-specific behavioural and structural actions that ensure communities' access to the full range of prevention choices. Pillar 4 on condoms and Pillar 5 on antiretroviral-based prevention describe high-impact prevention tools that are relevant to all populations. Pillar 5 emphasizes the

vital complementarity between HIV prevention and HIV treatment and care services. Pillar 1, on key populations, applies globally, while Pillars 2 and 3 apply mostly in eastern and southern Africa and some locations in western and central Africa (settings with high HIV incidence). Pillar 4 is also relevant globally, although outside sub-Saharan Africa, it mostly relates to prevention programs for key populations (due to low HIV incidence among other populations and generally widespread availability of condoms on the commercial market). Pillar 5 is also relevant globally, with a focus on key populations and HIV-discordant couples, though it is relevant for other populations as well as in settings in eastern and southern Africa where HIV incidence is high.

The pillars rest on a foundation of other enhancements. These include sustained investments, integrated service delivery platforms, the use of a multisectoral approach, the creation of enabling environments, and actions to reduce inequalities. There is a strong focus on addressing policy and structural barriers that hinder access to prevention services, ending stigma and discrimination, and advancing gender equality. Figure 4 provides an illustrative summary of the implementation period from 2023/24 to 2026/27.

Figure 4: The Five Prevention Pillars for 2023/24 -2026/27 Road Map (Adopted from the GPC's 2025 Global Prevention Coalition Road Map)



PILLAR 1: Combination Prevention for Key Populations

Key populations (KP) are defined groups that, due to specific high-risk behaviours, are at an increased risk of acquiring HIV irrespective of the epidemic type or context. Also, they often face legal and social issues related to their behaviours that increase their vulnerability to HIV and limit their access to services. The WHO guidelines focus on five key populations: 1) men who have sex with men, 2) people who inject drugs, 3) people in prison and other closed settings, 4) sex workers, and 5) transgender people. In the Tanzanian context, the definition has been broadened to include other vulnerable populations (VP) such as migrant and mobile workers (i.e., long-distance truckers, fisherfolks, miners, construction workers, prisoners, displaced people, orphans, homeless children, and people with disabilities, just to mention a few. Sexual partners and children of KVP also fall into this group. Collectively, key and vulnerable populations (KVP) are pivotal to the epidemic because of the risk of onward HIV transmission. In accordance with the UNAIDS 2021 report, data shows that, while KVP accounts for <5% of the global population, they and their sexual partners contribute 70% of new HIV infections. In the Eastern and Southern Africa region, key populations and their sexual partners comprise less

than half of new HIV infections (46% in 2021). Through the current national guidelines, programming KVP uses a public health approach and employs combination prevention approaches. Interventions for creating an enabling environment are also part and parcel of programming. Service delivery modes include facility-based and facility-led community-based approaches. National guidelines clearly stipulate that services should be voluntary, nonjudgmental, accessible, and competent in addressing KVP needs on the continuum of prevention, testing, and treatment services. In alignment with universal health coverage (UHC) 2030 goals, the Road Map is that services are structured in ways that increase equitable access and availability of the minimum package. The package encompasses services for preventing and treating HIV, tuberculosis, viral hepatitis, and sexually transmitted infections (including the provision of condoms and, where appropriate, Pre-Exposure Prophylaxis (PrEP) and post-exposure prophylaxis (PEP). Given the prominence of unsafe injecting drug use due to the limited availability of needle and syringe programs in the HIV epidemics in many countries, comprehensive harm reduction services (including needle and syringe programs and opioid substitution therapy) are part and parcel of the package.

PILLAR 2: Combination Prevention for Adolescent Girls and Young Women in High-Prevalence Locations.

Women and girls continue to be disproportionately affected by HIV, accounting for 63% of the region's new HIV infections in 2021. New HIV infections are three times higher among adolescent girls and young women (aged 15-24 years) than among males of the same age. Since 2010, the decline in new HIV infection has been much sharper among adolescent boys and young men (56%) than among adolescent girls and young women (42%) or older women (aged 25-49 years) (29%). In Tanzania, in the year 2022, spectrum estimates indicate new HIV infections accounted for 54,000 individuals of all ages in Mainland Tanzania. Notably, over 34.3% of these new infections occur among adolescent young people, and out of these, nearly three-quarters (74.1%) are contributed by (AGYW. Program data shows that as of the end of December 2022, only 66% of the 10-19-year-olds and 73% of 20-24-year-olds were aware of their HIV status. Increased investment, including through the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund, has enabled more than 40% of locations with high HIV incidence in 19 focus countries in sub-Saharan Africa to implement dedicated combination prevention programs for young women. According to Tanzania's Scorecard 2022 report, only 26% of locations have a dedicated comprehensive program on AGYW. In order to ensure access in 95% of locations with high HIV incidence, those efforts must become more widespread. The HIV Prevention 2023/24-2026/27 puts a strong focus on AGYW by prioritizing the vulnerable ones. In accordance with the current guidelines, the recommended service packages include comprehensive sexuality education (in and out of school), HIV and sexual and reproductive health services (including male and female condoms and other contraceptive tools), antiretroviral-based prevention and harm reduction for women who use drugs. Gender inequalities and discrimination deny women and girls the ability to realize their basic rights, including their right to education, good health, bodily autonomy, and economic well-being—all of which can also reduce their risk of HIV infection. Combination prevention packages, therefore, comprise interventions to change harmful gender norms, end gender-based discrimination, inequalities, and violence, improve social protection, and support economic empowerment.

PILLAR 3: Combination Prevention for Men and Adolescent Boys in Settings with High HIV Incidence

HIV prevention programs for boys and men remain essential for their health and for the health of their female partners. This population segment has diverse needs, interests, beliefs, and unique barriers to accessing health services. Furthermore, evidence suggests that the main fueling factor that raises the HIV acquisition risk among AGYW is the presence of a high prevalence of non-virally suppressed HIV-infected ABYM and adult males in a particular locality. Therefore, preventing HIV infection among men and adolescent boys and linking them to HIV services to reduce their own risk, as well as the likelihood of transmitting the virus to their female partners, is critical. Therefore, Tanzania's HIV Prevention Road Map 2023/24-2026/27 emphasizes offering an expanded package of HIV prevention for men and boys while maintaining a strong focus on the provision of condoms, as well as on voluntary medical male circumcision. Some of the at-risk populations described in the earlier section (i.e., long-distance truckers, fisherfolks, miners, construction workers, prisoners, and partners of KP) are part of this population. In recognition of the diverse needs of this group, the Road Map focuses on providing male-friendly services within and outside clinic settings. This entails community-based HIV testing, self-testing, linkages to early antiretroviral treatment as required, condoms, pre-exposure and post-exposure prophylaxis, comprehensive sexuality education, and other sexual and reproductive health services, and harm reduction. Specifically, voluntary medical male circumcision (VMMC) services need to reach greater numbers of adult uncircumcised men who are at high risk of acquiring HIV infection. Early infant medical circumcision (EIMC) services must also be strengthened as it is an approach to ensure the local sustainability of VMMC. The Road Map emphasizes building sustainable systems to create service demand and improve access, especially for men with lower incomes. In line with the UHC 2030 agenda for the country, these services need to be offered as part of broader sexual and reproductive health services for men and boys. Services include education on safe sex, condom use, provision, and healthy gender norms, as well as information on HIV testing (and linkages to care and treatment, if required) and prevention and management of sexually transmitted infections. It is important to support these services with systematic efforts to promote gender-equitable norms and reduce gender-based violence.

PILLAR 4: Promotion of Condoms

Since the heterosexual route is the most predominant means of acquiring and transmitting HIV, condom programming is among one of the important pillars of primary HIV prevention. Condoms are safe and do not require a prescription. The correct and consistent use of male and female condoms remains the only available highly effective multipurpose prevention technologies (MPT) that provide triple protection in preventing HIV, STIs, and pregnancy. Condoms remain the most widely used HIV prevention method, and they are a low-cost option for large numbers of people who are at moderately high risk of acquiring HIV. Increased condom use is estimated to have averted more than 100 million new HIV infections globally since 1990. Despite its capability to offer dual protection, gaps and inequities in condom access and use persist, and they are widening in several countries in the context of reduced investment. In Mainland Tanzania, implementing the total market approach (TMA) has ultimately increased the market share of public sector condoms from 21% to 50%. However, as of today, huge unmet needs for condoms (including a persistent shortage of female condoms) exist. There is an insufficient number of public condoms due to limited budgetary allocation. Condoms procured meet only 50% of the required needs. But what is also alarming is the fact that, despite the procured condoms can meet 50% of

the projected needs, data also shows that access and utilization of the available condoms is unacceptably low. Close to 70% of at-risk men, adolescent boys, but also women, and adolescent girls are not using condoms during sex. This situation justifies a heavy focus on the National Prevention Road Map 2023/24-2026/27 to strengthen comprehensive condom programming in Mainland Tanzania. Both availability and accessibility challenges need to be addressed. Enhanced demand creation (especially for new generations of potential users), procurement and supply of male and female condoms, social marketing, and private-sector sales must be implemented to ensure full-scale access. Condom program stewardship at national, regional, and district levels needs to be revived. Evidence-based design and TMA in which public, private, and social marketing sectors work in synergy is strongly emphasized.

PILLAR 5: Wider Access to Antiretroviral Based Prevention, including Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

Available data since the inception of care and treatment programs globally provide conclusive evidence of the contribution of viral suppression in preventing HIV transmission. Although statistically, a non-zero risk estimate can never be completely ruled out in a mathematical sense, despite the number of observations, the data tell us that the best estimate for the transmission risk is zero and that future HIV transmissions are not expected when people with HIV remain virally suppressed. If taken as prescribed, antiretroviral therapy (ART) reduces the amount of HIV in the body (viral load) to a very low level, which keeps the immune system working and prevents illness. This is called viral suppression—defined as having less than 1000 copies of HIV per millilitre of blood. HIV medicine can even make the viral load so low that a test can't detect it. This is called an undetectable viral load. Getting and keeping an undetectable viral load by taking ART is the best thing PLHIV can do to stay healthy and prevent transmission of HIV to others through sex. This is sometimes referred to as Treatment as Prevention (TasP). Treatment as prevention may also be referred to as Undetectable Equals Untransmittable (U=U). ART programming also includes providing ART to prevent mother-to-child transmission (MTCT).

Also, evidence shows the role of post-exposure prophylaxis (PEP) in HIV prevention. PEP is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion in exposed individuals (with maximum benefits if it is started as soon as possible and always within 72 hours of possible exposure). Furthermore, evidence also shows that. This Road Map denotes that PEP has been under-utilized in HIV prevention response, and there is a need to revitalize its use, particularly by ensuring that it remains a critical component of the clinical management of rape survivors and in reducing occupational risk and accidental occupational exposures.

Furthermore, evidence shows that pre-exposure prophylaxis (PrEP), where antiretroviral medications are given to negative individuals with a substantial risk of HIV acquisition, is highly effective in preventing HIV when taken as prescribed. Despite progress in providing PrEP, as described earlier, the scale-up remains sub-optimal. THIS 2023 shows that the percentage of individuals aware of PrEP is very low (i.e., 8.8% and 4.9% for urban and rural areas, respectively). As a result of this, only 54.7% of people are willing to take PrEP (i.e., 59.7% and

49% for men and women, respectively).[12] Scale-up plans require an increased investment and actions that address barriers to consistent use. It also calls for linking the roll-out of PrEP with related services (for example, HIV testing and sexual and reproductive health) and with supportive social networks. This is why the national Road Map emphasizes ensuring that PrEP is provided as part of combination prevention interventions. Given the constantly emerging evidence on new prevention technologies, the Road Map includes strategies for rapidly analyzing new evidence and coordinating the prompt introduction of new prevention technologies and approaches as they become available depending on the country's needs. This includes the Dapivirine vaginal ring and long-acting injectable Cabotegravir (CAB-LA). This is expected to expand the choices for HIV prevention available to men, women, adolescent girls, and adolescent boys who are at risk and eligible for PrEP according to the current guidelines.

Newly acquired maternal HIV infections also drive new infections in children during pregnancy and the breastfeeding period. This requires increased focus on primary prevention for women and their partners through platforms for the prevention of vertical transmission of HIV. HIV prevention for women and their partners should be included in national guidelines for preventing vertical transmission, and proven HIV prevention choices, including PrEP, should be promoted for pregnant and lactating women and their partners in areas of high HIV incidence. In view of the above, the National HIV Prevention Road Map 2023/24-2026/27 emphasizes ensuring that primary prevention, HIV treatment, and programs for elimination of vertical transmission need to work hand-in-hand.

2.3. Prevention Programming Focus Informed by Modeling the Impact and Cost of the HIV Interventions

With technical assistance from Avenir Health and through close coordination with UNAIDS/Tanzania SI team, in October 2022, a simulation modelling with the GOALS Age Structured Model (GOALS ASM) was conducted to estimate the impact of achieving the 2025 targets and the expected cost. GOALS ASM, represents HIV transmission driven by age-related factors such as behaviours and use of biomedical interventions. It exists as a module with the Spectrum model, which has been used in Tanzania for many years to produce annual estimates of key HIV indicators. The model uses Spectrum's cohort component projection method to simulate population dynamics and uses Spectrum's AIDS Impact Module (AIM) to model HIV disease progression and mortality by age, sex, and CD4 cell count, track ART status, and simulate mother-to-child transmission. GOALS ASM is designed to model generalized HIV epidemic contexts and represents heterosexual HIV transmission based on age-dependent inputs: rates of partner change, preferential sexual mixing, and the risk of HIV transmission within heterosexual serodiscordant partnerships. These transmission risks depend on condom use within the partnership; the HIV infection stage, ART status, and viral suppression status of the partner living with HIV; and male circumcision status, use of pre-exposure prophylaxis (PrEP) methods, and STI status of the HIV susceptible partner. The model incorporates general population behaviour change programs, including economic empowerment and school-based prevention and sexuality education programs. The impacts of these programs are mediated by their coverage levels and their effects on the frequency of condomless sex and other risk behaviours.

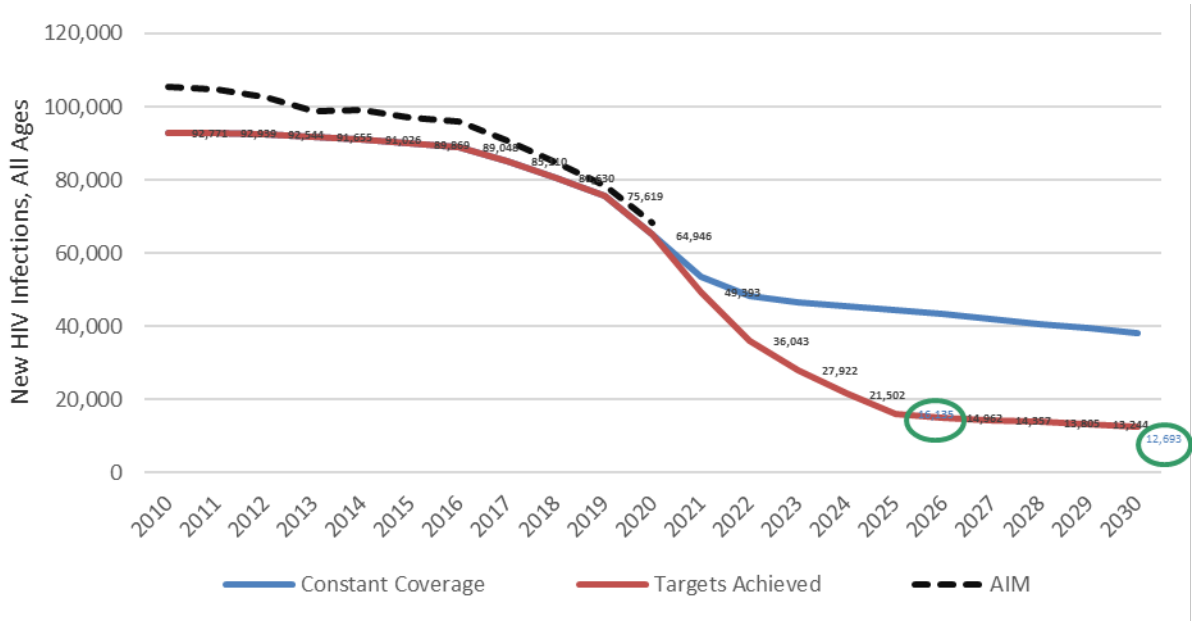
The fitted model can be used to project into the future by making assumptions about the future coverage of HIV interventions. For this analysis, two projections were used:

[12] THIS2022-2023_Summary_Sheet.pdf (nbs.go.tz)

- **Constant coverage:** This projection assumes that the coverage of all interventions remains constant at 2020 levels. This serves as the counter-factual scenario for the calculation of infections and deaths averted.
- **Targets achieved:** This scenario assumes that the 2025 national targets (as per NMSF V & HSHSP V) are achieved.

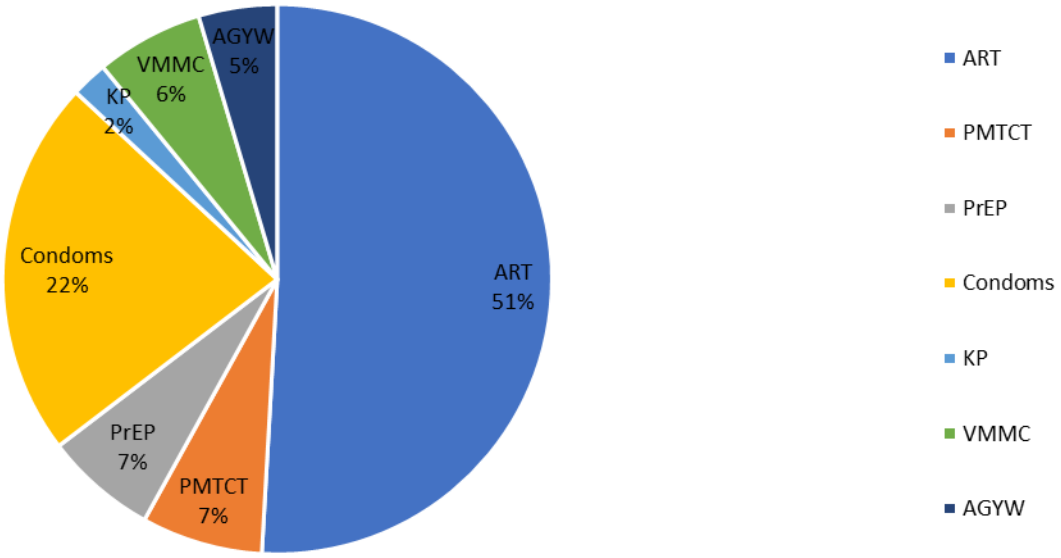
Figure 5 shows the impact of achieving these targets on the number of new infections through 2030. Trends clearly show that reducing new HIV infections by 85% by 2025 and, further by 90% by 2030 (all from the 2010 baseline of 110,000 infections per year) translates into ensuring that there are ≤16,135 and ≤12,693 newly infected HIV individuals in those two-year marks, respectively

Figure 5: Impact of Achieving the Targets on New HIV infections



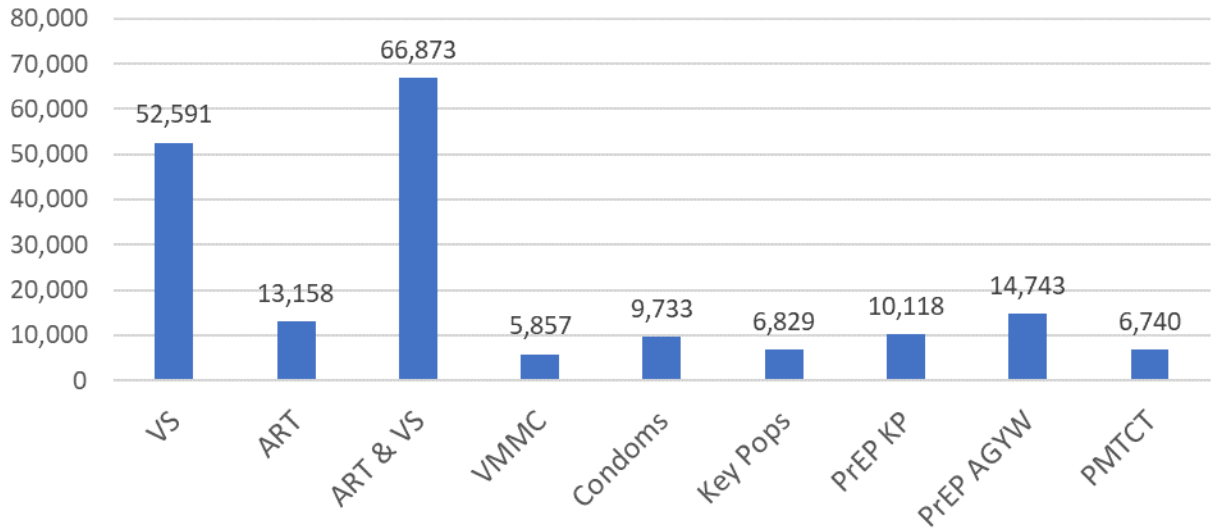
The contribution to this decline by intervention is shown in Figure 6. About half the impact is due to the increased proportion of PLHIV who are virally suppressed on ART. The next largest contributions are from condoms (23%), PMTCT (7%), PrEP (7%), VMMC (7%), key populations (excluding PrEP) (2%), and AGYW programs (1%).

