UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

TANZANIA COMMISSION FOR AIDS

NATIONAL HIV AND AIDS ADVOCACY AND COMMUNICATION STRATEGY (2013 - 2017)

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ACRONOMY

ABCT	AIDS Business Coalition in Tanzania
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drug
BCC	Behaviour Change Communication
CAB	Community Advisory Board
CBO	Community Based Organization
CHAC	Council HIV and AIDS Coordinator
CMAC	Council Multi-sectoral AIDS Committee
CMO	Chief Medical Officer
CSO	Civil Society Organization
CSW	Commercial Sex worker
DACC	District AIDS Control Coordinator
DAP	Director for Administration and Personnel
DP	Development Partner
FBO	Faith Based Organization
GOT	Government of Tanzania
GBV	Gender Based Violence
HAART	Highly Active Antiretroviral Therapy
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSHSP	Health Sector Strategy HIV and AIDS Strategic Plan
HTC	HIV Testing and Counseling
IDU	Injecting Drug Users
IEC	Information, Education, Communication
IMTC	Inter-Ministerial Technical Committee on HIV and AIDS
KP	Key Population
LGA	Local Government Authority
MARPS	Most at risk population
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MoHEST	Ministry of Science and Technology & Higher Education,
MoHSW	Ministry of Health and Social Welfare

MSM	Men who have sex with men
MVC	Most Vulnerable Children
NACOPHA	National Council of People Living with HIV and AIDS
NACP	National AIDS Control Programme
NATP	National AIDS Treatment Plan
NBTS	National Blood Transfusion Services
NGOs	Non-Governmental Organizations
NHACAS	National HIV/AIDS Communication and Advocacy Strategy
NMSF	National Multi-sectoral Strategic Framework
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
RACC	Regional AIDS Control Coordinator
RAS	Regional Administrative Secretary
RFA	Regional Facilitating Agency
RFE	Rapid Funding Envelope
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TAC	Technical AIDS Committee
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TDHS	Tanzania Demographic Health Survey
THIS	Tanzania HIV and AIDS Indicator Survey
THMIS	Tanzania HIV and AIDS and Malaria Indicator Survey
ToR	Terms of Reference
TRCHS	Tanzania Reproductive and Child Health Services
TWG	Technical Working Group
USAID	United States Agency for International Development
UNAIDS	The Joint United Nations Programme on HIV and AIDS
VCT	Voluntary Counselling and Testing
VMAC	Village Multi-sectoral AIDS Committee
WHO	World Health Organisation
WMAC	Ward Multi-sectoral AIDS Committee

FOREWORD

The 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) found that 5.1% of Tanzanian adults aged 15-49 years are HIV-infected. HIV prevalence is higher among women than men (6.2% and 3.8%, respectively). Urban residents have considerably higher infection levels than rural residents (7.5% to 4.5%). In responding to the epidemic, the nation has embarked into preventive, care and treatment programs, since 2004. These efforts have registered a number of achievements. For example, by December 2012, about 400,000 HIV-infected people were using life-long antiretroviral therapy (ART).

The nation efforts recognize communication and advocacy as a central channel to not only increase awareness about HIV and AIDS but also create demand for services. The first national HIV and AIDS Advocacy and Communication Strategy (NHACAS) was launched in 2005 and was successful implemented for five years. Since 2005 HIV epidemic has dramatically changed calling for new approaches and messages to address emerging issues and accommodate new evidence to suit the current needs. According to recent data, the HIV prevalence is stabilizing and even slightly decreasing in many parts of the country.

The aim of this strategy is to support national and community based HIV and AIDS responses by providing information that will lead to the development of new and enhanced existing advocacy and communication interventions. The strategy is also informed by the national and international vision of eliminating HIV related death, stigma and new infections (3 zeros) which will require a hard look at the societal structures, beliefs and value systems that present obstacles to effective HIV response efforts. The second NHACAS will therefore be a support tool for national and local implementing agencies and civil societies to improve HIV and AIDS responses in Tanzania.