Figure 6. Contribution to Decline in New Infections by Intervention Area



In terms of the cumulative impact on HIV incidence by the different interventions, figure 7 below provides an illustrative summary of the absolute number of new infections averted contributed by each of the interventions (independent or in combination).

Figure 7: Cumulative Infections Averted, 2022-2030 by Intervention Compared to Constant Coverage of All Interventions



Based on the insights brought about by the modelling data, there are several key programmatic considerations for the HIV Prevention Road Map 2023/24 – 2026/27. Box 2 below provides an illustrative summary of issues to be taken into account in the Road Map document.

Box 2: Implications & Considerations of Modeling Results for 2023/24 – 2026/27 HIV Prevention Road Map

- The 95 -95 -95 achievement will only address 50% of incident HIV infections, and therefore, being a low-hanging fruit, the Road Map prioritizes sustaining care and treatment services.
- Condom is the second largest impactful intervention with an estimated 25% attributable impact, but currently has a very low uptake; therefore, the Road Map puts a strong focus on reinvigorating condom programming.
- Promotion and scaling up PrEP are high priorities for the Road Map, considering its efficacy, cost-effectiveness, and low level of access and uptake of this service.
- Road Map continues advocating for increased investments in VMMC programming; this is because the yearly gains are unsustainable due to the younger population and high HIV incidence.
- Informed by the current epidemiological trend, a special focus is put on designing and delivering interventions targeting mature women.

3.0. DEVELOPING TANZANIA'S NATIONAL HIV PREVENTION 2023/24 – 2026/27 ROAD MAP

3.1. Need to Adopt the Global HIV Prevention 2025 Road Map

Globally, HIV remains a significant health challenge affecting all regions, with the brunt of the disease hitting Sub-Saharan Africa. Despite years of investment, besides a few countries whose HIV burden has been reduced, new HIV infections have either plateaued or continue to rise in some other countries. Whilst new HIV infections have reduced by 23% globally and by 38% in the Eastern and Southern Africa region since 2010, UNAIDS reports that HIV infections increased by 72% in Eastern Europe and Central Asia, 22% in the Middle East and North Africa and 21% in Latin America. This unacceptably sluggish reduction in new HIV infections warrants a need for a paradigm shift in programming. This is why, in June 2021, the United Nations General Assembly issued an ambitious new Political Declaration that renewed the call on all countries and all communities to make the necessary shifts to end AIDS as a public health threat by 2030 and accelerate progress toward achieving the Sustainable Development Goals, in particular Goal 3 on good health and well-being. In response to this, member states resolved to take urgent action over the next five years through a coordinated HIV response based on global solidarity and shared responsibility to meet the targets and fully implement the commitments contained in the declaration. In particular, they agreed to prioritize HIV prevention to reach a new global target of reducing new HIV infections to under 370,000 by 2025 (82.5% reduction in new infections). These targets are underpinned by the Global AIDS Strategy (2021–

2026. Accordingly, the GPC issued a revised HIV Prevention 2025 Road Map that charts a way forward for country-level actions to achieve an ambitious set of HIV prevention targets by 2025. The 2025 Road Map builds on the previous HIV Prevention 2020 Road Map (also adopted in Mainland Tanzania to fit the country's context and needs) and responds to the need for stronger action against the inequalities that hold back progress. It accounts for an evolving context marked by persistent pandemics and economic challenges.

The Global HIV Prevention 2025 Road Map is aligned with the Southern Africa Development Community (SADC) Roadmap for Health and HIV and AIDS Sustained Responses and the East and Southern Africa (ESA) commitments. It also serves as a means to facilitate the acceleration of the Abuja Declaration Targets wherein the Member States committed to allocate 15% of national budgets to the health sector across the four pillars, which are Country-led multi-sectoral response, Unwavering political commitment, Investing for impact and increased efficiencies; Improve and accelerate "people-centred" integrated delivery that reaches those left behind (HIV and UHC); and Sustainable multi-sectoral financing for long-term impact. The Road Map is also aligned with the NMSF V and HSHSP V, whose development processes were guided by the **"2021 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030" and the Global AIDS Strategy 2021-2026: End Inequalities, End AIDS."**

Therefore, the Government of Tanzania (Mainland) adopted the National HIV Prevention 2025 Road Map in order to guide country-level efforts to achieve the global and national goals, considering the slow progress towards achieving the prevention indicators (i.e., new infections reduced by only 38% as of 2020 from the 2010 baseline). While the Global Road Map covers the 2021-2025 implementation period, the domesticated Tanzania's National HIV Prevention Road Map covers the 2023/24-2026/27 timeframe. The Road Map seeks to portray a state of urgency given that the HIV prevention targets for 2020 in Tanzania were not met.

3.2. Purpose of the National HIV Prevention 2023/24 -2026/27 Road Map

The purpose of the Tanzania National HIV Prevention Road Map 2023/24 – 2026/27 is to ensure sufficient guidance on HIV prevention program implementation that adequately responds to changing epidemic contexts and addresses existing social, cultural, and legal barriers. The Road Map ensures community participation and service integration to attain clearly defined milestones and targets aligned with global strategies. Specifically, the Road Map seeks to:

- Provide granular details to implementers on the combination of HIV prevention strategies, interventions, and service delivery models defined in the NMSF V and HSHSP V.
- Ensure that the HIV prevention program goals, targets, and strategies are aligned with current global HIV prevention program targets and strategies.
- Provide guidance for geographical and population prioritization of HIV prevention interventions to optimize the reduction of new HIV infections.
- Provide detailed guidance and milestones to facilitate the scale-up of precision combination HIV prevention through community leadership and an integrated approach.
- Identify and adequately respond to the changing epidemic context.
- Facilitate rapid adoption of new technologies, digitalization, and innovations, such as the use of virtual platforms to increase access to services for hard-to-reach populations.

- Ensures multi-sectoral engagement in HIV prevention response efforts.
- Accurately defines HIV prevention resource needs and strengthens resource mobilization and efficient utilization.
- Provide guidance for monitoring and tracking progress in HIV prevention.
- Reinforce HIV prevention leadership and accountability.

3.3. Approach to Road Map 2023/24 – 2026/27 Domestication Process

The process of developing the Road Map was participatory in nature, and it involved a wide range of multiple stakeholders. This iterative process used diverse approaches, including document review, data analysis, and stakeholder engagement. It started with a comprehensive review of the Global HIV Prevention 2025 Road Map and the Global AIDS Strategy 2021-2026. Despite the fact that recently released NMSF V and HSHSP V were informed by the Global AIDS Strategy 2021-2026, the review process revisited these documents to ensure that all pertinent HIV prevention issues and priorities were adequately prioritized in the current national strategies for prevention. In conjunction with this step, consultative data reviews using multiple sources were conducted. This included analyzing the HIV program data (programmatic and modelling), HIV surveys and surveillances, GPC prevention self-assessment (P-SAT) findings, GPC HIV prevention scorecards, as well as other international and national reports depicting HIV trends in Tanzania. Through a series of multi-stakeholder workshops, experts and participants from the health sector and beyond reviewed all the five HIV prevention pillars of focus. The main goal of this systematic process was to ensure that high-impact HIV prevention interventions were identified, standardized and prioritized based on the available evidence, as well as the country's needs and context. Stakeholders also thoroughly reviewed and adopted the 10-point actions action plans to reach the 2025 targets and get on track to end AIDS by 2030. As a part of this process, a Strength, Weakness, Opportunities, and Threat (SWOT) analysis and a Root Cause Analysis (RCA) of the gaps and challenges of both the national response as well as the country's readiness and ability to implement the 10-point action plan was conducted. All the insights gathered during this process and proposed solutions have been used to inform key strategies in this document. Box 3 below lists the stakeholders represented in the process.

Box 3: List of Stakeholders Engaged in the Road Map Domestication Process

- **Government Agencies:** NASHCoP, DRMCH, TACAIDS, MoCDGWSG, PO-RALG, PMO-LYED, and PMO-DCEA.
- **Donor Agencies:** PEPFAR (DoD, USAID, and CDC).
- **Multi-Laterals:** UNAIDS, UNFPA, UNICEF, WHO.
- **Communities and KVP-Led Entities/ Representatives:** Civil society organizations, KVP-led/centred NGOs, Key and Vulnerable Population Forum (KVPF) Members, KVP and PLHIV.
- **Local and International Implementing Partners: Included** PEPFAR implementing partners (represented by FHI360, THPS, and HJF), GF SR (i.e., AMREF), and NACOPHA.
- **Prevention Technical Working Group:** Selected members were represented from inception to implementation.
- **TNCM Members:** Represented by the Secretary.

- **Private Sector:** Tanzania Private Sector Foundation.

Under the leadership of both TACAIDS and NASHCoP, the engaged health and non-health experts and stakeholders unanimously recommended the timeframe of the domesticated Road Map to cover the period of 2023 – 2027. Furthermore, the overall consensus was that the 10 priority actions should ensure that by 2025, 95% of people at risk of HIV infection have access to and use an appropriate, prioritized, person-centred, and effective combination; and by 2030, this figure will increase to 100%.

3.4. Guiding Principles

The National HIV Prevention Roadmap 2023/24 – 2026/27 embraces the following guiding principles:

1. **Ending Inequalities:** Health outcomes will be addressed through Public Health approach by improving the understanding the response to human rights and gender-related barriers to accessing services.
2. **Evidence-Based & Results-Driven Programming**: Scaling up evidence-informed and result-driven program design, planning, implementation, monitoring, and evaluation inspired by flexibility, cost-effectiveness, and strategic investments.
3. **Quality, Comprehensive & Integrated Services:** Commitment to promoting access, quality, integrated HIV services under principles of universal health coverage and promotion of human rights as well as social justice, equality, and equity, and promoting gender equality.
4. **People-centred service delivery:** Placing people at the centre of the decision-making, with the inclusion and participation of all stakeholders, including communities, people living with HIV, and key and vulnerable populations.
5. **Gender Responsiveness:** A gender-responsive approach that caters to the different needs of women, girls, men, and boys in accessing HIV information and Sexual Reproductive Health (SRH) related services.
6. **Inclusiveness:** An inclusive and people-centred approach that recognizes different prevention options that individuals may choose at different stages of their lives.
7. **Country-Owned & Multi-Sectoral approach:** Embracing partnership between the government and communities, non-state actors, private sector, and development partners and shared accountability for results.
8. **Community-led program leadership, service delivery, and monitoring:** Communities

such as key and vulnerable populations participate in delivering and monitoring HIV prevention services to improve acceptance and retention in HIV prevention, care, and treatment services.

9. **Sustainability:** Building on the principle of a sustainable program that includes reliance on domestic resources, increasingly strategic partnerships with external funders, community ownership, and leadership commitment.
10. **Value for Money:** Maximize and sustain equitable and quality health outputs, outcomes, and impacts in a constrained economic and financial environment. The Roadmap applies the principleof economy - HIV prevention programs strive to minimize costs of inputs for service delivery whilst attaining acceptable levels of quality. Furthermore, the roadmap ensures effectiveness,allocative, and technical efficiency in designing, implementing, monitoring, and evaluating HIV prevention programs.

4.0. HIV PREVENTION STRATEGIC PRIORITIES, INTERVENTIONS AND TARGETS

4.1. Strategic Priorities for the 2023/24 – 2026/27 Road Map

The recently launched Global AIDS Strategy (2021–2026) by UNAIDS seeks to end inequalities that drive the AIDS epidemic and put people at the centre to get the world on-track to end AIDS as a public health threat by 2030. The strategy aims to reduce the number of new infections to fewer than 370,000 per year by 2025. According to UNAIDS reports, inequalities are a key reason why the 2020 global targets were missed. The2021-2026 Global AIDS Strategy outlines a comprehensive framework for transformative actions to confront these inequalities and, more broadly, respect, protect, and fulfil human rights in the HIV response. By reducing the inequalities driving the AIDS epidemic, the strategy aims to close the gaps in HIV prevention, testing, treatment, and support by 2025 and put the world back on course to end AIDS by 2030.

The strategy encourages countries to set granular targets for population and geographic localities. It also underlines the need to recognize that key populations are at high risk of HIV infection and set a target to reach 95% of people at risk of HIV infection with combination HIV prevention interventions. It aims to attain the new 95–95–95 testing, treatment, and viral suppression targets across all demographics, populations, and geographic settings. It also aims to eliminate new HIV infections in children. Additional targets include the 95–95–95 targets for access to HIV services, the 10–10–10 targets for removing social and legal impediments to accessing or using HIV services, and 30-60-80 targets for community-led services.

Note: The 30–60–80 targets are defined as follows in the Global AIDS Strategy: 30% of testing and treatment services to be delivered by community-led organizations; 60% of the programs to support the achievement of societal enablers to be delivered by community-led organizations; 80% of service delivery for HIV prevention programs for key populations and women to be delivered by the community, key population and women-led organizations.

Informed by the Global AIDS Strategy 2021-2026 and the Global HIV Prevention 2025 Road Map, the Domesticated National HIV Prevention Road Map 2023/24 – 2026/27 for Tanzania Mainland focuses on scaling up primary prevention of HIV infections and introducing the policy,

legal and societal enablers to prevent people from acquiring HIV infection. The Road Map emphasizes the need for an intensified focus on reaching key and vulnerable populations (including vulnerable adolescent girls and young women) and their sexual partners. It emphasizes the need for addressing inequalities that fuel new HIV infections and strengthening the roles of communities in HIV prevention.

The strategy builds on five interlinked strategic priorities:

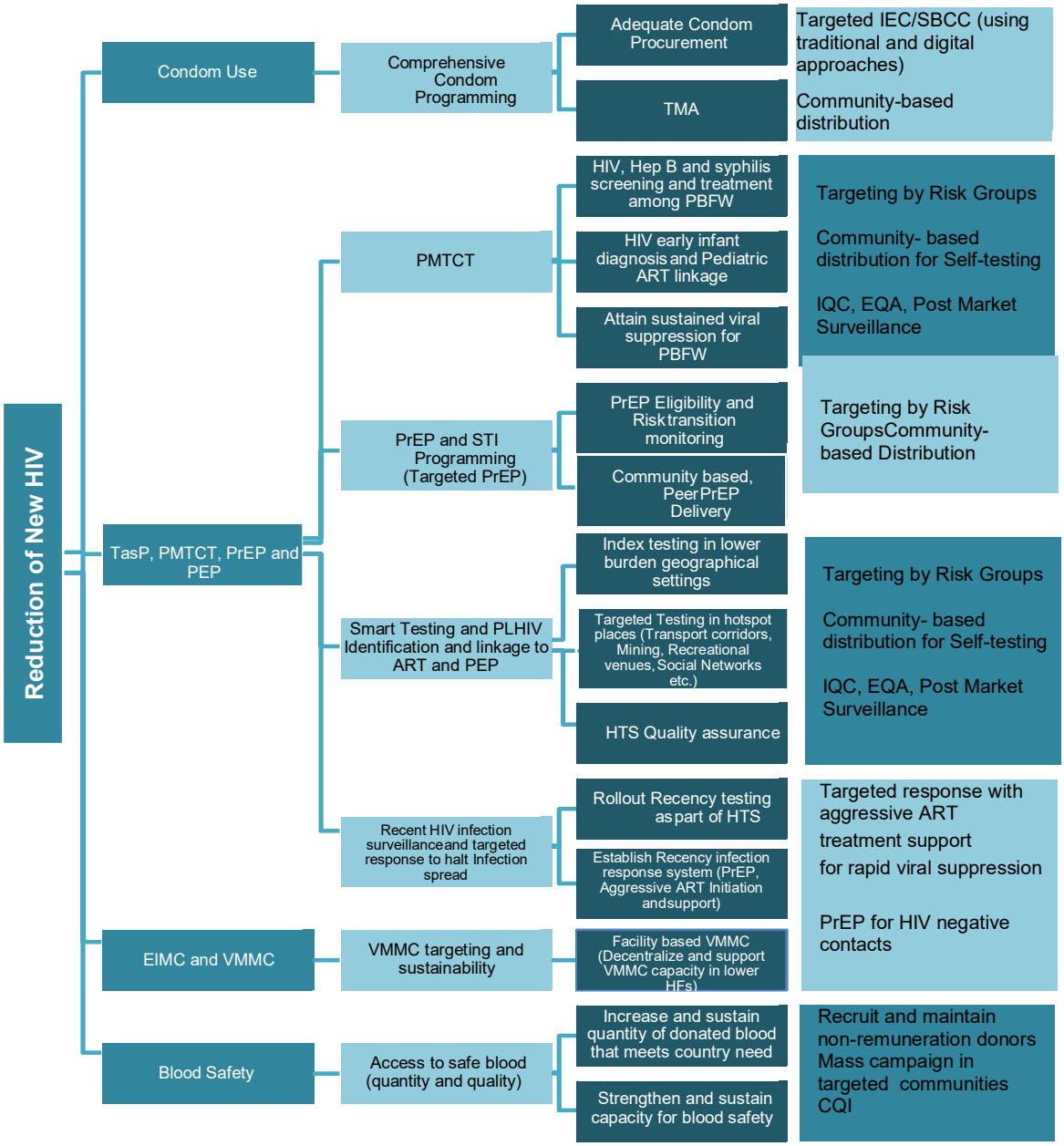
- **Strategic Priority 1:** Maximize equitable and equal access to HIV services and solutions
- **Strategic Priority 2:** Break down barriers to achieving HIV outcomes
- **Strategic Priority 3:** Fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings, and pandemic responses.
- **Strategic Priority 4:** Precision Prevention
- **Strategic Priority 5:** Enhance Multi-Sectoral Engagement

4.2. HIV Prevention Interventions

In order to achieve an 85% reduction in new HIV infections by 2025, compared to the 2010 baseline, and to bring Tanzania closer to epidemic control by 2030 in line with NMSF V and HSHSP V, the National HIV Prevention Road Map 2023-2027, prioritizes the 'scaling up' of evidence-based prevention strategies. This involves targeting all at-risk population segments in an 'equitable' manner. The focus is on 'effectively reaching' and 'saturating' key and vulnerable population (KVP) groups such as PWID, FHR, men at-high risk, fisherfolks, miners, long-distance truck drivers, plantation workers, and sex partners of key and vulnerable populations, among others. It also extends to segments of the underserved general population, including adult men, adolescent boys, and young men (ABYM), who have not been systematically targeted in an impactful manner by the scopes of HIV prevention interventions.

The development of this Road Map ensures the preservation of the gains achieved during past implementation periods. Deliberate efforts are made to strengthen proven interventions like PMTCT, VMMC, blood safety, STI screening and management, and condom programming. Simultaneously, the Road Map embraces new evidence-based interventions such as PrEP, HIVST, and HIV recency testing. (Figure 8 refers)

Figure 8: Conceptual Model for Reduction of New HIV Infections



Based on the above conceptual framework of 'HIV prevention activities, and in alignment with the 5 HIV prevention pillars, the National HIV Prevention Road Map 2023/24 - 2026/27 has organized HIV prevention interventions into four priority strategic areas. For consistency purposes, these priority strategic areas and specific interventions are matched with the structure used in HSHSP V as well as NMSF V.

4.3. Key Elements of the 2023/24 - 2026/27 Road Map

The HIV prevention goal is aligned with the NMSF V, HSHSP V, and other national strategies. Below are the key elements of the 2023/24 - 2026/27 Road Map for Tanzania Mainland.

- **Geographic prioritization:** This Road Map groups councils into three clusters (high, medium, and low risk), based on Tanzania's geographical disparities in HIV incidence, and draws on this to identify priority populations. Key age groups and sex-disaggregated data inform service delivery and prioritization.
- **Combination prevention:** Modelling is used to prescribe the optimal combination of interventions and required coverage for each cluster and council in the country.
- **Efficiency in delivery:** This Road Map outlines implementation strategies and options in community and facility settings. Tanzania Essential Package of Health cycles are used to optimize provider contacts to deliver services.
- **Leveraging:** This Road Map identifies opportunities for leveraging other sectors and emerging technologies and making HIV prevention 'everyone's business' through shared responsibility.
- **Forecasting and tracking progress:** This Road Map emphasizes monitoring outcomes instead of processes. It anticipates emerging technologies, aims to increase research uptake, and outlines national and cluster-specific research priorities.

5.0. THE 10-POINT ACTION PLAN TO ACCELERATE HIV PREVENTION IN MAINLAND TANZANIA (2023/24 - 2026/27)

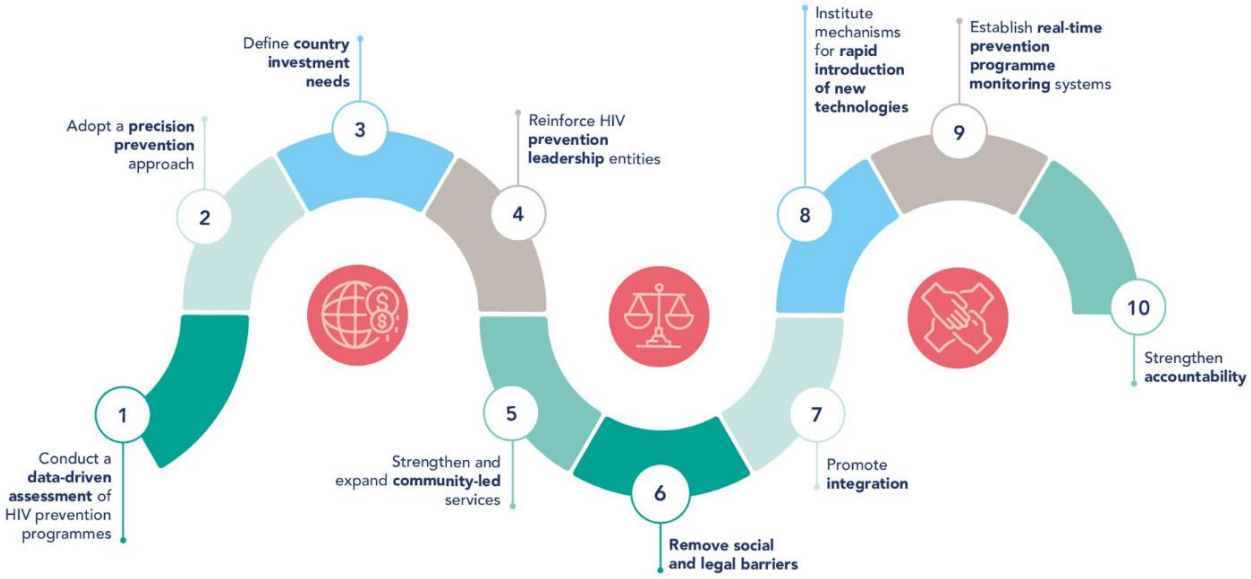
This new Road Map charts a way forward for country-level actions to achieve an ambitious set of HIV prevention targets by 2025 and 2027, which will set Tanzania on the trajectory to meet the 2030 targets. Those targets emerged from the 2021 Political Declaration on HIV and AIDS, which the United Nations General Assembly adopted in June 2021, and they are underpinned by the Global AIDS Strategy (2021–2026). Tanzania adopted these targets in the NMSF V and HSHSP V. Through the National HIV Prevention Technical Working Committee (PTWC), which falls under the broader HIV Joint Thematic Working Group (JTTWG) chaired by the Permanent Secretary of the Prime Minister's Office (coordinated by TACAIDS), already Tanzania is employing multi-sectoral structures to provide oversight, leadership, and coordination in monitoring country's progress towards achieving the set global and national goals. PTWC's mandate is to serve as the coordination and oversight platform to support the operationalization of global and regional commitments linked to HIV and SRH programming for adolescents and young people aged 10-24 years. These include but are not limited to the Global AIDS Strategy 2021-26, Political Declaration on HIV and AIDS (2021), Global HIV Prevention 2025 Road Map, Africa Union Commitment to End AIDS (2023), SADC Commitments to HIV and AIDS (Maseru Declaration to combat HIV and AIDS, 2003 and Joint Meeting of Ministers of Health and Ministers Responsible for HIV and AIDS, 2019), and the ESA Commitment on CSE and SRHS (2013), amongst others. This scope also assists in planning, reviewing, validating, monitoring, and evaluating the National HIV Prevention Road Map 2023/24 - 2026/27.

5.1. The Adopted 10-Point Action Plan for Tanzania Mainland

Tanzania has domesticated GPC's 10-point action plan to accelerate HIV prevention in line with the Global HIV Prevention 2025 Roadmap. This 10-point plan for accelerated action lays out the immediate concrete steps each country can take to accelerate progress towards meeting the 2025 and 2030 commitments on HIV prevention (Figure 9). The actions have been adjusted to align with the country's context, realities, and planning processes and completed through an inclusive and participatory approach. Proposed milestones and dates are included at the end of the document. The key actions that Tanzania has prioritized include the following:

- **Action Point # 1:** Conduct an evidence-driven assessment of HIV prevention program needs and barriers.
- **Action Point # 2:** Adopt a precision prevention approach to develop national HIV prevention goals and aligned 2025 targets precision prevention approach.
- **Action Point # 3:** Determine country investment needs for adequately scaled HIV prevention responses and ensure sustainable financing.
- **Action Point # 4:** Reinforce HIV prevention leadership entities for multisectoral collaboration, oversight, and management of prevention responses.
- **Action Point # 5:** Strengthen and expand community-led HIV prevention services and set up social contracting mechanisms.
- **Action Point # 6:** Remove social and legal barriers to HIV prevention services for key and priority populations.
- **Action Point # 7:** Promote the integration of HIV prevention into essential related services to improve HIV outcomes.
- **Action Point # 8:** Set up mechanisms for rapidly introducing new HIV prevention technologies and program innovations.
- **Action Point # 9:** Establish real-time prevention program monitoring systems with regular reporting.
- **Action Point # 10:** Strengthen accountability of all stakeholders for progress in HIV prevention.

Figure 9: HIV Prevention Road Map: Ten-point Action Plan



During the process of adopting the National HIV Prevention Road Map 2023/24 - 2026/27, informed by insights from the P-SAT 2022 findings, HIV prevention 2022 scorecard, and the 2023 baseline assessment findings (conducted in each GP member state) of the HIV prevention 2025, a strength, weakness, opportunities, and threats (SWOT) analysis was conducted using multi-stakeholder engagement process. Thereafter, priorities were developed to address the identified weaknesses and threats while capitalizing on the strengths and opportunities. Annex 2 provides a summary of SWOT findings.

5.2. Operationalizing the 10-Point Action Plan

In order to achieve the specified HIV prevention targets for 2025 and 2030 in Tanzania Mainland, the next phase of the HIV prevention response will centre on the effective implementation of combination prevention interventions outlined in earlier sections, derived and refined from the NMSF V and HSHSP V. This Road Map delineates the necessary actions to address various challenges, acknowledging the dynamic nature of the HIV epidemic and its variations across the country. Central to this Road Map is the pursuit of a 95% coverage target for individuals at risk of HIV infection, with a focus on high-impact prevention programs for key and priority populations. Community-led activities play a pivotal role in the scale-up of these programs, aiming to significantly reduce new HIV infections. The Road Map advocates for discontinuing investments in interventions of limited effectiveness and efficiency, emphasizing the reallocation of resources. Furthermore, it underscores the imperative to end the inequalities that fuel the HIV epidemic, hindering efforts to end it. It also highlights the importance of sound management and accountability processes within a multisectoral response. Detailed below are the activities corresponding to each of the 10-point actions, accompanied by their respective progress markers for monitoring advancement.

Action Point # 1: Conduct an Evidence-Driven Assessment of HIV Prevention Programme Needs and Barriers

The process of developing this Road Map is coming at a time when the final analysis of THIS 2.0 (2022-2023)[13] is about to be concluded; the process of sharing preliminary findings is continuing; therefore, this action point needs to build on the soon-to-be-availed granular national and sub-national epidemiologic data. Listed below are the agreed activities proposed to be undertaken from 2023/24 - 2026/27.

- Convene a national-level technical meeting to review THIS 2.0 report, TDHS 2022 findings, key global reports (GAM, Scorecards, and PSAT), and HIV/AIDS program data (health and non-health), and conduct additional secondary analysis as needed to examine HIV transmission trends and patterns (national, regional and council).
- Conduct an evidence-based and data-informed review of critical enablers and barriers to prevention programming (i.e., stock-taking of policy, legal, and societal barriers hindering service access and utilization).
- Conduct bi-annual multi-stakeholder workshops to review progress in implementing prevention programs at scale, identify obstacles to service access and usage, and determine critical technical and capacity needs to address any gaps (use the existing Prevention TWC structure).
    - Barriers/ obstacles are to be categorized into leadership, policy, legal, structural, etc.
- Conduct regular (5-yearly) HIV stigma index studies.
- Conduct regular (5-yearly) legal and policy environmental assessment surveys.

MILESTONES	TIMELINES
1) Report of epidemiology trends and patterns disseminated to national and sub-national stakeholders	July 2024*
2) Multistakeholder meetings to review transmission trends and patterns convened as per the set schedule	November 2024
3) Report on barriers and enabling factors for prevention programming (policy, legal and societal)	December 2024
4) HIV stigma index survey conducted as per the set schedule	July 2025

Action Point # 2: Adopt a Precision Prevention Approach to Develop National HIV Prevention Goals and Aligned 2025 Targets Precision Prevention Approach

In order to meet its 2025 and 2030 HIV prevention goals, the Government of Tanzania will build on evidence-based and data-driven assessments and analysis to gather insights that will inform targeting. The gathered data will identify and profile the populations and locations that require urgent focus. Primary and secondary THIS 2.0 data will be utilized to calibrate programming (as

[13] THIS2022-2023_Summary_Sheet.pdf (nbs.go.tz)

per NMSF V and HSHSP V), but more importantly, it will help the smart targeting of combination prevention interventions in all population segments at risk. This is envisaged to also guide the allocative efficiency of HIV prevention programming resources tailored to the needs.

- Conduct a data-driven multi-stakeholders review of the spectrum and THIS 2.0 (primary and secondary) data to identify the age and sex-disaggregated populations and locations at increased risk of HIV transmission and acquisition.
- Disseminate national and sub-national HIV prevention targets to national, regional, and council stakeholders.
- Improve dissemination of spectrum estimates for HIV infections at national and sub-national levels.
- Conduct regular (3-yearly) IBBS and KVP size estimates in order to guide HIV programming (for classical and non-classical KVP).
- Adopt or adjust interventions and approaches shown to reduce new HIV infections with an appropriate balance between biomedical, behavioural, and structural approaches.
- Adjust, adapt, and reprioritize HIV prevention interventions and investments to align with the needs.
    - Use THIS 2.0[14], spectrum, and AIM modelling data to recalibrate programming.
    - Use the AGYW PSE and UNAIDS decision-making tools[15] to guide and recalibrate programming for AGYW.
- Conduct advocacy and sensitization meetings to build consensus and a common understanding of precision HIV prevention approaches.
- Engagement of private sectors to deploy precise HIV prevention approaches, e.g., PrEP provision through private drug dispensing units.

MILESTONES	TIMELINES
1) Revised age, sex, and population disaggregated national, regional, and council-level HIV prevention targets (for all combination prevention interventions)	June 2024
2) Updated IBBS report disseminated and used to guide programming	August 2026
3) Circular on HIV prevention targets (national, regional, and council) released and disseminated to all stakeholders (also hold virtual meetings on the same)	June 2024
4) Mid-term review of the HIV prevention roadmap conducted	December 2025
5) Annual HIV prevention program report developed and disseminated as per set schedule	Annually
6) Updated KVP size estimates disseminated and used to guide programming	January 2027

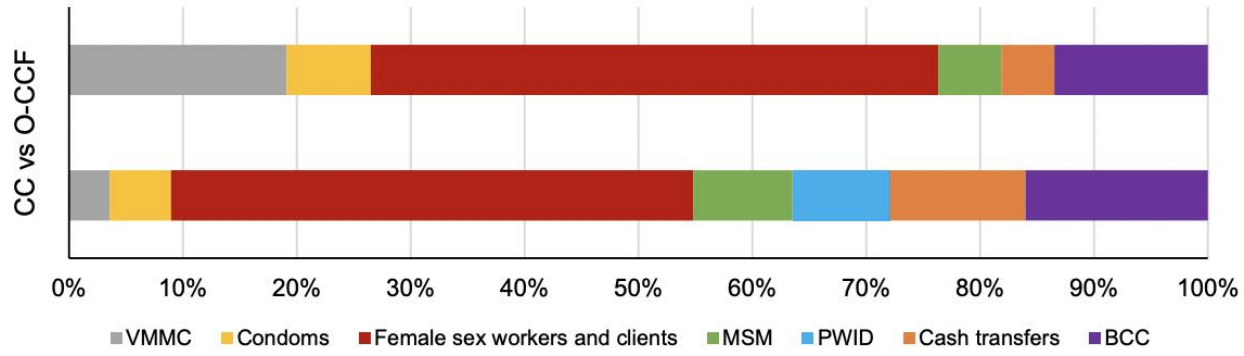
Action Point # 3: Determine Country Investment Needs for Adequately Scaled HIV Prevention Responses and Ensure Sustainable Financing

In accordance with the UNAIDS report, funding for HIV programs has continued to decline from both international and domestic sources. In 2022, it fell back to the same level as in 2013 (i.e., approximately US$ 21 billion), far short of the US$ 29.3 billion needed by 2025. With this observed trend, in the 2023/24 - 2026/27 implementation period, the Government of Tanzania commits to strengthening its strategies to mobilize more resources, but more importantly,

[14] THIS2022-2023_Summary_Sheet.pdf (nbs.go.tz)
[15] AGYW-DMA-2023.pdf (unaids.org)

improve allocative efficiency, reduce any potential wastages, and improve program efficiency. The Government shall make concrete plans for adequate investments in HIV prevention as part of a fully funded national response so that increased domestic resources and a quarter of HIV spending on average goes towards prevention programs. In alignment with the GOALS ASM results (see section 2.3) and the HIV Investment Case 2.0 recommendations, concerted efforts will be made to direct funding towards the most cost-effective interventions in order to maximize the impact of limited HIV prevention funds available. These include PMTCT, KVP (particularly FHR and AGYW), PrEP, Comprehensive Condom Programming, and VMMC. Mass media interventions will also be employed to generate demand for various services, address critical enablers, and deliver SBCC messages. The allocation shifts towards the more cost-effective interventions would occur gradually through a multi-stakeholder consultative engagement process. Figure 10 shows the relative resource shifts for prevention funding as informed by the HIV Investment Case 2.0 analysis.

Figure 10: Constant Coverage vs Optimization- Optimization- Constant Coverage Funding Scenario (O-CCF) Resource Allocation 2019-2030 (Prevention Interventions)



Throughout the implementation, the Government will employ various evidence-based approaches to assess the impact of all HIV prevention interventions; during this process, interventions that will be found to be less cost-effective would have to be partially scaled back or paused to free up additional funds. Below is the list of activities linked to this action.

- Revise and update HIV prevention financing needs, targets, and gaps in line with the updated Global HIV Prevention Road Map (building on NMSF V and HSHSP V analytics, as well as the HIV Investment Case 2.0 and the 2022 GOALS ASM Results).
- Convene a national dialogue between key domestic and international financing partners to agree on how acute gaps can be filled and how to include the engagement of private-sector to complement external and domestic funding allocated for prevention.
- Reallocate and prioritize HIV prevention investments by targeting the most at-risk populations and locations (strengthen allocative efficiency).
- Incorporate HIV prevention into 5-year sustainability and transitioning plan to be developed guiding shifting HIV financing framework from external support to domestic sources.
    - Formalize CHWs carder and link to the health system.
- Improve domestic resource mobilization and utilization for HIV prevention programming.
    - Advocacy for domestic resource mobilization for the AIDS Trust Fund through earmarked levies.
    - Establish a social contracting mechanism (public funds to support communities to lead program implementation, service delivery, and monitoring).

- Advocacy with members of parliament for increasing the Government budget for health to reach the Abuja Declaration (15%).
- Advocacy for inclusion of HIV prevention budgets into MTEF and CCHPs.
- Strengthen primary health care to deliver comprehensive HIV prevention services.
- Integrate HIV prevention programming in existing health and social service platforms.
- Strengthen multi-sectoral coordination on HIV prevention at all levels (MDAs and development partners) .
- Promote complementary financing for HIV response.
- Mobilize social protection system to support health promotion interventions for HIV prevention i.e., NHIF and health insurance systems under Social security schemes.
- Mobilize the private sector for domestic resource mobilization earmarked for HIV prevention.