In a world that has had to learn to live with an evolving and seemingly unstoppable epidemic over the course of three decades, the zero discrimination, zero new infections and zero AIDS-related deaths vision poses a challenge that must be met. This strategy aims to contribute in strengthening programs using the latest knowledge and best practices to deliver effective prevention, treatment and care services to people in need, or at risk.

The current edition serves as a basic reference for information on HIV and AIDS communication and advocacy in Tanzania. At the same time, we hope, presented in a style that is easy to read and implement. As rapid changes continue to take place in the study of HIV and AIDS, feedback from users of this strategy is vital, and will be used to revise, improve and update the national advocacy and communication strategies.

Dr. Florens M. Turuka

Permanent Secretary

Prime Minister's Office

ACKNOWLEDGEMENT

This document resulted from of the review of the first edition of the NHACAS, published in 2005. Current developments and knowledge in the field of HIV and AIDS necessitated review and revision of first, especially the growing knowledge on evidence based interventions to combat HIV/AIDS.

The second NHACAS was developed in a consultative process that involved zonal and national stakeholders including representatives of key populations. The NHACAS (2012-16) incorporates an analysis of the lessons learned from implementing the first NHACAS (2005-2010), existing and previous national and global interventions, and recommend a series of approaches that will enhance HIV/AIDS advocacy and communication.

Thus, the Tanzania Commission for AIDS (TACAIDS) appreciates and acknowledges the valuable technical guidance obtained from its partners, both for their technical support and their financial assistance towards meeting the expenses of the initial preparation and consultancy work, including the cost of the workshops, finalisation exercises and printing of this document. Special thanks go to the second NHACAS development steering committee and the National prevention working group.

Secondly, TACAIDS would like to commend all the other institutions and organisations that worked hand in hand with the Department of Information Education and Coomunication towards the production of this document. Of special note are the following institutions:United Nations Joint Programme for AIDS ,United Nations Children Fund and Center for Disease Control (CDC)

We also thank all who participated in workshops and other consultations, either as individuals or as representatives of their institutions and organisations. Special tribute goes to the team of consultants Dr. Emanuel Matechi and Dr. Isaac Maro who excelled in their commitment towards the production and finalization of this document.

Finally and most important we thank all national and local level implementing agencies who have been using the first edition and who provided suggestions for improvement leading to the review of old version and develop this new edition. We still welcome and encourage more input and suggestions during the use of this strategy.

Dr. Fatma H. Mrisho

Executive Chairman

EXECUTIVE SUMMARY

The second National HIV and AIDS Advocacy and Communication Strategy (NHACAS) for Tanzania has been developed to enhance cross-cutting communication support to the priority strategies identified in the National Multisectoral Framework for HIV response in Tanzania. NHACAS is a support tool for the national and local implementing agencies and civil societies to improve national and community based HIV/AIDS responses in Tanzania.

This NHACAS incorporates an analysis of the lessons learned from implementing the first NHACAS (2005-2010), existing and previous national and global interventions, and recommends a series of approaches that will enhance HIV/AIDS advocacy and communication. As a general contextual overview, it provides a summary of situation analysis and HIV response in Tanzania. The strategic objective section illustrates a framework and recommends approaches for addressing the context of HIV response highlighting lessons learnt and successful global interventions.

The first chapter of NHACAS provides an overview of situation analysis and HIV response in Tanzania. The Strategic Objective section illustrates a framework and recommends approaches for addressing the context of HIV response highlighting lessons learnt and successful global interventions.

Thereafter, recommended priority messages are listed with comprehensive description of awareness, behavior change and advocacy messages within each message. The priority messages section was developed with stakeholders in zonal meetings and consultative workshop provides a basis for a coordinated message strategy. Included are explanations of why messages have been prioritized and the current national response to specified advocacy and/or communication issues. The recommended priority messages, education and information channels and opportunities can be utilized to carry out recommended activities. The message strategy should eventually be built into the content of all recommended capacity building, IEC and BCC material.

Planners, programme administrators and implementers must make sustained and dedicated effort to use the best social and scientific knowledge available. As we embark on more facility based HIV prevention measures such as treating STIs, getting men circumcised in order to reduce the chances of getting infected during sexual intercourse, and preventing an infected mother from infecting her child by offering PMTCT services, we should not resign on interventions that change people's sexual behavior among both HIV positive and negative individuals in order to prevent new HIV infections.

1. SITUATION ANALYSIS

Tanzania, the country with an estimated population of nearly 45 million, has made significant progress in responding to the generalized national HIV epidemic, where infections are largely spreading through heterosexual contact. The 2011-12 Tanzania HIV and AIDS and Malaria Indicator Survey (THMIS) found that 5.1% of Tanzanian adults aged 15-49 years are HIV-infected, which translates to an estimated 1.4 million Tanzanians living with HIV and AIDS. HIV prevalence is higher among women than men (6.2% and 3.8%, respectively). This record a 2% drop from similar survey conducted in year 2004. In most areas of the country, as women are typically infected at a younger age than men and have added vulnerabilities including inequitable gender norms, early marriage and gender-based violence (GBV). Urban residents have considerably higher infection levels than rural residents (7.5% vs 4.5%).

1.1 HIV and AIDS Awareness: Despite enormous efforts to create awareness about HIV transmission, lack of comprehensive knowledge is still a problem. According to the THMIS 2011-12, less than half of Tanzanians youths have comprehensive knowledge of HIV and AIDS transmission and prevention methods; 40 percent of them, women and 47 percent, men.

1.2 Multiple Concurrent Partnerships: Moreover, lack of comprehensive knowledge is much more reflected in the prevailing engagement into risk behaviors among Tanzanians. According to the 20011/12 THMIS data, about 26% of married or cohabiting men and 4% of married or cohabiting women reported having extramarital sex. Also from the same report it was found that 4% of women and 21% of men reported to have had more than one sexual partner. In addition, 6% of all women and 33% of all men aged 15-49 had sex with two or more partners in the 12 months before the survey. Among those who ever had sex, the mean number of lifetime sexual partners is 2.3 for women and 6.6 for men.

1.3 Condom Use: According to THMIS 2011/12, only about one-quarter of those who had two or more sexual partners in the previous 12 months (both females and males 27 percent) reported to have used a condom the last time they had sex (26.8% men and 27.3% women). Meanwhile, among men of ages 15-49 who paid for sex in the past 12 months, only 53% used a condom (THMIS 2011-12)

Access to free condoms, especially in rural areas, is still a problem. Use of both male and female condoms is hampered by women's limited decision making power in sexual issues. Messages on condoms and their effectiveness in the prevention of HIV infection have been highly unbalanced leaving majority of prospective users in confusion.

1.4 Alcohol Abuse: Alcohol abuse is a major social and cultural problem and there are increasing occurrences of violence, rape and high-risk sexual behaviour that have been directly linked to drunkenness. This eventually increases the risk of new HIV infections among high-risk, non infected populations. In many areas of the country, alcohol is socially accepted. Alcohol abuse is also known to be influenced by peer pressure; gender roles that support men spending a considerable number of hours at pubs; idleness and lack of alternative recreational activities; poverty and frustrations about life; lack of counseling in family conflicts; and failure to value life when under the influence of alcohol. The tolerance reduces inhibitions; and excessive drinking that leads to carelessness and unprotected sex. The 2007-08 THMIS has shown that men who

drink alcohol have HIV prevalence rates three times higher than those who do not drink (20% versus 7%) while women who drink alcohol have double the HIV prevalence rate than those who do not drink (14% versus 7%).

The places with the highest number of reported incidents of drinking are in most cases associated with high-risk sex. Locations for high-risk sexual behaviour fall into three settings. First, it is most prevalent in entertainment locales such as bars, clubs, brothels, local video theatres and others. Second, it occurs at transit locations such as highways stop overs, public transport areas and weigh bridges. Third, high risk sexual behaviour occurs in employment settings such as construction sites, mining areas, plantations and markets.