- Institutionalize HIV expenditure tracking through the available proven approaches i.e., NASA, PER, and NHA (Every two years)

MILESTONES	TIMELINES
1) Existence of the costed plan to achieve the 2023-2027 HIV Prevention Road Map	April 2024
2) Country-specific financing needs, targets, and benchmarks for HIV prevention developed	November 2024
3) Multi-stakeholders national dialogue between domestic and international partners (including the private sector) conducted through advocacy and sensitization meetings	August 2025 June 2026
4) Improved allocative efficiency for HIV prevention programming (aligned with the HIV Investment Case 2.0 and the 2022 GOALS ASM Results or future updates)	Throughout
5) 5-year sustainability and transitioning plan for HIV prevention financing	March 2026
6) US $ 1,095,953,767.18 for HIV prevention mobilized	Throughout

Action Point # 4: Reinforce HIV Prevention Leadership Entities for Multisectoral Collaboration, Oversight and Management of Prevention Responses

Tanzania has several lead entities responsible for oversight, leadership, and coordination of HIV prevention efforts. Due to the multifaceted nature of HIV, TACAIDS – a multisectoral instrument established by the Government of Tanzania takes the overall leadership in coordinating HIV response efforts, including prevention. As the country is implementing last-mile efforts to control the epidemic, the government is committed to working with public sector institutions, development partners, the private sector, non-governmental and civil society organizations, and service providers to fast-track efforts to make Tanzania AIDS-free. This goal is envisaged to be attained by implementing the following steps:

- Enhance TACAIDS' capacity to hold all sectors and implementers accountable in ensuring a coordinated HIV response for impact.
  - Review/ reinvigorate TACAIDS mandate and specific capacities to strengthen mechanisms for cross-sectoral collaboration on HIV prevention, initiate policy reviews, and design communications around prevention, including through the use of new media.
  - Improve coordination and maximize synergies between different prevention program components (NASHCoP, DCEA, PO-RALG, MOEST, MOH, MOJCA).

- Revitalize reporting needs by various sectors on progress towards national targets and commitment.
- Clarify roles and responsibilities of other Ministries in facilitating the delivery of KVP combination prevention services using public health approach (e.g., MOHA and MOJCA).
- Capacitate and coordinate the functionality of regional, council, ward, and village multi-sectoral AIDS committees (R/C/W/VMACs).
- Capacitate TACAIDS to coordinate with NASHCoP and other stakeholders to translate NMSF V and HSHSP V to regional and council levels.

- Revitalize the Prevention TWC, including its three sub-TWC (i.e., Adolescent and Young Adult Stakeholders [AYAS], KVP, and Condom), and sustain the PrEP TWG under MoH.
  - Review TOR, improve functionality, and their capacity to track prevention progress.
  - The TOR will include guidance on adopting new initiatives and technologies for HIV prevention programming.
  - Ensure close coordination and synergy of the sub-TWC.
- Strengthen the Technical AIDS Committees (TAC') led by Permanent Secretaries for Public Sector and Private Sector Coordination led by the Association of Tanzania Employers (ATE).
- Strengthen the engagement of multisectoral stakeholders on the regional framework for HIV prevention (including all actors, especially CSO and community representatives).
- Strengthen financial and technical support to HIV prevention TWC, sub-TWC, and the R/C/W/VMACs.

MILESTONES	TIMELINES
1) Annual progress reports from all sectors (health, education, tourism, transport, fishing, agriculture, private sector, etc.) on how they are participating in HIV prevention efforts submitted	Annually
2) Prevention TWG and the respective sub-Committees (i.e., AYAS, Condom, PrEP, and KVP) meeting as per schedule (quarterly)partners conducted through Advocacy and sensitization meetings	Quarterly
3) TOR for HIV prevention leadership entities and TWGs reviewed/developed	June 2024
4) National HIV Prevention Strategies (i.e., NSMF V, HSHSP V, and Road Map) translated at regional and council levels to guide implementation, i.e., HIV prevention targets developed and disseminated both at national, regional, and sub-national levels	June 2024
5) Improved participation of CSO and community-led organizations in planning, implementation, and monitoring of HIV prevention interventions	Throughout

Action Point # 5: Strengthen and Expand Community-Led HIV Prevention Services and Set Up Social Contracting Mechanisms

As narrated in the earlier section, in order to achieve HIV prevention goals by 2025 and 2030, the Government of Tanzania has committed to working in close partnership with local non-governmental and community-based entities to design, plan, budget, implement, monitor and evaluate HIV prevention programs at both national and sub-national levels. Building on lessons learned from the ongoing community-led monitoring, for the 2023/24 - 2026/27 implementation period, the following initiatives will be employed.

- Set national and regional targets and milestones for increasing the proportion of HIV prevention services delivered by community-led organizations (adapt the 30-60-80

targets according to local context).

- Build technical and managerial capacity of community-led organizations and networks at national, regional, and council levels.
    - Train implementers on the use of KVP peer outreach SOP.
    - Support the rollout of these KVP peer outreach SOP.
- Advocacy and sensitization of local government structures to meaningfully engage community organizations.
- Engage the registrar of NGO to orient and facilitate community organizations to register and implement interventions in accordance with the country's laws, regulations, culture, norms, and traditions.
- Forge strategic partnerships with international financing agencies to co-finance community-led organizations to implement HIV interventions.
- Develop a social contracting framework for support and engagement of community-led organizations/ entities (to include a legal framework for sub-contracting and an implementation roadmap of gradually increasing the proportion of HIV prevention services delivered by community-led organizations).
- Sub-contract eligible local entities to implement and monitor HIV prevention interventions (using domestic resources).
    - Prioritize and ringfence resources for community-led interventions.
- Monitor community-led response at national and sub-national level.

MILESTONES	TIMELINES
1) National and regional-level targets and milestones for increasing the proportion of HIV prevention services delivered by community-led organizations developed	June 2024
2) Community organizations capacitated and supported to implement HIV prevention interventions	October 2024
3) Social contracting framework developed	June 2024
4) Number of community organizations financed to implement HIV prevention interventions (domestic and external sources)	January 2025

Action Point # 6: Create an Enabling Environment for HIV Prevention Programming (Renamed from "remove social and legal barriers to HIV prevention services for key and priority populations")

Successful prevention programming is directly linked with the presence of a conducive policy and legal landscape to facilitate the smooth implementation of HIV prevention interventions at health facility and community levels. This includes the use of a public health approach to providing services for key and vulnerable populations. In line with the country's legal framework, culture, norms, and traditions, Tanzania provides services to PLHIV, people living with disabilities, and KVP using a public health approach. Healthcare providers, community health workers, and volunteers are all expected to provide non-judgmental, non-discriminatory, gender-responsive, age-appropriate, and KVP and youth-friendly services to any person seeking care irrespective of their sexual behaviour and practices. Therefore, the Road Map will focus on removing any social and legal barriers faced by individuals who are seeking HIV prevention

services. Specific strategies are outlined below.

- Disseminate HAPCA, HIV Policy, and relevant HIV/AIDS Guidelines (e.g., KVP Guidelines).
- Build the capacity of healthcare providers, religious leaders, academic institutions, research institutions, media, civil society organizations, community, and KVP beneficiaries about the link between HIV and KVP and the use of public health approach to provide HIV and SRH services to KVP.
- Empower PLHIV and KVP beneficiaries by providing them with legal orientation (knowing their rights and their responsibilities/ obligations in relation to the national and local laws relevant to HIV prevention).
- Capacity building of CSO/ CBO implementing HIV combination prevention interventions
- Sensitize all the key gatekeepers (law enforcers, lawmakers, etc.) about HAPCA, provisions of the current constitution, national KVP guidelines, and other key relevant strategies, regulations, and policies that allow for and emphasize the use of public health approaches to providing services to KVP. This assignment should go hand in hand with revising the pre-service curriculum and developing learning resource packages for in-service training.
- Expand community legal and paralegal services for PLHIV, people living with disabilities, and KVP.
- Strengthen collaboration between the Government and relevant global partnerships for creating a conductive HIV prevention environment.
- Adapt service delivery approaches (e.g., use of self-care, virtual/ mHealth services, and outreaches) to cater to at-risk populations' unique needs.
- Establish a System for Monitoring and Enabling Environment for HIV Prevention Programming.

MILESTONES	TIMELINES
1) Key gatekeepers sensitized on national HIV prevention intervention strategies and Road Map (using public health approach)	August 2024
2) Key strategies, policies, and guidelines on HIV prevention disseminated	December 2024
3) Functional system for monitoring enabling environment for HIV prevention programming	January 2025
4) Tanzania joining the Education Plus initiative	October 2024
5) Populations at heightened risk of HIV transmission and acquisition empowered	Throughout

Action Point # 7: Promote the integration of HIV prevention into essential related services to improve HIV outcomes

Integration of HIV services with other health services has been proposed as an important strategy to boost the sustainability of the global HIV response. Evidence suggests that when HIV services are integrated with other health services, improvement in both health and health systems outcomes is observed. As the Government of Tanzania is making strides in implementing UHC 2030 goals, integrating HIV prevention services into other essential related services such as Viral Hepatitis, STIs, and other SRH services is pivotal. The release of the

three WHO global health sector strategies on, respectively, HIV, viral hepatitis, and STIs[16] serves as a model of how this Road Map seeks to enhance readiness and operationalize integration. In line with these strategies, in November 2023, Tanzania launched an Integrated Health Sector HIV, Viral Hepatitis, and Sexually Transmitted Infections (STI) National Strategic Plan. In tandem with this launch, the Ministry of Health has also restructured its National AIDS Control Program (established in 1988) to form a newer program, namely, the National AIDS, STIs and Hepatitis Control Programme (NASHCoP). Below is the list of strategies to be employed for the 2023/24 - 2026/27 implementation period.

- Revise/ update and disseminate national strategies, policies, and guidelines for integration of HIV prevention with other services.
  - National Integrated Health Sector HIV, Viral Hepatitis and Sexually Transmitted Infections (STI's) Strategic Plan.
  - National eMTCT Strategy.
  - National Integrated HIV, Viral Hepatitis, and STI Management Guidelines.
  - National Integration Guideline for RMNCAH and HIV Integration.
  - Update HIV/SRH integration M&E indicators.
- Redesign current HIV services by integrating them with other services, including social services (either collocating, linking, or providing one-stop services).
- Revise/ update HIV/AIDS service delivery training packages to include integration with other essential services.
- Revise supportive supervision checklist/ tools to include integration of HIV and other services.
- Allocate domestic funding for improving infrastructure to support the provision of integrated services (e.g., HIV and RMNCAH).
- Capacitate healthcare providers on the provision of HIV-integrated services.
- Integrate HIV prevention services within the insurance schemes (align with UHC/ strategy).
- Advocate for private health facilities to integrate HIV prevention services.
- Strengthen existing integrated supply chain systems to enhance the provision of integrated services.
- Advocate with the donor community to design grants/ interventions that consider the integration of services.
- Revitalize HIV Integration TWG/TWC/ Committees and sub-TWG/TWC at the national level.
- Monitor and report HIV integration M&E indicators.

MILESTONES	TIMELINES
1) National Strategies. Policies and Guideline for Integration of HIV with Viral Hepatitis, STI, and SRH/RMNCAH services updated and disseminated	October 2024
2) National HIV, STI, and Viral Hepatitis Training Package updated and disseminated	March 2025
3) National FP/HIV integration training package/curriculum updated and disseminated	June 2024
4) Regional/District AIDS Control Coordinators (R/DACCs), Regional/District Reproductive and Child Health Coordinators (R/DRCHCOs), Regional Coordinators for TACAIDS (RCT), and Council HIV and AIDS Coordinators	July 2024

[16] Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030 (9789240053779-eng.pdf (who.int))

(CHACs) capacitated on HIV, Viral Hepatitis, STI, and SRH Integration	
5) FP/HIV sub-TWG revitalized	July 2024
6) HIV/SRH indicators reported through existing M&E systems	Throughout

Action Point # 8: Set Up Mechanisms for the Rapid Introduction of new HIV prevention Technologies and Programme Innovations

Tanzania has been adopting innovations and technologies that enhance program effectiveness, efficiency, and sustainability in the health sector. As far as HIV prevention is concerned, in the last decade, new innovations/ technologies have emerged; these include oral PrEP, Dapivirine ring, and injectable PrEP (CAB-LA). More innovative tools/ technologies are at different stages of research and development. Therefore, this Road Map seeks to do the following.

- Develop a national guide/ framework for adopting/domesticating new technologies and innovations *(National HIV Technology & Innovations Adoption Guide/Framework defining the process, approaches, and timeframe).*
- Incorporate **"the adoption of new HIV prevention technologies and innovations"** as a permanent agenda of the Prevention TWG and the broader HIV Joint Thematic Working Group *(revise TORs and track this action).*
- Streamline the process of adopting new HIV prevention technologies/ innovations.
  - Strategically engage key HIV technology entities (e.g., TMDA, TBS, Government Chemist Laboratory Authority, Chief Pharmacist & MSD) to fast-track the registration of new innovations and technologies.
  - Initiate timely in-country discussions of the new innovations and technologies through the existing TWG and forums.
  - Domestication and adoption of new technologies and innovation through early revision of existing policies and guidelines.
- Scale up the use of newly adopted HIV prevention technologies/ innovations.
  - Strengthen community distribution of HIV prevention technologies.
- Advocate for domestic funding allocation for new HIV prevention technologies.
- Enhance and make adaptations of the current HIV prevention service delivery models to increase their resilience for global pandemics/ unplanned life-threatening events.
  - Enhance the provision of virtual HIV prevention services (including demand creation).
  - Scale-up self-care services (HIVST scale-up).

MILESTONES	TIMELINES
1) National Guide/ Framework for Adoption of HIV Prevention Innovations and Technologies developed and disseminated	June 2024
2) P-TWG and JTTWG have integrated New HIV Prevention Technology/Innovation in their quarterly meeting agenda	Quarterly
3) HIV prevention service delivery models adapted to increase resilience during pandemics/ life-threatening events (including virtual demand creation, counselling, and service provision)	June 2024
4) Number of new HIV prevention technologies/options adopted (including PrEP options)	August 2025

Action Point # 9: Establish Real-Time Prevention Programme Monitoring Systems with Regular Reporting

Successful prevention programming relies on the presence of quality, gender-sensitive, and

population-specific routine monitoring systems that are able to promptly identify and address implementation gaps and challenges and track program performance at all levels of implementation, including both health and community components. Therefore, as it implements the last mile actions to ending AIDS by 2030, the Government of Tanzania will continue to closely coordinate with various stakeholders to prioritize real-time monitoring of the implementation progress, including the ten-point Action Plan. Below are the specific strategic actions:

- Conduct M&E systems need/ gap assessment to identify areas of strengthening.
- Allocate adequate resources to support competent institutions and expertise to develop and maintain real-time data systems in the country.
- Review national data management guidelines to incorporate new developments and indicators for HIV prevention interventions.
- Review national HIV prevention indicators to align with HIV prevention scorecards.
- Re-design/ upgrade the existing systems to allow real-time data reporting
    - Map all relevant data elements for inclusion into the existing M&E. system for GAM reporting.
- Fast track rollout and utilization of unified community system.
    - Synchronize and harmonize recording and reporting systems for community HIV interventions.
- Strengthen existing national multi-sectoral M&E system for routine data to capture all HIV prevention programming/implementation barriers.
- Strengthen periodic program and data reviews for both national and sub-national levels on a quarterly basis.
    - Update HIV prevention scorecards at global, national, and subnational levels and evaluate the cost-effectiveness and value for money of national institutions coordinating and managing HIV prevention.
    - Conduct bi-annual joint program and data review meetings both at national and sub-national levels to inform HIV prevention programming.
- Conduct regular HIV M&E TWG meetings to support the coordination and monitoring of HIV prevention interventions (with a constant agenda to review and track HIV prevention indicators and scorecards).
-
- Strengthen capacity at regional and council levels to use M&E systems and data utilization for programming and decision-making.
- Cascade down regular dialogues, joint reviews, and data reviews from the national to regional and council levels.

MILESTONES	TIMELINES
1) Routine M&E system gap assessment report (delineating the identified gaps and areas of improvement)	Throughout
2) M&E data management guidelines updated and disseminated	Throughout
3) Upgraded routine M&E system	June 2024
4) Unified community system rolled out nationwide (all implementing partners using it)	October 2025
5) Increasing the number of community-based HIV implementers reporting through TOMSHA (GC 7 goal is to increase from 1,700 to 2,080)	December 2025
6) National, regional, and council-level M&E personnel capacitated	July 2024
7) M&E TWG meetings convened as per schedule	Bi-annual

Action Point # 10: Strengthen the Accountability of All Stakeholders for Progress in HIV Prevention

Ending AIDS requires all key stakeholders (including financing partners, government, implementers, private sector, and civil society) to work harmoniously while maintaining accountability for the fidelity of program implementation, robust monitoring, and timely reporting of results. This mutual accountability fosters cooperation and enables different sectors involved in HIV prevention to work in coordination towards a common goal. Therefore, this Road Map shall focus on the following:

- Develop an accountability framework for implementing, monitoring, and reporting HIV prevention interventions (building on NMSF V's Coordination, Governance, and Leadership and HSHSP V's Governance, Coordination, and Implementation guidance).
  - Incorporate mechanisms within the existing P-TWG to ensure existing national-level coordination structures (.e., technical working groups) deliver intended results.
  - Strengthen data systems for monitoring accountability.
  - Share the responsibility matrix with all sectors (government and non-government).
- Establish a robust system for all sectors (i.e., other ministries, departments, and agencies with a stake in HIV prevention) to report sector-specific HIV prevention implementation progress (for all sectors to report to TACAIDS).
- Conduct a high-level national stakeholders stewardship meeting *(including stakeholders from all sector Ministries and the private sector to review HIV prevention priorities, implementation challenges, financing needs, gaps, and sectoral contributions).*
- Increase efficiency on fund utilization within the government system to implement HIV prevention interventions.
- Reinforce timely disbursement of funding commitments from development partners.
- Engage the private sector to increase their financial contribution to the overall health sector budget.
- Review the HIV prevention Policy of 2008 and 2014 guidelines at the workplace (focus on roles and responsibilities and accountability of employers, Association of Tanzania Employers, and Workers Union).
- Track the National HIV Prevention Road Map implementation to identify weaknesses, take corrective steps, and share lessons learned and good practices (monitor progress indicators/ milestones for the 10-point actions).
  - Bi-annual national performance monitoring.
  - Quarterly regional and council-level performance monitoring.
- Utilize community-led monitoring reports on HIV prevention indicators and shadow reports on Road Map implementation to improve accountability.
- Monitor and evaluate the impact of existing plans, strategies, and guidelines against resources.

MILESTONES	TIMELINES
1) Accountability framework developed and disseminated (including sharing of stakeholder's responsibility matrix	January 2025
2) National-level multisectoral accountability meeting convened as per planned schedule (annually)	Annually
3) Joint accountability report incorporating government and community perspectives/insights (the latter to include community-led monitoring reports and shadow reports)	Annually

MILESTONES	TIMELINES
4) Biannual and quarterly performance reports from all sector ministries timely obtained	Quarterly
5) Financial expenditure report on HIV prevention interventions implementation	Annually

6.0. STAKEHOLDERS' ROLES AND RESPONSIBILITIES IN NATIONAL HIV PREVENTION EFFORTS

This chapter presents the coordination and management framework. In alignment with the NMSF V, it lists various stakeholders' granular and specific roles and responsibilities in implementing sector-specific HIV prevention efforts. Table 2 is a responsibility matrix that provides the scope of all accountable stakeholders in ensuring multi-sectoral HIV prevention interventions, and Table 3 further details a responsibility matrix outlining the key HIV prevention interventions and specific details of stakeholders' accountability expectations.