1.5 **Injection Drug Abusers (IDUs):** IDU epidemic is fueled by increased trafficking and economic conditions in Tanzania (Ross, 2008). It's estimated that there are at least 25,000 injection drug users in Tanzania and that 42% of the IDU population is HIV positive (Kilonzo, 2010). The infection rate is even higher among women 50% (Nyandindi, 2011). The profile of IDU is that of jobless males, young people and sex workers who trade sex for drinks or drugs. About 53% of men reported sharing needles compared to 24% of women. About 51% of men reported using alcohol during sexual encounter compared to 12% of women. Most of IDUs are also involved in high risk sexual activities; among female IDUs in both mainland Tanzania and Zanzibar, 94% reported having had sex within the last 30 days. Of these, 84% traded sex for money and 28% traded sex for drugs. During the last sexual encounter 69% of female respondents reported condom use, compared to only 28% of men. A greater proportion of intraveneous drug using men than intraveneous drug using women engage in the riskier needle use practices such as using used needles or sharing needles.

1.6 **Female Sex Workers (FSWs)**: In a study among FSWs in Dar es Salaam, one-third of respondents were reported to be divorced or separated, while over half were never married. A total of 69.7% of the FSWs declared that sex work being their main source of income, 31.4% tested HIV sero-positive. Condom use was dependent on the client's ability to pay more for not using a condom. The number of FSW who reported to regularly use a condom with a regular client was 69.3%. A high prevalence of sexual and physical abuse was reported (51.7%) in the previous 12 months**.**

According to the Violence Against Children (VAC) Survey results, 4% of Tanzanian girls received money or goods in exchange for sex at least once in their lifetime. 82% of girls who reported receiving money or goods for sex also reported childhood sexual violence; 90% who received money or goods for sex reported childhood physical violence by a relative, and 50% who received money or goods for sex reported childhood emotional violence. These data call for an urgent need to educate, empower, and equip girls and young women from being exposed to non-consensual, forced sex and sexual violence.

1.7 **Men Who Have Sex with Men (MSM):** In a research study of 271 MSM, with a mean age of 26 years, 41% were reported to have tested HIV sero-positive; 63.1% had also been married or cohabited with a woman at least once in their life. Those reporting no condom use with their last casual sex partner was 43.2%, while 49.1% used condoms with their last regular sex partner, demonstrating little regard for self-risk exposure. About 30% of all respondents were reported to

be engaged in commercial sex work. As with this research study, programme activities that reach MSM in Tanzania typically also include a large percentage of male sex workers.

1.8 Parent to Child Transmission: There has been a steady increase in the coverage of Prevention of Mother to Child Transmission (PMTCT) services in the country. By December 2012, 94% of Reproductive and Child Health (RCH) facilities had integrated PMTCT in routine ANC delivery and Post natal care services; and about 70% of estimated HIV infected pregnant women and 57% of babies born to them received ARVs. According to THMIS 2011/12, 85% of women and 79% of men knows that HIV can be transmitted by breastfeeding. Somewhat fewer (68% of women and 63% of men) know the risk of transmission can be reduced by special drugs during pregnancy. These results represent an increase from those reported in THMIS 2007/08 which reported 49% women and 38% men.

However, male participation in PMTCT remains low making it more difficult for women to disclose their HIV test result to their partners for fear of rejection or even violence. Furthermore, antenatal care services are not currently organized in a way that encourages joint attendance by both parents (NMSF 2008-2012). The current strategies on HIV and AIDS in Tanzania are geared towards improving the health of HIV-infected mothers and reducing the transmission of the virus to their children during pregnancy, labour, delivery, postpartum, and breastfeeding, as outlined in the National Policy on HIV and AIDS.

1.9 Sexually Transmitted Infections (STIs): The prevalence of untreated sexually transmitted infections is still high, with THMIS 2011-12 data showing that 4% of sexually active men and 3% of women indicated that they had recently had symptoms of STIs,(THMIS 2012) of whom, only 50% of women and 62% of men sought treatment from a qualified health care provider. While the reported number of patients with STI has increased, there remain concerns about the quality of the services, especially the observed lack of proper counseling, condom demonstration and referral for HIV testing.

Efforts have been stepped up to increase the number of people who are utilizing existing services for the past five years, reports of poor clinical treatment and self - medication are on the rise.

The challenges for STI case management include low numbers of people seeking health care services in general and inadequate coverage of STI services, especially among high-risk groups. Prevention and treatment of STIs for HIV prevention in Tanzania is integrated into routine health service delivery and is available in about 60% of public hospitals, health centers, dispensaries, faith-based organisations and private health facilities (Tanzania Services Provision Assessment).

The Surveillance of HIV and Syphilis Infection among Antenatal Mothers in the RCH 2008 indicates the overall syphilis sero-prevalence of 4.2% (Surveillance of HIV and Syphilis Infections among antenatal clinic attendees 2008).

At a health facility, the survey conducted by the National AIDS Control Programme (NACP) in 2005 showed that 67.2% of service providers made correct choice of drugs, dosage and duration of treatment for their clients.

1.10 Male Circumcision: the practice of male circumcision in Tanzania is often for religious and cultural reasons rather than for the purpose of HIV prevention. In Tanzania male circumcision prevalence is about 72%, with considerable variation between regions. (THMIS 2012) Ecological comparison from the same study shows a pattern of lower HIV prevalence in circumcising than in non-circumcising belts. For example the high HIV prevalence regions of Mbeya and Iringa have relatively low male circumcision rates (34.4% and 37.7% respectively) compared to Manyara with male circumcision rate of above 80% and HIV prevalence of 2%. Therefore the GoT (government of Tanzania) has prioritized eight regions (Iringa, Mbeya, Shinyanga, Rukwa, Kagera, Mwanza, Mara (one district) and Tabora), with lower than average MC rates and relatively high HIV prevalence for the scale up of MC for HIV prevention services. HIV-negative males aged 10 to 34years are given priority for free MC for HIV prevention services. MC can be carried out in health facilities (static sites) and also in outreach campaigns.

1.11 Gender Based Violence (GBV): has to a greater extent proven to be one of the major attributing factors to the spread of HIV and AIDS infection in Tanzania. It is estimated that more than one-third, (39%) of all Tanzanian women, have suffered from either physical, emotional or sexual violence at some point since age 15 in their lives and 33% of all women suffered from acts of violence during the past 12 months. Unlike single women (21%), married, widowed and divorcees who constituted (46%) were seen to be particularly vulnerable. Research shows that one in five women have ever experienced sexual violence while 10% of women in Tanzania had their first sexual intercourse forced against their will, (TDHS 2010). Such incidences may have resulted into new HIV infection. Furthermore, 54% and 48% of Tanzanian women and men respectively, believe that, being beaten by their husbands or beating their wives is justifiable under certain conditions. Moreover, GBV is said to be more pronounced among spouses with drinking problems. Cultural traditions like early initiation and marriage of girls, as well as widow 'cleansing' are still practiced in some regions. Girls are often pulled out of school to look after sick relatives, denying them the opportunity to gain skills to become economically independent and driving them towards transactional sex or early marriage -often with much older husbands- and thus exposing them to the risk of HIV infection.

1.12 HIV Testing and Counseling: According to THMIS 2012, 62% of women and 47% of men have been tested for HIV which is an increase compared to THDS 2010 which reported 55% of women and 38% of men had ever been tested for HIV and received the results. Furthermore, the National HIV Counseling and Testing Campaign, developed to mobilize more people for testing and to determine their HIV zero-status, was launched on July 14th 2007 by His Excellency the President of the United Republic of Tanzania, Hon. Jakaya Mrisho Kikwete. During the intensive campaign period, July to December 2007, about 3.2 million were tested. According to THMIS 2011-12, 91% of women and 91% of men know where to get an HIV test. Number of PLHIV who have disclosed their sero-status has also increased. In order to accelerate the increase in the number of people tested, provider initiated testing and counseling, has been introduced for all clients attending health facilities.

Also mobile and community/family counselling and testing have been implemented in some pilot projects, with positive results. In order to expand these new approaches, the human resources for testing and counselling will need to be increased substantially.

1.13 **Stigma and Discrimination:** Although substantial efforts have gone into educating the general public about HIV, stigma and discrimination against individuals infected and families affected by HIV remain rampant. In most communities' stigma, denial and discrimination continue to be major drawbacks to access HIV services, including lifesaving antiretroviral treatment. According to THMIS 2012, 25% and 40% of men and women respectively expressed stigmatizing attitude towards people living with HIV.