Table 3: Multi-Stakeholders' Roles in Implementing HIV Prevention Road Map 2023/24 – 2026/27 In Mainland Tanzania

Sectors	Focus Populations	Priority Responsibilities
Ministry of Health	All populations at risk	• Integrate HIV programming into the Ministry's plans and budgets. • Ensure workplaces have peer educators trained on HIV combination prevention interventions. • Strengthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • Lead the development of policy framework, strategies, and guidelines for the delivery of high-quality combination prevention services; • Ensure the availability of quality HIV and AIDS prevention, HIV testing, care, and treatment services delivered under a differentiated service delivery mode. • Adopt strategies to increase access to and utilization of quality HIV prevention services in the country. • Develop policy, guidelines, and operational plans. • 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. • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Prime Minister's Office (Policy, Parliamentary Affairs &	Lawmakers	• Integrate HIV programming into the Ministry's plans and budgets. • Ens

Sectors	Focus Populations	Priority Responsibilities
Coordination)		ure workplaces have peer educators trained on HIV combination prevention interventions. • Stre ngthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • Spearhead the development of policy framework, strategies, and guidelines for the delivery of high-quality combination prevention services. • Sensitize parliamentarians (including parliamentary committees) on HIV prevention issues. • Sub mit quarterly implementation reports to POPSM GG & TACAIDS.
President's Office - Regional Administration and Local Governments	Implementor s (all sectors)	• Prov ide 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. • Plan ning, budgeting, coordinating, and monitoring all HIV and AIDS activities in the local government. • Ens uring 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. • Sup ervising 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. • Guid ing 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. • Ens ure readily accessibility and utilization of HIV prevention services such as condoms, VMMC, PrEP throughout the Country. • Wor king with NSAs, facilitate and support community mobilization activities to create demand for services using enhanced SBCC, including mainstream and social media. • Facil

Sectors	Focus Populations	Priority Responsibilities
		itate effective recruitment and deployment of skilled workers in collaboration with POPSM GG and related ministries and designing and developing planning guidelines (MTEF) for the national AIDS response. • Man age, coordinate and sustain 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).
Ministry of Works	Construction workers	• Integr ate workplace HIV programming into the Ministry's plans and budgets. • Provid e prevention messages at all construction sites. • Ensur e all construction sites have condom dispensers and information on other HIV prevention services. • Streng then coordination with projects surrounding the community, health facilities, and local government authorities (LGAs) in the delivery and coordination of HIV and AIDS services. • Ens ure all construction sites have HIV self-testing kits and a constant supply of condoms. • Ens ure construction sites have peer educators trained on HIV combination prevention interventions. • Ens ure construction sites have HIV nurse counsellors (mobile or stationed). • Sub mit quarterly implementation reports to TACAIDS.
Ministry of Transport	Mobile and migrant (bridging populations)	• Inte grate workplace HIV programming into the Ministry's plans and budgets. • Stre ngthen coordination with the surrounding community along the hotspot transport corridors, Health facilities, and LGAs in the delivery and coordination of HIV and AIDS services. • Prov ide prevention messages at all public transport stops and stations for vehicles, trucks, and boda bodas. • Ens ure all stations/truck stops and hotspots have condom dispensers, a regular supply of condoms, and information on other HIV prevention services. • Ens ure all stations/truck stops and hotspots have HIV self-testing kits.

Sectors	Focus Populations	Priority Responsibilities
		• Ensure stations/truck stops and hotspots have peer educators trained on basic HIV preventive interventions. • Ensure stations/truck stops and hotspots have HIV nurse counsellors (mobile or stationed). • Organize outreach HIV testing and prevention services. • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Ministry of Agriculture	Mobile agricultural/ plantation workers and surrounding communities (tea, tobacco, sugarcane)	• Integrate HIV programming into formal and informal agriculture sector plans and budgets. • Strengthen coordination with LGAs and Health facilities around the agricultural plantations to facilitate the delivery of HIV and AIDS services for agricultural plantation workers and the surrounding communities. • Provide HIV prevention messages to agricultural/ plantation workers to reduce high-risk sexual behaviours. • Ensure all hotspots in the agricultural/ plantation have access to condoms and information on other HIV prevention services (including HIV self-testing kits). • Ensure agricultural/ hotspot community hotspots have peer educators trained on basic HIV prevention interventions. • Organize outreach HIV testing and prevention services. • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Ministry of Livestock and Fisheries	Fishing and pastoralist communities	• Integrate HIV programming into formal and informal livestock and fishery sectors. • Strengthen coordination with the LGAs and Health facilities around the fishing and pastoral communities to facilitate constant delivery of HIV and AIDS services. • Provide HIV prevention messages to at-risk pastoral and fishing communities to reduce high-risk sexual behaviours. • Ensure hotspot communities have peer educators trained on basic HIV prevention interventions. • Provide mobile services for HIV testing services and linkages to other HIV prevention services.

Sectors	Focus Populations	Priority Responsibilities
		• Submit quarterly implementation reports to POPSM GG & TACAIDS.
Ministry of Minerals	Miners	• Integrate workplace HIV programming into the Ministry's plans and budgets. • Provide prevention messages at all construction sites. • Strengthen coordination with the LGAs and Health facilities around the mining communities to facilitate constant delivery of HIV and AIDS services. • Ensure all construction sites have condom dispensers and information on other HIV prevention services. • Ensure all hotspots in the mining areas (informal and formal) have HIV self-testing kits. • Ensure mining sites/ hotspots have peer educators trained in HIV combination prevention. • Ensure mining sites/ hotspots have HIV nurse counsellors (mobile or stationed) • Submit quarterly implementation reports to POPSM GG & TACAIDS.

Ministry of Home Affairs	Uniformed services, including those in prison settings, immigration, fire brigade, and armed forces.
	
	Also, KVP (including prisoners)
		• Integrate HIV programming into the Ministry's mandate to offer safety and security services to citizens.
		• Strengthen coordination with the LGAs and Health facilities around the Uniformed forces and surrounding communities to facilitate constant delivery of HIV and AIDS services.
		• Provide HIV prevention services to reduce high-risk sexual behaviours while on duty and away from home.
		• Ensure regular supplies of condoms with correct messaging on their correct and consistent use.
		• Sensitize police officers on using the public health approach for KVP service provision (create an enabling environment).
		  ○ Orient police and prison officers to support HIV prevention, especially among KVP groups.
		  ○ Sensitize police on harm reduction service approach.
		  ○ Orient police and prison officers to facilitate HIV prevention, especially among KVP groups.
		  ○ Others face social and legal barriers.
		• Provide HIV prevention services for prisoners.
		• Conduct orientations to address HIV prevention issues such as rape and other forms of sexual abuse, human rights, domestic violence, and the relation between

Sectors	Focus Populations	Priority Responsibilities
		alcohol and HIV infection; Ensure uniformed forces offices have peer educators trained on HIV combination prevention. • Engage police in referrals of PWID. • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Ministry of Defense and National Service	Defense and security services, led by the Tanzania People's Defense Force (TPDF)	• Integrate HIV programming into the Ministry's mandate to protect and defend the country (including securing borders). • Strengthen coordination with LGAs around defence and security units to facilitate constant delivery of HIV and AIDS services. • Provide HIV prevention services to reduce high-risk sexual behaviours while on duty and away from home. • Ensure regular supplies of condoms with correct messaging on their correct and consistent use. Ensure defense and security units have peer educators trained in HIV combination prevention. • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Ministry of Justice and Legal Affairs	Addressing enabling political environment for HIV prevention and legal and structural reforms	• Integrate workplace HIV programming into the Ministry's plans and budgets. • Ensure workplaces have peer educators trained on HIV combination prevention interventions. • Strengthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • Integrate HIV programming into the Ministry's mandate to defend human rights and facilitate the administration of justice (budgets and plans). ○ Review and mainstream HIV and AIDS in all national and sector policies, legislation, agreements, and conventions. ○ 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. • Sensitize legal and paralegal officers on the use of public health approaches for KVP service provision (create an enabling environment) • Facilitate gender-based violence campaign human

Sectors	Focus Populations	Priority Responsibilities
		rights advocacy (free SMS and platforms). • Ensure justice centres promote HIV prevention and reform laws and policies. • Integrate HIV prevention packages into judicial training. • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Ministry of Natural Resources and Tourism	Tourism and hotels, including bars, lodges and casinos	• Integrate HIV programming into the Ministry's plans and budgets. • Ensure workplaces have peer educators trained on HIV combination prevention interventions. • Strengthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • Integrate HIV prevention messages and a regular supply of free condoms into hotel facilities and other touristic attractions (reception, bars, toilets, and washrooms). • Link with health facilities for prevention services and outreach services for at-risk populations. • Integrate HIV prevention packages into tourism training. • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Ministry of Community Development, Gender, Women,	Adult males and females, out-of-school	• Integrate HIV programming into the Ministry's plans and budgets. • Ens

Sectors	Focus Populations	Priority Responsibilities
and Special Groups	youth, orphans, and children made vulnerable by AIDS, cultural institutions, and religious leaders.	ure workplaces have peer educators trained on HIV combination prevention interventions. • Stre ngthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • Facilitate and support the mainstreaming of gender in HIV-related policies, programs, and budgets in public and private entities. • Address sociocultural issues, including gender-based violence, harmful cultural practices (such as female genital mutilation, early marriages, and widow inheritance), gender roles, inequality, and issues surrounding masculinity. • Use the platforms of cultural and religious leaders to address men about issues that escalate HIV transmission. • Enhance the engagement of cultural and religious institutions, special populations, and orphans and vulnerable children. • 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; • Programming for adolescents, orphans, and children made vulnerable by AIDS to reduce vulnerability. • Integ rate programs into social sector development programming and budgeting. • Sub mit quarterly implementation reports to TACAIDS.
Ministry of Education Science and Technology	Adolescents and young people in school	• Integ rate HIV programming into the Ministry's plans and budgets. • Ens ure workplaces have peer educators trained on HIV combination prevention interventions. • Stre ngthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • Ensure that the pre-service curriculum in training and learning institutions integrates HIV and AIDS. • Provide peer counselling and support, including AIDS clubs and directives that address HIV and AIDS-related stigma and discrimination. • Collaborate with CSO 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. • Ensure there is a supportive environment for the

Sectors	Focus Populations	Priority Responsibilities
		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. • Provide age-appropriate messages and comprehensive sexuality education in accordance with the national guidelines. ○ Provide adolescent-friendly messages and clubs. • Ensure implementation of workplace interventions in all institutions under the ministry. • Integrate programs in education sector development programming and budgeting. • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Ministry of Information, Communications, and Information Technology	Youth and adult men and women	• Integrate HIV programming into the Ministry's plans and budgets. • Ensure workplaces have peer educators trained on HIV combination prevention interventions. • Liaise with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • 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 the utilization 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. • Ensure appropriate storage and security of HIV data. • Submit quarterly implementation reports to TACAIDS.
Ministry of Culture, Arts and Sports	Adolescents and young people in school	• Integrate HIV programming into the Ministry's plans and budgets. • Ensure workplaces have peer educators trained on HIV

Sectors	Focus Populations	Priority Responsibilities
		combination prevention interventions. • Strengthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services, • Enhance the engagement of cultural and religious institutions, special populations, and • orphans and vulnerable children in implementing the NMSF, • 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 the mainstreaming of gender in HIV-related policies, programs, and budgets in public and private entities. • Submit quarterly implementation reports to POSPM GG & TACAIDS.
President's Office Public Service Management and Good Governance	Employers, youth, and adult men and women	• Integrate HIV programming into the Ministry's plans and budgets. • Ensure workplaces have peer educators trained on HIV combination prevention interventions. • Strengthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • 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 cooperation with MOFP, use human resource information to make human resource planning projections for HIV and AIDS response coordination across the government and ensure that targets are met. • Collaborate with TACAIDS on monitoring the implementation of the Workplace Code of • Conduct across sectors. • Ensure appropriate workplace policies are in place and enforced. • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Ministry of Finance	Decision makers	• Integrate HIV programming into the Ministry's plans and budgets • Ensure workplaces have peer educators trained on HIV combination prevention interventions • Strengthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and

Sectors	Focus Populations	Priority Responsibilities
		AIDS services • 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 • Ensure that all national development initiatives integrate HIV as envisaged in the NMSF • Submit quarterly implementation reports to POPSM GG & TACAIDS
Other MDAs and Parastatals	All populations	• Integrate HIV programming into Ministries' and Parastatals' plans and budgets. • Ensure workplaces have peer educators trained on HIV combination prevention interventions. • Strengthen coordination with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • Ensure that the National HIV and AIDS Response priority activities are mainstreamed in all MDAs and Parastatals. • Ensure that appropriate HIV prevention interventions are implemented in the respective sectors. • Provide leadership in integrating HIV and AIDS in livelihood programs/ • Disseminate HIV and AIDS messages and services to staff families and surrounding communities • Submit quarterly implementation reports to POPSM GG & TACAIDS.
Private sector	Include banks, microfinance institutions, private clinics, industries and markets	• Integrate HIV programming into the private sector. • Ensure workplaces have peer educators trained on HIV combination prevention interventions. • Liaise with the LGAs around respective Ministry offices to facilitate constant delivery of HIV and AIDS services. • Provide HIV prevention messages in the workplace (including HIV workplace policies). • Institute preferential loan packages for vulnerable

Sectors	Focus Populations	Priority Responsibilities
		groups (e.g., AGYW). • Fund scholarship projects for keeping young girls in school. • Invest in HIV corporate social responsibility • Budget for HIV prevention campaign. • Contribute to funds/awards for good leadership on HIV prevention, HIV testing services, and linkages and referrals of staff for HIV prevention. • Integrate programs into private-sector programming and budgeting.
CSO/ CBO	Implementers, communities	• Actively participate in the processes of establishing and reviewing HIV and AIDS policies on prevention program financing and ensure they address structural challenges such as stigma, 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, KP, 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 the public and private sectors to reduce vulnerabilities and promote equity. • Spearhead efforts to build the capacity of lower-level community-based organizations to fulfil their roles in social mobilization, education, and resource mobilization • Bridge the resource gap (financial and human resource mobilization) to complement government investment in program interventions. • Work with partners to engineer changes in social-cultural beliefs, knowledge, behaviour, and attitudes at the local level as factors that influence norms and practices that fuel HIV transmission, GBV, and VAC.
Development Partners	Donors	• Supporting the GoT to achieve its commitment to end the HIV/AIDS epidemic by 2030. • Provide financial, programmatic, and technical support to the Government of Tanzania. • Support program design, planning, implementation, monitoring, and evaluation.

Table 3: Stakeholder Stewardship Matrix

Areas of Focus	Timelines					Stakeholders to be Involved (Illustrative)	Accountable Entities
	2023	2024	2025	2026	2027		
ESTABLISH HIV PREVENTION PROGRAMMING NEEDS							
• Conduct analysis of epidemiologic trends and patterns (THIS 2.0 primary and secondary data analysis, spectrum data review, and program data review)	X	X	X	X	X	NASHCoP, TACAIDS, DCEA, PO-RALG, UNAIDS, UNICEF, WHO, PEPFAR, GF, HIV Prevention IPs, Community-led organizations, Academic Institutions, Research Institutions	Prevention TWG & SI Teams from TACAIDS & NASHCoP
• Update KVP size estimates (all populations)	X	X	X	X	X	NASHCoP, TACAIDS, DCEA, UNAIDS, WHO, Academic Institutions	M&E TWG, Prevention TWG, SI Teams from TACAIDS & NASHCoP
• Generate HIV prevention targets at national and sub-national levels (by different interventions and populations)	X	X	X	X	X	NASHCoP, TACAIDS, DCEA, UNAIDS, WHO, Academic Institutions	M&E TWG, Prevention TWG, SI Teams from TACAIDS & NASHCoP
• Determine HIV prevention technical, program, administrative, and operational needs. ○ Commodity/ supply forecasting and quantification ○ HRH (number and training needs assessment) ○ M&E systems/ tools review/ development ○ Infrastructure/ equipment needs assessment	X	X	X	X	X	MOH (NASHCoP, DPP, DHRM), TACAIDS, DCEA, WHO, PO-RALG, UNAIDS, UNICEF, PEPFAR, GF, HIV Prevention IPs, Community-led organizations, Academic Institutions, Research Institutions	Prevention TWG, Prevention Units/ Teams at TACAIDS & NASHCoP, DCEA
• Develop/ revise the HIV prevention financial budget to establish resource needs informed by the targets, geographical coverage, and implementation plan (establish funding gap/ needs)	X	X	X	X	X	NASHCoP, MOH-DPP, TACAIDS, DCEA, PO-RALG, UNAIDS, UNICEF, WHO, PEPFAR, GF, HIV Prevention IPs, Community-led organizations, Academic Institutions, Research Institutions	Prevention TWG & SI Teams from TACAIDS & NASHCoP

Areas of Focus	Timelines					Stakeholders to be Involved (Illustrative)	Accountable Entities
MOBILIZE HIV PREVENTION PROGRAMMING RESOURCES							
• Advocacy with external donors	X	X	X	X	X	NASHCoP, MOH-DPP, TACAIDS (Advocacy & DNR), PO-RALG, DCEA, UNAIDS, UNICEF, UNDP, UNFPA, UNWOMEN, UNDOC, WHO, CSO/ community-led organizations	NASHCoP, MOH-DPP, TACAIDS, PO-RALG, DCEA, MoFP, PMO
• Allocate domestic resources	X	X	X	X	X	TACAIDS, NASHCoP, MOH-DPP, PO-RALG, DCEA, MoFP, and all sectoral ministries, departments, and agencies (MDA)	TACAIDS, MOH, and other MDA
• Establish social contracting mechanisms						TACAIDS, NASHCoP, MOH-DPP, PO-RALG, DCEA, MoFP	TACAIDS, MOH, and other MDA
CREATE AN ENABLING ENVIRONMENT FOR HIV PREVENTION PROGRAMMING							
• Multi-sectoral sensitization and buy-in	X	X	X	X	X	NASHCoP, TACAIDS, DCEA, PO-RALG, UN Agencies, WHO, bilateral and multilateral partners, CSO/ community-led organizations	NASHCoP, TACAIDS, DCEA
• Community empowerment and monitoring						--- as above---	--- as above---
• Policy and guidelines development/ reviews	X	X	X	X	X	--- as above---	--- as above---
• Training package development/ reviews	X	X	X	X	X	--- as above---	--- as above---
• Establish/ reinvigorate oversight and coordinating structures (TWGs)	X	X	X	X	X	--- as above---	--- as above---
PREPAREDNESS FOR IMPLEMENTATION							
• Capacitate national, regional, and council stakeholders to meaningfully participate in designing, planning, and implementing HIV prevention interventions	X	X	X	X	X	NASHCoP, TACAIDS, DCEA, PO-RALG, UN Agencies, WHO, bilateral and multilateral partners, CSO/ community-led organizations	Prevention TWG, NASHCoP, TACAIDS, DCEA, PO-RALG, PEPFAR, GF,
• Procurement of commodities and supplies	X	X	X	X	X	MOH, TACAIDS, PO-RALG, MSD, TMDA, DCEA, PEPFAR, GF, UN Agencies, WHO, CSO/ community-led organizations, private sector, MoFP	Prevention TWG, NASHCoP, TACAIDS, DCEA, PO-RALG, PEPFAR, GF,