1.14 **Community Response:** There is limited motivation and commitment in supporting CSOs or advocating for local resources for HIV response. HIV responses are mostly viewed as foreign interventions and community responsibility is only in accepting and engaging in implementation. Despite the fact that CSOs have made tremendous efforts to prevent HIV and mitigate its impact, the extent to which these organizations have been able to stem the epidemic has not been assessed or documented in a systematic and rigorous way. Most at Risk Children, who are often orphans, are abandoned by their relatives to rely on support from community organization and donor support. Some families are purposely ignoring their responsibilities to MVCs arguing that, donors and government should take care of them. While positive experiences exist in a limited number of regions, districts and communities, scaling up these experiences to all districts faces severe constraints with regards to human resources and capacity for district planning and community mobilization.

1.15 **Impact Mitigation:** Community mobilization and sensitization events have been used to identify MVC as part of implementing National Coasted Plan for most vulnerable children throughout the country. A number of local advocacy meetings and national mass media advocacy messages are being used to advocate for local response in providing quality services to PLHIVs and MVCs. By the end of year 2011, 86 districts (reaching 56% of all wards and 53% of all villages and *mitaa* in the country) had identified 776,128 most vulnerable children (52% males; 48% females). Most of whom (89.4%) are reported to be receiving at least one core service.

Drivers of Epidemic and Target Audiences:

Multiple sexual partners	▪ At risk adults and youth who have more than one sexual partner ▪ Youth/partners in cross generational sexual relationships ▪ Men and women engaged in commercial sex and their clients ▪ Men and women who work away from home (transportation workers and the uniformed services)
Vertical transmission	▪ Parents who plan to have children, or who are pregnant
Geographic areas:	
High prevalence areas	▪ Regions with high HIV prevalence such as Iringa, Dar es Salaam, ▪ Epidemic hotspots: transport corridors, borders (crossing points), night "red streets", bars and guest houses, ▪ Urban areas

Structural drivers:	
Societal norms	▪ Gender norms that promote values of masculinity & femininity ▪ Gender-based violence, Intimance Gender Violence, ▪ Widespread acceptance of multiple sexual partnerships
Individual factors	Including, but no exclusive to: ▪ Inaccurate risk perception ▪ Low self efficacy ▪ Low locus of control
Substance abuse	▪ Alcohol and other substance abuse ▪ Injecting drug users

1.16 **Care Treatment and Support:** Most communications for care, treatment and support occurs at health facilities level. Health Care Workers (HCW) interact with clients and inform them of available care and support services related to HTC, ARVs treatment, PMTCT and home based care. HCW also disseminate various IEC materials mostly related to appropriate use of ARVs, their side effects and nutrition advice. Community events and mass media particularly, community radio discussions are being used to raise awareness on availability and promote uptake of care and treatment services. PLHIVs support groups are also becoming an important vehicle in sharing experience and advocating for quality services including support for PLHIVs groups to engage in income generating activities. PLHIVs groups are also used to promote adherence among peers and educate on HIV prevention including promotion of PMTCT.

On the other front, traditional healers are well accepted by the community and are often visited before the formal health system. Some herbal medicines are known to strengthen the immune system and treat several opportunistic infections effectively. The cooperation between the traditional and the modern health care system needs to be improved and referral systems created in both directions. The MOHSW has to engage in a constructive dialogue and build a relationship based on mutual respect and trust.

In Tanzania, some faith and traditional healers have been noted to hub and entertain HIV transmission myths and claim to offer HIV treatment therapy. There are reports of individuals who are seeking for HIV care from these healers and end up with undesired health outcome. Few others who are already on ARVs treatment, continue to seek for alternative treatment and end up abandoning ARVs. This has resulted in deterioration of their health and could potentially aggravate unwanted effects such as drug resistance. Efforts to meaningfully engage faith and traditional healers with specific message and action points to support national response are crucial.

In addition, lack of nutrition education and awareness about an appropriate diet is another limitation. Nutrition education for PLHIV as well as care-givers is therefore essential. Service providers must be able to advice on nutrition according to the kind of food available in the respective areas. Although there has been a substantial increase in number of people who are enrolled into care and treatment, male's uptake is quite low (less than 20%) as compared to female uptake.

This situational analysis calls for focused Strategic approaches to strengthen advocacy and Communication programmes for effective national HIV and AIDS response.

2 STRATEGIC APPROACHES

2.1. Increase emphasis on "know your epidemic" response for HIV prevention, care and support advocacy and communication activities:

Led by UNAIDS, *Know your epidemic, know your response* has become a rallying call for an intensified focus on HIV prevention, care and support. The quest to better understand epidemics reflects growing recognition that there is no single global HIV epidemic, but rather a multitude of diverse epidemics. The HIV epidemic in Tanzania is no exception, with regional variation in prevalence and known drivers of epidemic. Furthermore, it is useful to define local and national epidemic trend including social behavior and societal norms. There is evidence of concentrated epidemic in defined vulnerable groups—typically sex workers, men who have sex with men, and injecting drug users, and their sexual partners.

An emphasis in learning and using local data on the epidemic, prioritize high-transmission areas and populations will enhance selection of appropriate continuum of response for each population. It is also important to ensure that content of interventions directly addresses key drivers and incorporates clear behavioral messages with assurance of adequate quality, dose, and intensity of interventions. Such efforts need to be supported with a well-coordinated implementation among partners, including harmonizing messages across partners and incorporating process, outcome, and impact evaluation.

2.2 Build on and expand traditional and emerging advocacy and communication channels

In Tanzania, many advocacy and communication interventions have focused on building HIV and AIDS knowledge levels, including knowledge of the availability of HIV prevention, care, and treatment services. While this is an important first step, it is important to note that high knowledge levels are not enough to foster behavior change. Although HIV prevention efforts have resulted in high levels of awareness of HIV and AIDS, prevention, and availability of services, many interventions still focus on knowledge and not social and behavior change. There is need to develop an appropriate mix of communication channels, balancing mass media and interpersonal communication. Mass media is particularly effective in influencing social norms, and transmitting brief but powerful messages. Interpersonal communication is critical for the thorough processing of culturally-adapted messages and activities designed to influence risk perception, self-efficacy, and skills at both the society and individual levels. Achieving this requires coordination and systems to align messages to target audience and drivers of the epidemic, coordinate the mix of communication messages, build capacity in the design and implementation of sound social and behavior change programs, and ensure quality assurance.

According to the audience scope analysis conducted in Tanzania, in year radio ranked the top source for information about specific health issues, such as malaria, HIV and AIDS or family planning. The importance of television varied between demographic groups and between different health topics. The importance of word-of-mouth networks, whether between friends and family or medical doctors, also varied significantly between groups and health topics. Although much work in the media sector has been focusing on news media, carrying factual material and some editorial comments, more attention is now being given to the possibly greater impact of using entertainment media in HIV and AIDS communication, especially for inducing social and behaviour change.

New media sources of information have also shown potential. The fact that mobile penetration in rural areas is higher than television (54 percent said they have household access to a mobile phone at home versus 14 percent having access to TV), however, suggests there is a potential to promote health information dissemination via mobile phones, with greater use of SMS text messaging.

2.3 Increase roll out of sustainable evidence-based interventions that build local capacity

The direction in advocacy and communication for HIV and AIDS in Tanzania needs to focus on well-defined approaches that include expanding targeted efforts to prevent HIV infection using a combination of effective, evidence-based biomedical, behavioral, and structural interventions. Program should emphasize on interventions that are prioritized in the global and national plans, and that are well-coordinated, cost-effective, focused on high-risk populations/areas, and/or not adequately funded through other resources. This also includes aligning distribution of prevention, care, and treatment resources to maximally reduce HIV incidence, including; appropriate targeting of current services and combinations of services and support for interventions that are evidence-based and effective in reducing HIV at the individual and population level. In line with the UNAIDS investment framework, the following six basic programme activities have been recommended as essential to an adequate HIV response and need to be delivered at scale according to the size of the relevant population:

- Focused programmes for key populations at higher risk (particularly sex workers and their clients, men who have sex with men, and people who inject drugs);
- Elimination of new HIV infections in children (eMTCT);
- Programmes that focus on the reduction of risk of HIV exposure through changing people's behaviour and social norms;
- Procurement, distribution and marketing of male and female condoms;
- Treatment, care and support for people living with HIV;
- Voluntary medical male circumcision in areas with high HIV prevalence and low rates of circumcision

These activities work together for maximum impact and should therefore be delivered as a package, where each element reinforces the other.