Areas of Focus	Timelines					Stakeholders to be Involved (Illustrative)	Accountable Entities
HRH training	X	X	X	X	X	--- as above---	--- as above---
CSO capacity building and support	X	X	X	X	X	--- as above---	--- as above---
Design/ refine M&E systems and tools	X	X	X	X	X	--- as above---	--- as above---
Assign HIV prevention scopes/ roles and responsibilities to implement stakeholders (including sharing of targets and reporting tools)	X	X	X	X	X	--- as above---	Prevention TWG, NASHCoP, TACAIDS, DCEA, PO-RALG
PROGRAM IMPLEMENTATION							
Scale up combination prevention interventions nationwide (using precision approaches) tailored to HIV prevention needs, priorities, and HIV incidence. ○ AGYW ○ KVP (KP and other VPs beyond AGYW) ○ Adolescent Boys & Men ○ Condom Programming ○ PrEP (including new options) ○ PEP ○ VMMC/ EIMC ○ STI ○ SBCC & CSE ○ Blood Safety	X	X	X	X	X	NASHCoP, MOH (NBTS), MSD, TMDA, Chief Pharmacist, TACAIDS, DCEA, PO-RALG, UNAIDS, UNICEF, WHO, PEPFAR, GF, HIV Prevention IPs, Community-led organizations,	Prevention TWG, Prevention Units/ Teams at TACAIDS & NASHCoP, DCEA
Support community-led organizations to implement combination prevention interventions (aiming to achieve the 30-40-80 global targets)	X	X	X	X	X	--- as above---	--- as above---
Expand eMTCT Services	X	X	X	X	X	NASHCoP, TACAIDS, DRMCH, PO-RALG, UNAIDS, UNICEF, WHO, PEPFAR, GF, HIV Prevention IPs, Community-led organizations	NASHCoP, DRMCH, TACAIDS
Strengthen treatment as prevention/ ARV	X	X	X	X	X	NASHCoP, TACAIDS, PO-RALG, UNAIDS, UNICEF, WHO, PEPFAR, GF, HIV Prevention IPs, Community-led organizations	NASHCoP, DRMCH, TACAIDS
Address social/ legal barriers and inequalities. ○ Fight stigma and discrimination ○ Remove gender inequalities ○ SGBV Prevention and management	X	X	X	X	X	NASHCOP, TACAIDS, DCEA, PO-RALG, MoHA, MoCJA, CHRAGG	Prevention TWG, Prevention Units/ Teams at TACAIDS & NASHCoP, DCEA
MONITORING, EVALUATION & LEARNING							

Areas of Focus	Timelines					Stakeholders to be Involved (Illustrative)	Accountable Entities
• Monitoring fidelity to implementation	X	X	X	X	X	NASHCoP, TACAIDS, DCEA, PO-RALG, UN Agencies, WHO, bilateral and multilateral partners, CSO/ community-led organizations	M&E TWG, Prevention TWG, SI Teams from TACAIDS & NASHCoP, DCEA
• Monitor the quality of services	X	X	X	X	X	--- as above---	--- as above---
• Monitor progress toward targets	X	X	X	X	X	--- as above---	--- as above---
• Monitor the flow of resources	X	X	X	X	X	--- as above---	--- as above---
• PSAT Assessments	X	X	X	X	X	--- as above---	--- as above---
• GAM report filling	X	X	X	X	X	--- as above---	--- as above---
• Scorecard filling/ reviews	X	X	X	X	X	--- as above---	--- as above---
• Mid-term review of the NMSF V	X	X	X	X	X	--- as above---	--- as above---
• Mid-term review of the HSHSP V	X	X	X	X	X	--- as above---	--- as above---
• Expenditure tracking	X	X	X	X	X	--- as above---	--- as above---
• Monitor implementation of the 10-point actions	X	X	X	X	X	--- as above---	--- as above---
• End-line review of the NMSF V	X	X	X	X	X	--- as above---	--- as above---
• End-line review of the HSHSP V	X	X	X	X	X	--- as above---	--- as above---
GOVERNANCE, OVERSIGHT & COORDINATION							
• Multi-stakeholder HIV prevention Road Map reviews (quarterly)	X	X	X	X	X	NASHCoP, TACAIDS, DCEA, PO-RALG, UNAIDS, UNICEF, WHO, PEPFAR, GF, HIV Prevention IPs, Community-led organizations, all other key MDA	Prevention TWG, Prevention Units/ Teams at TACAIDS & NASHCoP, DCEA
• R/C/W/VMAC meetings (quarterly)	X	X	X	X	X	--- as above---	--- as above---
• Community-led monitoring report review (bi-annually)	X	X	X	X	X	--- as above---	--- as above---
• Prevention TWG meeting (quarterly)	X	X	X	X	X	--- as above---	--- as above---

7.0. FINANCING THE HIV PREVENTION ROAD MAP 2023/24 - 2026/27

7.1. Introduction

This chapter presents an analysis of the estimated resource needs, projected future funding, and resource gaps. It highlights key financing strategies for achieving HIV Prevention Road Map 2023/24-2026/27 strategies. The costing and financing analysis for the Road Map builds on a similar analysis conducted for the Fifth National Multisectoral Framework (NMSF V 2021–2025), Fifth Health Sector HIV Strategic Plan V (HSHSP V 2021-2025), and Condom Needs and Resource Requirement Estimation Tool (The Condom Tool) 2019-2023, and the Fifth Health Sector Strategic Plan V (HSSP V 2021/22-2025/26). The costing analysis was done and presented in line with the National HIV Prevention Road Map 2023/24-2026/27, which prioritized evidence-based prevention strategies and the domesticated GPC's 10-point actions.

7.2. Methodology

7.2.1. The Costing Approaches

The costing of the Road Map employed a mixed-method approach in determining the resource needs for its implementation: The top-down and bottom-up methods. The top-down method was applied to cost the priority prevention interventions, and the general costing formulae were applied, including $\sum$ **(Targeted Population size X % of Population in Need (PIN) X %Coverage target X Unit cost).**

Where:

(1). Relevant/target population size estimate for the priority populations # (data preloaded).
(2). PIN refers to the population estimates of the target population in need of service or intervention.
(3). Coverage targets (%) reach of the intervention. Obtained from national and international targets or experts' opinions.
(4). Unit cost computed or adapted from the literature.

For consistency, we adopted unit costs from existing studies and other recent cost estimations done in various HIV/AIDS applications such as 7th GF cycle application (GC7), NMSF V 2021–2025, HSHSP V 2021-2025, Condom Needs and Resource Requirement Estimation Tool (The Condom Tool) 2019-2023, HSSP V 2021/22-2025/26), and the Activity-Based Costing and Management (ABC/M) study[17] conducted by Health Policy +.

The bottom-up or micro-costing method was used to cost the 10-point action plan. Microcosting was applied by measuring and valuing each resource consumed in the process of implementing the 10-point action plan. Steps in conducting the micro-costing/activity-based costing included (1) defining the 10-point action plan activities and identifying inputs. (2) quantify inputs. Step 2 required systematically measuring the unit quantity of each type of resource consumed. (3). Value

[17] 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

inputs and aggregate. In step 3, each type of input was assigned a unit cost, and for each input type, the unit cost was multiplied by the unit quantity and aggregated to find the total cost.

7.2.2. 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, KVP, and other stakeholders working in HIV/AIDS response. Data sources to inform costing included the NMSF V, 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, GFGC7 application, Investment case 2.0, PEPFAR COP 21, and other published and unpublished costing studies. Expert opinions were used in case of missing or incomplete data. Government circulars and group consensus were used to standardize prices for common costing inputs such as conference packages, Per Diem rates, transport costs, etc. Costs were collected in both TZS and U.S. dollars using an exchange rate of TZS 2600 to 1 USD.[18]

7.2.3. Adjusting for Inflation

GDP implicit price deflators[19] were used to adjust for inflation during the costing. To apply the GDP implicit deflator, you multiply the cost by the ratio of the relevant metric from the year you want to adjust the costs to and the year they are currently in. The adjustment for inflation applies the following formulae:

$$\textbf{Cost (year X)} = \textbf{Cost price(base year)} * \frac{\textbf{GDP Deflator(year x)}}{\textbf{GDP Deflator (base year)}}$$

7.2.4. Adjusting for Foreign Exchange

The assumption was made on the forex exchange rate at 1USD = TZS 2600

7.2.5. Total Fund Needs for Implementing the Road Map

Total Cost for Implementing the Road Map

The total cost for implementing the Road Map 2023/24-2026/27 will amount to US$ 1,101,859,718 (TZS 2,864,835,268,099.79), combining the priority intervention and the 10 Action Point Plan.

The HPRM 2024-2027 Priority Interventions

As reported in Table 4, the cost for the entire planning timeframe of the activities reported in the HIV Prevention Road Map 2023/24-2026/27 Priority Interventions is equal to around US$ 1,095,953,767.18 (TZS 2,849,479,794,668). This cost will continue to grow in the next 4-years from US$ 224,671,543 in 2023 to US$ 311,698,859 by 2027.

[18] BOT.2022. Monthly Economic Review April 2022
[19] GDP implicit price deflators measure the changes in prices for all the goods and services produced in an economy

Table 4: HIV Prevention Program Resource needs estimate

Interventions	Priority Interventions Implementation Costs (USD)				Total (USD)
	2024	2025	2026	2027	
Reducing New Infections					
KVP Interventions					
▪ *MHR*	5,326,779.78	6,841,939.27	8,546,492.22	9,266,196.83	**29,981,408.10**
▪ *FHR*	21,710,407.32	25,343,282.14	29,174,590.09	31,631,397.68	**107,859,677.24**
▪ *PWID*	1,776,600.00	2,073,884.40	2,387,406.92	2,588,451.72	**8,826,343.04**
▪ *Prisoners*	1,920,978.36	2,242,422.07	2,581,423.53	2,798,806.56	**9,543,630.52**
▪ AGYW Interventions	85,848,674.84	111,775,265.35	134,863,425.65	138,909,328.42	**471,396,694.25**
Condom Programming	202,036.61	226,963.08	252,367.47	273,619.47	**954,986.64**
PrEP	8,333,663.94	15,451,009.20	16,652,754.36	17,167,788.00	**57,605,215.50**
STI	12,496,891.39	14,593,701.05	16,304,277.64	17,677,269.44	**61,072,139.52**
Blood Transfusion	12,093,750.00	15,770,250.00	17,221,500.00	19,350,000.00	**64,435,500.00**
VMMC	32,069,303.64	33,160,190.58	33,031,382.75	36,334,521.02	**134,595,397.99**
SBCC (all at risk groups)	2,512,778.80	10,388,379.19	10,352,648.66	10,663,228.12	**33,917,034.78**
Critical Enablers					
Stigma & Discrimination	3,944,992.04	3,470,098.54	2,593,622.42	890,477.03	**10,899,190.03**
GBV/VAC	16,728,303.42	1,728,581.05	1,723,015.25	1,774,705.71	**21,954,605.43**
PMTCT					
Mothers	17,817,350.43	18,262,787.41	18,786,936.85	20,368,994.69	**75,236,069.38**
Infants	1,889,032.53	1,837,064.11	1,945,703.51	2,004,074.61	**7,675,874.76**
Total USD	**224,671,543**	**263,165,817**	**296,417,547**	**311,698,859**	**1,095,953,767.18**

The Cost of Implementing the 10-Point Actions of the Road Map

The total cost for implementing the 10 Action Point Plan for a period of four years (2024-2027) will amount to US$ 5,905,951.32, ranging from US$ 1,536,222.91 in 2024 to US$ 948,806.24 in 2027. Table 5 shows the costs of implementing the 10 Action Point Plan.

Table 5: Road Map 10 Action Point Plan Implementation Cost

10-Point Actions	2024	2025	2026	2027	TOTAL (USD)
Action Point #1: CONDUCT AN EVIDENCE-DRIVEN ASSESSMENT OF HIV PREVEPROGRAMME NEEDS AND BARRIERS	140,755.77	146,942.84	153,551.75	160,672.09	**601,922.44**
Action Point #2: ADOPT PRECISION PREVENTION APPROACH TO DEVELOP NATIONAL HIV PREVENTION GOALS AND ALIGN 2025 TARGETS	125,576.92	131,192.90	136,993.01	171,114.02	**564,876.85**
Action Point #3: DETERMINE COUNTRY INVESTMENT NEEDS FOR ADEQUATELY SCALED HIV PREVENTION RESPONSES AND ENSURE SUSTAINABLE FINANCING	54,346.15	70,122.86	69,990.30	70,184.33	**264,643.64**
Action Point # 4: REINFORCE HIV PREVENTION LEADERSHIP ENTITIES FOR MULTISECTORAL COLLABORATION, OVERSIGHT AND MANAGEMENT OF PREVENTION RESPONSES	134,597.27	-	-	-	**134,597.27**
Action point# 5: STRENGTHEN AND EXPAND COMMUNITY-LED HIV PREVENTION SERVICES AND SET UP SOCIAL CONTRACTING MECHANISM		230,683.57	152,869.57	-	**383,553.13**
Action Point # 6: REMOVE SOCIAL AND LEGAL BARRIERS TO HIV PREVENTION SERVICES FOR KEY AND PRIORITY POPULATIONS	151,711.54	1,053,538.46	-	-	**1,205,250.00**
Action Point # 7: PROMOTE THE INTEGRATION OF HIV PREVENTION INTO ESSENTIAL RELATED SERVICES TO IMPROVE HIV OUTCOMES	343,283.33	302,740.77	251,653.85	174,350.00	**1,072,027.95**
Action Point # 8: SET UP MECHANISM FOR THE RAPID INTRODUCTION OF NEW HIV PREVENTION TECHNOLOGIES AND PROGRAM INNOVATIONS	120,403.85	52,238.46	67,500.00	70,630.04	**310,772.35**
Action Point # 9: ESTABLISH REAL-TIME PREVENTION PROGRAMME MONITORING SYSTEMS WITH REGULAR REPORTING	424,240.38	266,567.31	334,336.54	266,567.31	**1,291,711.54**
Action Point # 10: STRENGTHEN ACCOUNTABILITY OF ALL STAKEHOLDERS FOR PROGRESS IN HIV PREVENTION	41,307.69	-	-	35,288.46	**76,596.15**
Total (USD)	**1,536,222.91**	**2,254,027.16**	**1,166,895.01**	**948,806.24**	**5,905,951.32**

8.0. MONITORING AND RESULTS FRAMEWORK

8.1. Monitoring and Evaluation Framework

The Road Map builds upon existing or planned infrastructure for data management systems, extending from the facility level through local government authorities to the national level. The importance of effective monitoring, evaluation, and research systems in reporting on and guiding the national response to HIV and AIDS cannot be overemphasized.

Throughout the implementation of this plan, the M&E system will be enhanced to measure progress towards the timely achievement of the established objectives. The M&E system will monitor the realization of planned program inputs, processes, outputs, outcomes, and impact. Ideally, a comprehensive national M&E system will encompass various types of data collection and reporting tools, as well as mechanisms to distribute attention to both data production and utilization equitably.

8.2. Core Indicators

Both impact and outcome indicators measure the extent to which the program has achieved its objectives. Explicitly, impact indicators are linked to program objectives, while outcome indicators are associated with the program goal. Table 6 highlights a few selected impact and outcome indicators for the Road Map derived from NMSF V and HSHSP V.

8.3. HIV Prevention Indicator Matrix

Table 6: HIV Prevention Results Framework

Intervention Area	Indicator Description	Baseline		2025 Targets		2027 Targets	
		%	Year	Target %	Year	Target %	Year
1. NEW INFECTIONS	**IMPACT INDICATORS**						
	1.1. HIV Incidence	15-24 years –0.07% 15-49 years -0.24% 15-64 years -0.25%	2020	15-24 years – 0.00% 15-49 years –0.12% 15-64 years – 0.12%	2025	15-24 years – 0.00% 15-49 years - <0.1% 15-64 years - < 0.1%	2027
	1.2. Proportion of infants born to HIV-infected mothers who are HIVinfected after 18 months from birth or three months after cessation of breastfeeding.	7.9%	2018	<4%	2025	<2%	2027
	OUTCOME INDICATORS						
2. ELIMINATION OFMOTHER-TO-CHILD TRANSMISSION (MTCT)	2.1. Proportional of exposed infants surviving and HIV-free at18 months of age.	90%	2020	98%	2025	100%	2027
	2.2. Proportion of pregnant women tested for HIV and who know their status	98% (2017 data)	2020	100%	2025	100%	2027
	2.3. Proportion of pregnant and lactating/ breastfeeding women who know their status	96%(2016 data)	2020	95%	2025	100%	2027
	2.4. Percentage of HIV-infected pregnant women receiving ARVs to reduce the risk of MTCT of HIV	98.6%	2020	100%	2025	100%	2027
	2.5. Proportion of Pregnant and lactating/ breastfeeding women with HIV virally suppressed	87%(2017 data)	2020	95% at 12 months, >90% at 24 months	2025	95% at 12 months, >95% at 24 months	2027

Intervention Area	Indicator Description	Baseline		2025 Targets		2027 Targets	
		%	Year	Target %	Year	Target %	Year
3. REDUCTION OF SEXUALLY TRANSMITTED AND BLOOD-BORNE NEW HIV INFECTIONS	3.1. Number of NEW HIV infections	68,000	2020	16,000	2025	<15,000	2027
Key and vulnerable populations (KVP)	3.2. Percentage of members of KVP who are reached with a minimum package of prevention interventions	FHR: 69%(2017 data) Fishermen: 0.% (2018 data) Prison inmates: 0%(2018 data) Miners: 0%(2018 data) MHR: Data unavailable PWID: Data unavailable	2020	95%	2025	>95%	2027
Vulnerable Adolescent Girls and Young Women (vAGYW)	3.3. Percentage of vulnerable AGYW who have tested for HIV in the last 12 months and know their results	27.8%	2020	95%	2025	>95%	2027
Comprehensive Condom Programming	3.4. Percent of females and males aged 15–49 who were in non-marital, non-cohabiting sexual relationships in the past 12 months who used a condom during their last sexualintercourse.	31.7%	2020	95%	2025	>95%	2027
	3.5. Percentage of youth 15-24 who used a condom at the last sexual intercourse	M: 42%(2016 data) F: 37%(2016 data)	**2020**	**80%**	**2025**	>95%	2027
	3.6. Percentage of members of KVPs who reported using a condom during their last high-risk sexual encounter in the last 3 months	67% - Mining Men 50% -people in transport corridor 20% - fisherfolks 71% - FHR 20% - Men at-high risk	2020	95%	2025	>95%	2027

Intervention Area	Indicator Description	Baseline		2025 Targets		2027 Targets	
		%	Year	Target %	Year	Target %	Year
		48% - MHR (2012 data) 35.8% - PWID					
Pre-Exposure Prophylaxis (PrEP)	3.7.a. Percentage of PrEP users who continued oral PrEP for three consecutive months after having initiated PrEP in the last12 months.	82%	2020	85%	2025	90%	2027
	3.7. b. PrEP Continuation (PrEP CT)	FHR 60% Men at high risk 50%	2020	70%	2025	85%	2027
	3.8. Proportion of targeted audience with comprehensiveknowledge about PrEP	67% - Miningmen 50% - People in transport corridor 20% - fisherfolks 71% - FHR 20% - Men at-high risk 35.8% - PWID	2020	95%	2025	100%	2027
Post-Exposure Prophylaxis (PEP)	3.9. Percent occupationally and non-occupationally exposed HIV-negative individuals timely received HIV Post- Exposure Prophylaxis (PEP) services	Data unavailable	2020	90%	2025	95%	2027
	3.10. Percentage of PEP users who seroconvert 3 months after completing the course.	No data	2020	0%	2025	0%	2027
Voluntary male medical circumcision (VMMC) Services	3.11. Proportion of circumcised males (disaggregated byregions)	75% (2020 Program data) 80% in THIS 2016	2020	95%	2025	>95%	2027
	3.12. Proportion of circumcised clients experiencing at least one moderate or severe adverse event (AE) during or following surgery within the reporting period	0.18%	2020	0.00%	2025	0.00%	2027

Intervention Area	Indicator Description	Baseline		2025 Targets		2027 Targets	
		%	Year	Target %	Year	Target %	Year
Sexually Transmitted Infections (STIs)	3.13. Prevalence of syphilis amongst pregnant women	1.5%	2020	NA	2025	**N/A**	2027
Blood safety and Quality	3.14. Proportion of donated blood units screened for HIV and other TTIs in quality-assured procedures per WHO standards	100%	2020	100%	2025	100%	2027
Social and behaviour change communication (SBCC)	3.15. Percentage of young women and men ages 15–24 whohave had sexual intercourse before the age of 15 years	9.1% Females 14.3% Males	2020	5%	2025	<5%	2027
4. CRITICAL ENABLERS [GENDER-BASED VIOLENCE (GBV) ANDVIOLENCE AGAINST WOMEN AND CHILDREN (VAWC), AND STIGMA & DISCRIMINATION)	4.1. Proportion of men and women ages 15–49 who experienced physical or sexual violence in the past 12 months	40%	2020	0%	2025	0%	2027
	4.2. Proportion of sexually abused clients receiving HIV post-exposure prophylaxis	No data	2020	100%	2025	100%	2027
	4.3. Proportion of sexually and physically abused clients tested for HIV	No data	2020	100%	2025	100%	2027
	4.4. Percentage of PLHIV who experienced or perceived	External stigma: 5.5%(2021 data)	**2020**	<5%	2025	<5%	2027
5. SUPPLY CHAIN MANAGEMENT	5.1. Percentage of tracer HIV prevention commodities that were available in the HF at a particular period out of items in use (Commodityavailability)	TBD	2020	100% for ARVs 90% for other HIV commodities	2025	100% for ARVs 95% for other HIV commodities	2027

9.0. REFERENCES

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10.0. ANNEXES

Annex 1: HIV Prevention Interventions

1. REDUCTION OF NEW HIV INFECTIONS
1.1. Combination Prevention for Key and Vulnerable Populations
• Scale up the provision of high-quality, comprehensive, and client-centred HIV services to all identified key and vulnerable population groups.
• Promote a 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
• Improve the mainstreaming of rehabilitation and reintegration of PWID into society through mapping and working with CSO, FBO, NGO, and CBO and trained KVPs.
• Strengthen the use of local epidemiological data to inform robust data-driven KVP programming (i.e., KVP profiling/characterization, size estimates, geographical mapping, and granularized target setting). This will include expanding combination prevention services to other unreached KVP (including sexual partners and children of KVP) as described in the earlier section.
• Improve resource allocation and accountability of KVP program implementation at all levels.
• Improve the current KVP M&E system, research and learning agenda (RLA) to be able to cater to program needs and shifts, inform policymakers and program implementers, and track interventions for KVP.
• Strengthen community systems and PPP to foster sustainability of KVP interventions (This will include fostering the engagement of KVP and capacity building of CSO to meaningfully engage in the design, implementation, and monitoring of KVP interventions).
• Scale-up community-led monitoring (CLM) to improve the quality KVP services.
• Increase investment in KP community-led organizations through existing partnerships.
1.2. Combination Prevention for Adolescent Girls, Young Women, and At-Risk Adult Women
• 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 for adolescent girls in collaboration with relevant stakeholders.
• Promote public-private partnerships with appropriate stakeholders working with AGYW.
• Support strengthening and expansion of youth-friendly services and improved health-seeking b[51]aviour among AGYW

• Scale-up evidence-based and innovative AGYW combination prevention program interventions nationwide (prioritizing geographical areas with high transmission dynamics).
• Strengthen the referral system and coordination between health and multi-sectoral social protection interventions.
• Strengthen the involvement of adolescent girls in HIV prevention programming for the elimination of new HIV/STI infections (engaging them in the design, planning, implementation, operational research, monitoring, and evaluation of HIV combination prevention interventions).
• Advance gender equality and girl empowerment.
• Strengthen parent/guardian engagement.
• Strengthen the integration of HIV and SRH services to meet AGYW needs.
• Create an enabling environment to facilitate access to HIV prevention programs and promote acceptable sexual and health-seeking behaviours among AGYW.
• Strengthen M&E systems and operational research to inform policymakers and program implementers on AGYW HIV-related issues. This initiative should include enhancing the capacity of frontline providers to analyze data for AGYW.
• Scale up comprehensive sexuality education (in and out of school).
1.3. Adolescent Boys, Young Men, and At-Risk Adult Men
• Revitalize the general population prevention programming agenda by advocating for donors, the private sector, community structures, and implementers to increase HIV prevention focus.;
• Scale-up the provision of cost-effective, evidence-based, and risk-matched HIV prevention interventions to this population, including re-launching, campaigns that showed evidence of better results, including mainstream social media and print SBC materials.
• Advocate for the inclusion 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.
• Expand adolescent and youth-friendly health services (AYFHS) to include adolescent boys.
• Mobilize resources and improve the allocation and accountability of R/CHMTs in planning, budgeting, coordinating, and overseeing interventions targeting the general population.
• Leverage KVP programming investments and tools to enhance reach to the general population;
• Strengthen the current M&E system and the research and learning agenda (RLA) to cater to the needs of the general population.
• Employ data-driven approaches to segment and target the general population according to risk profiles;
• Promote meaningful engagement of age-appropriate ABYM peers to maximize uptake of prevention services among adolescent boys and men.
• Integrate and intensify occupational and home-based approaches in reaching ABYM, at-risk women, and adult men with HIV prevention services.
• Scale up hotspot mapping for ABYM, adult at-risk men and women targeting recreational venues and male-friendly corners.
1.4. Comprehensive Condom Programming
• 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 condom 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 consistent use of condoms through mass media and social media strategies and through multiple channels.
• Empower adolescent girls and women to increase their condom negotiation skills.
• Diversify condom distribution and marketing approaches at different levels, including within communities:
a) Improve market stewardship through strong leadership and coordination in support of TMA.
b) Strengthen condom distribution from facility to community level (e.g., bars, guest houses, night clubs) using various community channels and structures (CHACC, WEO, VEO, peers).
c) Scale up the community dispenser model by installing additional condom dispensers in unreached community venues/hotspots, HLIs, and workplaces.
• Maximize market efficiency, equity, and sustainability by coordinating condoms available through the public, social marketing, and commercial sector (including introducing a mechanism to regulate condom prices).
a) Strengthen the integration of condom programming with HIV, SRH, and other facility-and community-based interventions (general population and at-risk groups).
b) Improve availability and consistent supply of male and female condoms.
c) Improve forecasting, quantification, and supply and planning of condoms, according to the NMCS and the newly issued condom distribution guide (this process is supposed to be done in a participatory manner).
d) Strengthen the condom supply chain and distribution systems to ensure that adequate quantities are available in a timely manner, accessible, and equitably distributed at the facility and community level, including workplaces. (This strategy goes hand in hand with the development of a sustainable, cost-effective condom distribution model/ecosystem that uses local structures).
e) Improve surveillance, evaluation, and operational research in condom programming.
f) Condom coordination at a low level is still an issue.
g) .Condom as an HIV prevention tool.
h) Quantification.
i) Condom use frequency of sexual acts is a challenge.
1.5. Pre-Exposure Prophylaxis (PrEP)
• Support improved coordination and linkages to scale up the 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.
• Enhance PrEP accessibility, acceptability, and effective use among PrEP users.
a) Support effective SBCC messages and ensure strong linkages between PrEP and existing and associated services, such as sexual and reproductive health services.
• Capacity building of healthcare providers nationwide (improve HRH for PrEP).
• Scale-up facility-based and facility-led community-based quality PrEP services nationwide in alignment with the approved implementation framework.
• Strengthen pharmacovigilance for PrEP.

• Establish a proactive mechanism for reviewing evidence, assessing acceptance, approval, registration, transitioning, and scale-up of the PrEP options.
• Enhance the integration of PrEP into HIV combination prevention services (with special emphasis on comprehensive condom programming).
• Build the capacity of CSO in PrEP service design, planning, delivery, and monitoring (Community-Led Monitoring).
• Engage multi-stakeholders at the national, regional, and council levels to foster ownership and sustainability (including R/CHMT, CSO, etc.).
• Strengthen PrEP M&E systems (including the capability for registering transfer outs), enhance data used for programming, and develop PrEP research and learning agenda to inform program improvement, quality assurance, and quality data for decision-making to improve PrEP program implementation.
• Strengthen the quantification, forecasting, and procurement of PrEP commodities (laboratory reagents and medications).
1.6. Post-Exposure Prophylaxis (PEP)
• Improve community and healthcare worker awareness of HIV PEP, including specific community sensitization on post-violence care for GBV/VAWC and sexually assaulted victims. This intervention will also include the dissemination of job aids for providers and SBCC materials for the community.
• Strengthen efforts to prevent accidental exposure in healthcare, community settings, and other sectors.
• Build the capacity of HCPs in PEP service provision.
• Build the capacity of law enforcers and legal officers in PEP to enable them to facilitate timely access to PEP (particularly for cases of sexual assault/rape)
• Strengthen the integration of HIV PEP in workplace programming.
• Strengthen oversight of PEP services at the central and local levels.
• Improve PEP reporting M&E system and tools.
1.7. Voluntary Male Medical Circumcision (VMMC)
• Support expansion of quality VMMC and EIMC services in line with the National VMMC sustainability manual. Specific efforts should ensure sustainability, including mobilization of domestic resources and encouraging community and family involvement in bearing the costs.
a) Strengthen VMMC/EIMC service integration.
b) Scale-up EIMC services to all hospitals and 50% of Health Centres in 17 priority regions.
c) Scale up VMMC services to high-risk groups and locations and increase focus on priority regions that have not yet attained 90% prevalence.
• Support demand creation efforts for VMMC services in priority regions through age-appropriate messages and developing SBCC materials that address myths and misconceptions associated with VMMC and EIMC.
a) Strengthen the involvement of traditional circumcisers in demand generation to mobilize clients, especially adults, to uptake services.
b) Strengthen community engagement, structures, and communication channels to promote VMMC among older males.
• 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.

• Develop and implement a cost-effective, shortened, modularized on-the-job training package for the utilization of the VMMC and EIMC Sustainability Operational Manual.
• Mobilize domestic resources for VMMC/EIMC services.
1.8. Sexual and Reproductive Health (SRH) Services, STI screening, diagnosis and treatment
• Increase community awareness about STIs (including promotion of HPV vaccination for those eligible).
• Strengthen STI management services for PLHIV and KVP as part of the standard package of HIV prevention.
• Strengthen the integration of STI management into combination prevention services, namely PLHIV care, treatment services, and other SRH services (including improving contact tracing).
• Revitalize regular antimicrobial resistance AMR surveillance of STIs to determine if current regimens are still effective and to guide the selection of appropriate treatment regimens.
• Improve the quality of STI services (in all service delivery platforms) as part of the quality assurance and quality improvement strategy.
• Rollout e-learning STI/RTI screening and management training.
• Improve the availability of STI commodities at the facility level (including medicines and laboratory reagents).
• Scale-up dual HIV/Syphilis testing for pregnant women attending ANC and appropriately manage those who are infected.
• Strengthen multi-sectoral approach to comprehensive HIV prevention modalities to meet community demand.
• Improve coordination, integrated management, and monitoring of HIV/SRHR services so as to ensure the quality of SRH.
• Strengthen the M&E system for the improvement of data collection and reporting from the source of STI management;
• STI surveillance and research.
• Improve quantification, procurement, and supply management for SRH commodities.
• Mobilize resources to support capacity building of HCWs on STI diagnosis and management, procurement of STI medicines and laboratory commodities.
1.9. Social Behavioral Change Communication & Comprehensive Sexuality Education
• Scale-up evidence-based, locally-contextualized, age-appropriate, human-centred design (HCD) SBCC interventions using multiple channels to facilitate risk reduction, increase uptake of HIV services, and address critical enablers and barriers of behavioural change.
• Enhance the engagement of parents /guardians in promoting acceptable behavioural change, moving away from deviant behaviour among adolescents and youth.
• Strengthen the engagement of religious and community leaders in behavioural change initiatives.
• Advocate for scale-up of faith-based community initiatives (FCI) to mainstream and integrate tailored SBCC activities for HIV prevention.
• Revitalize community peer support groups, alcohol rehabilitation groups, sober houses, post-test clubs, and economic empowerment groups to help increase access to information and education in the prevention of HIV.

• Integrate IEC into all HIV prevention interventions. IEC should be an integral element in promoting sustainable behavioural change among KVP and the general population at risk of HIV acquisition, such as adolescent boys and men, at-risk women, etc. For IEC to be effective, it should be administered nonjudgmentally based on known, factual, researched information to the targeted KVP and the general population. Paying respect to social and cultural norms within the limits of the existing policy environment is of paramount importance in the course of implementing IEC.
• Scale-up evidence-based messaging on the benefits of treatment as prevention (TasP), e.g., Undetectable = Untransmissible, and support re-engagement in care.
• Ensure integration of occupational-based SBCC and peer education on HIV prevention services, e.g., targeted SBCC and peer education for boda-boda, miners, fisher folks, garage, youth hangouts like spots and betting points, saloons, and massage parlours, formal jobs, e.g., banking industry, etc.
• Reinforce stakeholder coordination across all levels of implementation, i.e., national, sub-national, and community levels.
• Advocate for policy and regulatory changes to strengthen the supportive environment for SBCC interventions and service provision, e.g., alcohol and drug abuse prevention and management policies that promote behaviour change.
• Scale up comprehensive sexuality education.
• Strengthen SBCC M&E to include comprehensive HIV and AIDS behavioural and social science operational research.
• Ensure adequate financing and resources for implementing SBCC strategies at all levels. This strategy includes increasing the engagement of the private sector to support SBCC interventions.
1.10. Strengthen Blood Safety and Quality
• Increase blood collection to meet the national requirement by strengthening the NBTS and its networks.
• Increase public awareness and community engagement in voluntary blood donation through innovative initiatives.
• Strengthen the sample transportation and supply chain system to reduce TAT on test result feedback.
• Strengthen the electronic information system of blood safety programs at all levels to enable referral, tracking, and linkage of blood donors who tested HIV positive to care and treatment services.
• Establish and maintain engagement with private health facilities in the NBTS and blood safety program initiatives.
• Establish sustainable funding mechanisms to maintain access to and availability of safe blood and blood products.
• Support ZBTCs in implementing and maintaining quality management systems and participating in external quality assessment (EQA) and accreditation programs to ensure blood safety.
• Strengthen the DHIS2 system to capture and track blood safety indicators.
2. ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV INFECTION
• Enhance initiatives that increase access and provision of quality PMTCT services that are delivered under a differentiated service delivery model with a family approach.
a) Enhance the utilization of peer mothers to ensure more effective screening of infants and young children who are eligible for testing by using immunization cards and following up mother-baby pairs (with a specific focus on mothers who are adolescents and young women).
b) Expand and improve the quality of PMTCT services (HTS for pregnant women, retesting of previously negative women, EID and HVL).

c) *Scale-up mother-to-mother and peer-led mentoring, counselling, and other community-based psychosocial support services for pregnant and breastfeeding women.*
d) *Strengthen community involvement and enhance the participation of community structures in comprehensive eMTCT and pediatric care and support. This will include the engagement of trained peer mothers and other key community health volunteers using immunization cards and following up mother-baby pairs (with a specific focus on mothers who are adolescents and young women).*
e) *Strengthen primary prevention of HIV among HIV-negative women identified during antenatal, postnatal, and breastfeeding periods (including offering PrEP for pregnant and breastfeeding women who are at a greater risk of acquiring HIV).*
• 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.
• Promote programs that improve community knowledge, awareness, attitudes, perceptions, behaviourals, and practices to support eMTCT and Pediatric HIV care and treatment through communication interventions.
• Strengthen community-based OVC programs to support HIV testing among children and linkage to HIV care and treatment and social services.
• Scale-up couples testing (including for HIV/Syphilis Duo and viral hepatitis) as well as HIV re-testing of negative PBFW at ANC, Postnatal Care (PNC), and immunization clinics.
• Build the capacity of HCPs to improve their skills so that they can offer non-judgmental and supportive services to youth and KVP seeking ANC and PNC services.
• Create community awareness to boost male partner involvement in PMTCT services (including testing of partners of pregnant women).
• Deploy an electronic Case-Based Surveillance and Management (CBSM) response to all facilities offering PMTCT services.
3. ADDRESSING SOCIAL/ LEGAL BARRIERS AND INEQUALITIES
3.1. Fighting Stigma and Discrimination
• Advocate for the integration of stigma and discrimination programming into 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 causes and address stigma and discrimination practices in facilities and communities.
• 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 accessing HIV services.
• Promote meaningful engagement of PLHIVs, including young PLHIVs, in planning and delivering HIV services and build the capacity of their association and networks to strengthen their voice and influence.
• Empower networks/support groups for PLHIV, KVP, and GBV survivors.
• Increase community awareness of issues related to stigma and discrimination.
• Build the capacity of HCPs, CHWs, and social welfare and media professionals, including raising awareness on human rights and ethical issues related to medical records keeping to promote adherence to professional codes of ethics and conduct by HCWs.
• Create an enabling policy environment for HIV prevention, care, and treatment for all PLHIV, GBV survivors, and KVP that are free of stigma and discrimination. This will include:
a) *Scaling up SBCC interventions and campaigns to address harmful social norms at the community level.*

b) *Strengthening and enforcing the implementation of workplace HIV policies and regulations for reducing and eliminating HIV-related stigma and discrimination.*
c) *Capacity building on HIV-related Stigma and Discrimination among lawmakers and law enforcers.*
d) *Advocacy for the improvement of laws, legislations, regulations, and policies relating to HIV and AIDS and KVP HIV Programming. This will also include carrying out a follow-up Legal Environment Assessment.*
e) *Enhance meaningful engagement of the media (involve high-level Government leaders, Champions, Religious leaders, and PLHIV (testimonies) to address stigma and discrimination, gender, and age-related barriers to access HIV services).*
f) *Engage religious and community leaders in reducing stigma and discrimination based on HIV and gender-related barriers to accessing HIV services.*
• Enhance the implementation of Monitoring Evaluation and Reporting (MER) to track different forms of stigma.
3.2. Remove Gender Inequalities
• Promote mainstreaming of gender into comprehensive HIV strategies, programs, and services, including social protection for 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 CSO Coalitions, FBO, private sectors, and government MDAs to design, innovate, and improve interventions addressing societal norms, GBV, stigma, and other barriers to health services.
• Enhance health information systems to support the collection and utilization of gender-related data to support evidence-based decision-making and interventions.
3.3. Prevention and Management of Gender-based Violence and Violence Against Women and Children
• 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.
• Promote engagement of other sectors CSO, coalitions, and FBO to design, innovate, and improve interventions addressing post-GBV, stigma, and other barriers to services.
• Increase community awareness of GBV/VAWC (prevalence, link with HIV and other poor SRH outcomes, importance of reporting, and available services and support); Increase awareness of GBV/VAWC at workplaces and academic institutions.
• Strengthen the integration of GBV/VAWC/VAM prevention and response in HIV combination prevention programs for all populations.
• Advocate for the amendment of legislation that increases the risk of HIV transmission among women, girls, and adolescent boys.
• Strengthen the bi-directional referrals and linkages for reporting, prevention, and management of GBV/VAWC.
• Strengthen M&E systems to collect, analyze, and produce gender-responsive data.
• Advocate for increased investment in comprehensive combination prevention programs that have integrated GBV for all populations.
4. RESILIENT AND SUSTAINABLE HEALTH AND COMMUNITY SYSTEMS FOR HIV PREVENTION
4.1. HIV Prevention Commodity Supply Chain Management

• Roll out the redesigned logistics system to all HFs, including reporting of monthly stock in hand and consumption data, as well as improving logistics data quality at the last mile.
• Strengthen the use of electronic data systems (e-LMIS & PMD); integration of E10, e-LMIS, and PMD; analysis and use of data at all levels of the system, including system improvement (dashboard) to enhance end-to-end visibility of key logistics and supply chain data in the context of an integrated information system that links and triangulates facility-level logistic information and global PSM data (order and shipment data) for better planning and monitoring.
• Develop an in-country procurement and shipment tracking system (dashboard) for health commodities procured by MSD and donors (procurement tracking and upstream pipeline monitoring).
• Strengthen national-level capacity in forecasting and supply planning for HIV prevention commodities (MoH, MSD, and PO-RALG).
• Mobilize domestic resources through the AIDS Trust Fund using advocacy for increased government budget allocations and tap on other sources, such as insurance funds and private sector funds, to fund the procurement and distribution of HIV commodities.
• Strengthen collaborative efforts in coordination and monitoring of supply chain management interventions between the MoH, PO-RALG, and Implementing Partners.
• Improve MSD's storage and distribution capacity to facilitate the timely delivery of HIV prevention commodities.
• Improve HIV prevention commodity availability and reduce wastage through improved inventory and data management at all levels.
• Intensify health prevention commodity management, monitoring, and control to enforce accountability.
• Strengthen the use of the IMPACT Teams Approach to facilitate evidence-based decision-making.
• Employ and deploy pharmaceutical and laboratory personnel at all levels of the supply chain.
• Establish a dedicated Health Commodities Supply Chain Officer position (similar to LMS) at the regional and district level to support capacity building and monitoring of the supply chain at HFs.
• Institutionalize national supply chain Key Performance Indicators (KPIs), especially the indicator on wastage that aims to improve efficiency in health supply chains.
• Strengthen condom and lubricant quantification, procurement, and supply chain management.
4.2. Community-Led HIV Service Delivery and Monitoring
• Develop a Road Map and guidance on social contracting arrangements for CSO to provide funding, HIV commodities, and logistics to community-led organizations to implement HIV prevention, community-based HIV testing, and socio-economic empowerment services to PLHIV and KVPs.
• Build the capacity of community-led organizations and networks at national, regional, and council levels to enable them to participate meaningfully in HIV response efforts.
• Support CSO to access needed resources, contribute to stronger health systems, and ensure a seamless continuum of care from the health to the community system.
• Support implementation of community-led HIV program through involvement and engagement of affected communities, including KVP in service delivery and monitoring.
• Foster collaboration and synergies among government representatives, civil society organizations, community-led organizations, donors, and partners to strengthen country leadership and drive country-tailored solutions.
4.2. Preparedness & Mitigation of Impact of Pandemics and Emergencies on HIV Prevention Services
• Adapt prevention service delivery models to increase resiliency during times of pandemics/ emergencies.

• Build the capacity of healthcare providers (including community health workers).
• Reinforce infection prevention and control measures in HIV prevention platforms (including mask-wearing, hand hygiene, social distancing, lifestyle adjustments, and vaccination).
• Promote and scale up self-care approaches to allow for maintained uptake of services in times of outbreaks/ emergencies.
• Empower community structures (including community leaders, KVP, and CSO).
• Strengthen the engagement of community gatekeepers in raising awareness and influencing their followers for the process of pandemics and emergency mitigation.
4.2. Strengthen HIV Prevention Programing Monitoring, Evaluation, and Learning Agenda
• 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 sectors and, where possible, ensure their interoperability.
• Collaborate with sectors to strengthen data quality assurance mechanisms at each level of data generation and use.
• Enhance the 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 the 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.
• 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.
4.2. Fully Resourced, well-coordinated, Efficient, and Sustainable HIV Response
• Review and update the resource mobilization strategy to strengthen ATF's ability to effectively spearhead resource mobilization for a well-funded response.
• Facilitate development and implementation of the sustainable HIV financing framework for the ATF to ensure sustainability in HIV 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 prevention services into national health insurance schemes.
• Intensify advocacy to increase domestic funding from government, private, and other sectors. This will include the 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.

- Facilitate community-led HIV Financing through the economic strengthening of community structures and individuals to finance social protection schemes.

Annex 2: The 10-Point Action Plan SWOT Analysis

10 Point Actions	Strengths	Weaknesses	Opportunities	Threats
Action #1: **CONDUCT AN EVIDENCE-DRIVEN ASSESSMENT OF HIV PREVENTION PROGRAMME NEEDS AND BARRIERS**	•Existence of a national multi-sectoral M&E system for routine and periodic surveys DHIS2, UCS, CTC2 DB, TOMSHA, THIS, IBBS, ANC. •Availability of trained human resources for HIV M&E •Availability of a functional HIV M&E TWG •Existence of updated spectrum estimates for new HIV infections at national and sub-national level •KP PSE conducted in 2019 •Existence of a national HIV M&E plan that provides guidance on relevant disaggregates and data elements. •Existence of periodic HIV stigma index study •Existence of some national indicators for the global AIDS monitoring report and national targets for priority indicators (inputs to GAM)	•PSE for some of the KVP groups missing (e.g., fisher folks, miners, prisoners, and long-distance truckers)Inadequate capacity at sub-national levels on using M&E systems and data use for decision making •Existence of multiple and parallel recording and reporting systems for community HIV interventions •Lack of periodic legal and policy HIV assessments and surveys •Sub-optimal utilization of the existing HIV community M&E systems (e.g., condom programming, AGYW module, KVP, PrEP)	•Availability of external funding for HIV programs (e.g., Global Fund, USG, UN Agencies, etc.) •Availability of domestic resource mobilization funds for HIV (ATF) •Availability of potential TA support for HIV M&E	•Sub-optimal budget allocation for HIV M&E-related activities •Occurrence of global pandemics e.g. COVID-19 •Shifting of global priorities on the HIV agenda may affect HIV-specific funding, e.g., prevention.
Action #2: **ADOPT PRECISION PREVENTION APPROACH TO DEVELOP NATIONAL HIV PREVENTION GOALS AND ALIGN 2025**	•Existence of National Policy and guidelines guiding various HIV prevention approaches. •Availability of government coordinating bodies •Council-level risk stratification analysis conducted using the UNAIDS AGYW PSE tool (during GC 7 funding request development); ○ Prioritization of AGYW	•Guidelines that are not tailored to meet the needs of specific groups •Outdated size estimate for high-risk populations •Lack of evidence-based interventions for some high-risk populations •Lack of readiness to invest in interventions targeting some high-risk	•Readiness for the donors to fund targeted interventions for risk populations (GF, PEPFAR) •Member of the global prevention collation •Availability of global AIDS Policies and guidelines highlighting interventions for high-	•Existence of legal barriers and political shift •Complacency of achievement of HIV treatment target •Stigma and discrimination hindering the uptake of services •Donor dependency to deploy HIV prevention precise approaches

10 Point Actions	Strengths	Weaknesses	Opportunities	Threats
TARGETS	package of intervention tailored to AGYW risk category done ○ Geographical prioritization to target councils with moderate-high risk AGYW is also done •Risk profiling of MHR, FHR, PWID, fisher folks, and miners done through IBBS surveys •Availability of Prevention Technical working group with its working subcommittees (KVP, AYAS, Condoms & PWID) and HTS Technical working group, and PrEP Technical Working Groups, VMMC Subcommittee targeted to higher risk populations. •Availability and accessibility of prevention interventions in health facilities •Readiness to invest in interventions targeting high-risk population •Decreasing level of stigma and discrimination •HAPCA review to accommodate HIVST and lowering the age for consent	populations •Delays in adopting some proven and precise HIV interventions for high-risk populations, e.g., NSP for PWID	risk populations •availability of global data for size estimates for high-risk populations •	
Action # 3: **DETERMINE COUNTRY INVESTMENT NEEDS FOR ADEQUATELY SCALED HIV PREVENTION RESPONSES AND ENSURE**	•Good coverage of health facilities country-wide in 184 District councils, especially primary health care services •The commitment of the government to hire healthcare workers at all levels •Availability of laboratory equipment and supplies to support the provision of HIV prevention services.	•Donor dependency of more than 90% from bilateral and multilateral donors. support •Government budget (the financial year 2023/2024) for health is 7.3% below the Abuja Declaration •Limited multisectoral coordination on HIV	•Private sector engagement for domestic resource mobilization •Untapped CHWs through the formalization of the carder •Social protection system provides an opportunity for sustainable systems, i.e., NHIF and health insurance systems	•Political shift to other priorities, i.e., maternal health and human resources •Emerging global crises, including wars and disease pandemics •Absence of a sustainable financing plan •Private sector is willing to support but would wish

10 Point Actions	Strengths	Weaknesses	Opportunities	Threats
SUSTAINABLE FINANCING	•Availability of community health workers at the community level to link with health facilities. •Plan, strategies, and policies in place to address HIV prevention, i.e., five-year development plan III, National vision 2025, HIV Multisectoral strategic plan, Health policy). •Existence of well-established systems that can be linked to HIV prevention and sustainable financing.	prevention at all levels (MDAs and development partners). •Formal recognition of community health workers into the government health system, including the information from the community. •Availability of several independent unlinked health information systems. •6. Specific HIV expenditure is not well-tracked and not available.	under Social security schemes. •Existing legal framework and guidelines available to support prevention efforts, i.e., HIV Prevention and Control Act, ELRA, construction guidelines. •Existing AIDS trust fund.	to get ATF transparency and accountability and understand why they should contribute.
Action #4: **REINFORCE HIV PREVENTION LEADERSHIP ENTITIES FOR MULTISECTORAL COLLABORATION, OVERSIGHT AND MANAGEMENT OF PREVENTION RESPONSES**	•Existence of a strong AIDS Commission, which also independent. •Existence of well-established HIV prevention technical working groups at all levels, from the national to the ward level. •Position of TACAIDS at PMO for coordination of HIV response. •Political will under the prime minister's office leadership. •Presence of Technical AIDS Committees (TAC's) led by Permanent Secretaries for Public Sector and Private Sector Coordination led by Association of Tanzania Employers (ATE). •Existing efforts to engage civil society actors and other community-led organizations in the HIV prevention response (CSOs and community are well represented in the TNCM)	•Roles and responsibilities of other Ministries are not well clarified, especially when dealing with the key and vulnerable population. •Insufficient coordination and oversight of HIV resources for HIV prevention. •Slow progress towards achieving the 30-60-80 targets. •Sub-optimal accountability of HIV prevention key players.	•Roles and responsibilities of other Ministries need to be clarified, especially when dealing with key and vulnerable population. •Existence of regional framework for HIV prevention. i.e., ESA's commitment to gain political support. •To develop cost-effective and locally owned interventions for HIV response by tapping from existing HIV prevention structures at all levels. •Use of existing resources for integrated HIV prevention services	•Frequent changes on strategic directions due to changes in political leadership and technical leadership may jeopardize the continuity of prioritized interventions.

10 Point Actions	Strengths	Weaknesses	Opportunities	Threats
Action #5: **STRENGTHEN AND EXPAND COMMUNITY-LED HIV PREVENTION SERVICES AND SET UP SOCIAL CONTRACTING MECHANISMS**	•System is inclusive of service delivery. •Policy and laws are inclusive.	•Services are not defined by the community; for example, the time of getting the services. •Interpretation of individuals on policy leads to bias. •Stigma and discrimination hinder community participation and access to service. •Some of the social and cultural factors hinder the interaction of services to KVP. •Adequate allocation of funds for community-led intervention. •Insufficient local organizations to receive funds. •Competition of resources between local and international organizations. •Unfriendly service to youth (for example, the age of the service provider).	•	•Social, culture, and policies are not friendly to issues of KVP. •Contradiction between multisectoral stakeholders and ministries. •Competition of resources between national and international.
Action #6: **REMOVE SOCIAL AND LEGAL BARRIERS TO HIV PREVENTION SERVICES FOR KEY AND PRIORITY POPULATIONS**	•The laws, police, and guidelines regarding the provisions of health services are stated very clearly.	•The implementation of laws is not practical. •Policy and programs are not considered gender issues. •Pocket/exploit of society. •Gender-based violence. exists at the family and societal level	•The availability of committees such as CMAC and VMAC.	•The laws and guidelines contradict one another, e.g., the issue of sex workers and MHR are criminalized while we want them to access condoms.
Action #7: **PROMOTE THE INTEGRATION OF**	•Existence of National Policy and guidelines that advocate integration somehow. •Existence of government	•Inadequate integration of national guiding documents for HIV. prevention services	•Readiness for the donors to fund the Integration of HIV prevention services (GF, PEPFAR, WHO).	•Decrease in donor funding for HIV prevention limits integration plans. •Preferential investment for

10 Point Actions	Strengths	Weaknesses	Opportunities	Threats
HIV PREVENTION INTO ESSENTIAL RELATED SERVICES TO IMPROVE HIV OUTCOMES	coordinating bodies (e.g., MoH TACAIDS, NASHCoP) •Existence of Prevention Technical working groups with its working subcommittees (KVP, AYAS, Condoms), HTS Technical working group, PrEP Technical Working Groups, and VMMC Subcommittee. •Existence of an integrated supply chain system at the service delivery point/POC (Facility).	•Slow adoption of new technologies (delay in registration) for HIV prevention. •Inadequate integration knowledge among service providers. •Limited infrastructure for the provision of integrated services. •Inadequate resources and funding to integrate HIV prevention. •Inadequate integration of HIV combination prevention services with other HIV services. •Inadequate monitoring system and ownership of integration of HIV prevention services.	•Reducing HIV prevention service provision costs. •Availability of global AIDS Policies and guidelines. •Availability of best practices of HIV prevention integration services.	integration from the treatment point of services as compared to prevention. •Initial capital/cost (Investment) is the high cost associated with integration, especially at the PHC level. •Verticalization of the donor agency funding HIV prevention services.
Action #8: **SET UP MECHANISM FOR THE RAPID INTRODUCTION OF NEW HIV PREVENTION TECHNOLOGIES AND PROGRAM INNOVATIONS**	•Existence of National Policy and Guidelines allowing new technologies. •Availability of government coordinating bodies. •Availability of government regulatory authorities (TMDA, TBS). •Availability of Prevention Technical working group with its working subcommittees (KVP, AYAS, Condoms,) and HTS Technical working group, PrEP Technical Working. Groups, VMMC Subcommittee. •Presence of functional supply chain mechanism for storage and distribution of prevention commodities (MSD). •Readiness to invest in adopting	•Specific guidelines for the KVP and PrEP framework miss the adoption of new technologies. •Slow adoption of new technologies (delay in registration) for HIV prevention. •Inadequate knowledge among the prospective users. •Inadequate capacity building and technical assistance (Human resources, training, Infrastructure, equipment). •Poor community service delivery mode, including	•Readiness for the donors to fund the adoption of new technologies (GF, PEPFAR, WHO). •Member of the global prevention collation. •Availability of global AIDS policies and guidelines. •Availability of evidence-based discovered technologies.	•Decrease in donor funding for HIV prevention. •Preferential investment in Treatment as compared to prevention. •Complacency of achievement of HIV treatment target. •High cost associated with new technologies.

10 Point Actions	Strengths	Weaknesses	Opportunities	Threats
	new innovations and technologies.	the distribution mechanism of services to the community. •Inadequate integration of HIV combination prevention services with other HIV services. •Inadequate monitoring system of the new technologies (lack of tools). •Inefficient of the sustainable plan and transition Road Map for a financing mechanism		
Action #9: **ESTABLISH REAL-TIME PREVENTION PROGRAMME MONITORING SYSTEMS WITH REGULAR REPORTING.**	•Existence of a unified community system for all HIV prevention modules, e.g., KVP/PrEP, AGYW, CBHS, Condom programming, HIVST, VMMC etc. •Availability of priority HIV prevention indicators to input into HIV prevention scorecards. •Existence of HIV M&E TWG to support the coordination and monitoring of HIV prevention interventions. •Existence of regular National AIDS Spending Assessment (NASA) survey. •Existence of periodic programs and data reviews, especially at the regional level. •Existence of national HIV data management guidelines that inform data reviews. •Availability of competent institutions and expertise to develop and maintain real-time	•All existing HIV M&E systems cannot provide real-time data. •Sub-optimal data elements to complete HIV prevention scorecards. •Unrealistic KVP targets are attributed to the absence of national size estimates. •Irregular HIV M&E TWG meetings. •Sub-optimal joint program and data reviews at national and subnational levels to inform prevention program.	•Availability of external funding for HIV programs (e.g., Global Fund, USG, UN Agencies, etc.). •Availability of domestic resource mobilization funds for HIV (ATF). •Availability of potential TA support for HIV M&E.	•Sub-optimal budget allocation for HIV M&E-related activities. •Occurrence of global pandemics, e.g., COVID-19. •Shifting global priorities on the HIV agenda may affect HIV-specific funding, e.g., prevention.

10 Point Actions	Strengths	Weaknesses	Opportunities	Threats
	data systems.			
Action # 10: **STRENGTHEN ACCOUNTABILITY OF ALL STAKEHOLDERS FOR PROGRESS IN HIV PREVENTION**	•Existing plans, strategies, and guidelines with resources. •Existing and operational national-level coordination structures, i.e., technical working groups. •The government stakeholders are accountable for HIV prevention results. •Development partners committed and provide technical and financial support, and it is all committed and granted. •Establishment of AIDS Trust Fund. •Existence of Awareness creation through National Events across the country, e.g., the commemoration of AIDS day and the National Uhuru Torch rally. •Existence of the HIV prevention Policy of 2008 and 2014 guidelines at the workplace.	•HIV prevention system needs to be reviewed, i.e., TOMSHA. •Private sector is lagging behind, with only 2% of their contribution to the overall health sector budget. •Low level of community involvement in addressing GBV matters. •Low funding utilization within the government system delays implementation.	•Prioritized by global movements, i.e., the Global Alliance to Ending AIDS, Global Prevention Coalition.	•Implementing partners depend on external donors exclusively for interventions.

Annex 3: Unit Cost Assumptions

Intervention/ Priority Area	Unit costs (USD)	Data Source
HIV Case Finding	8.30	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
Linkage to Prevention, Care and Treatment Services	8.30	
Elimination of mother-to-child transmission (MTCT)	261.00	
Condoms	0.08	Tanzania Condom Needs and Resource Requirement Estimation (The Condom Tool); 2022
Voluntary Medical Male circumcision (VMMC)	55.00	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
Key and Vulnerable Populations [KVP]	78.96	Average from GOALS/RNM modelling
Vulnerable Adolescent Girls and Young Women (vAGYWs)	123.95	Average from GOALS/RNM modelling
Pre-Exposure Prophylaxis	162.00	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
Post-Exposure Prophylaxis	34.27	GOALS/RNM
Sexually Transmitted Infections (STIs)	16.59	GOALS/RNM
Blood Safety and Quality	43.00	Tull ,K.(2017)
Social and Behaviour Change Communication (SBCC)	3.90	Hutchinson ,P(2014)
Gender-Based Violence (GBV) and Violence Against Women and Children (VAWC)	21.00	Torres-Rueda, S. et al(2020)
Stigma and Discrimination	3.90	Hutchinson,P(2014)
Early Infant Circumcisions (EIMC)	55.00	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
ART for Adult Men	236.91	
ART for Adult Female	236.91	

Intervention/ Priority Area	Unit costs (USD)	Data Source
Screen HIV+ cases for TB	12.00	GOALS/RNM
HIV prevention for TB patients	1.07	GOALS/RNM
Cotrimoxazole for children	-	
Pediatric ART	461.00	GOALS/RNM
Diagnostics/lab costs for HIV+ in care	12.00	GOALS/RNM
Management of opportunistic infections associated with HIV/AIDS	45.00	Stefano Bertozzi et al (2016)
Facility and Community-Based HIV Care and Support Services	19.00	GOALS/RNM
Quality of HIV Care and Viral Suppression	12.64	GOALS/RNM
TB/HIV Collaboration	11.35	GOALS/RNM