2.4 Tailor and coordinate biomedical, behavioral and structural strategies (Combination HIV prevention)

Several HIV prevention interventions have shown success. It has further been shown that the approach known as "combination prevention" offers the best prospects for addressing documented lessons and generating significant, sustained reductions in HIV incidence. Successful prevention programs require simultaneous use of evidence-based, mutually reinforcing biomedical, behavioral, and structural interventions. Combination prevention programmes operate on different levels (e.g., individual, relationship, community, societal) to address the specific, but diverse needs of the populations at risk of HIV infection. The goal of combination prevention

is to reduce the transmission of HIV by implementing a combination of behavioral, biological, and structural interventions that are carefully selected to meet the needs of a population. Also, because individuals' HIV prevention needs change over a lifetime, combination approaches help ensure that people have access to the types of interventions that best suit their needs at different times. Combination approaches result in synergies in which the total effect of a set of carefully chosen interventions is greater than the sum of its parts, with a greater impact on reducing the transmission of HIV.

2.5 Advocate for local and community response at all levels including workplaces

The development of AIDS programs among communities have largely based on available support and not necessarily needs of their members. It is encouraging that there has been a growing international recognition and interest in the local response to HIV, but this interest has not been translated to capacity building and sustainability for local organizations.

It is important to recognize that local authorities and organizations are in a better position to craft a more effective strategy because they know their area; they know how communities would handle this problem, and the kinds of vulnerabilities in their areas. It is high time for local government and communities to take a lead to stimulate, coordinate and harmonize local HIV responses. This will entail strengthening the capacity of local civil society organizations to support and implement local responses, to hold government accountable for providing service support and to translate local experience into policies and strategies. Efforts to mainstream HIV agenda in local development agenda including budgets need to be translated into visible activities at community level. There is also a need to strengthen community-based, participatory monitoring and evaluation systems and continuous documentation of experiences and practices of new and existing innovative programmes, in partnership with NGO partners. Key actors within the communities including government, religious and traditional leaders are to take a lead in advocating for a local multisectoral response that identify and prioritize evidence based interventions.

2.6 Mainstream gender roles and human rights in HIV response

In the context of HIV, protections comprise legal approaches that implement international human rights commitments as well as efforts to address harmful social and gender norms that put women, men, and children at increased risk of HIV infection and increase its impact. A rights-based approach to HIV requires:

- Realization and protection of the rights people need to avoid exposure to HIV;
- enabling and protecting people living with HIV so that they can live positively, with dignity;
- attention to the most marginalized within societies; and empowerment of key populations through encouraging social participation,
- promoting inclusion and raising rights-awareness.

Significant advances have been made in expanding HIV prevention, treatment, care, and support services in recent years but some key populations at higher risk such as sex workers, people who inject drugs and men who have sex with men, remain often underserved. Resources directed

towards the needs of these populations, including support for them to claim and exercise their rights, are often not proportional to the degree to which they are affected by the epidemic.

Community-based approaches addressing social norms are essential to reducing intergenerational and transactional sex, multiple partnering, early sexual debut and alcohol-driven infections. Interventions focused on individual behavior change alone will not suffice. Such interventions should include ongoing activities emphasizing dialogue and community problem-solving. Advocacy with local leaders and decision-makers is also essential to addressing social norms that create risk - and to enforcing both healthy norms and formal regulations once they are developed. Because harmful practices are driven in part by inequitable gender dynamics, programs that emphasize transformation of gender norms and male involvement in sexual health hold promise.

2.7 Call for actionable response at individual, institutional and communities level

People living with HIV and AIDS are the most important partners in prevention, especially couples where only one person is infected. Prevention efforts need to focus more effectively, paying particular attention to young people at risk; those who inject drugs; men who have sex with men; and female, male and transgender sex workers. Coverage of prevention services remains low for all these groups. Most NGOs have a thorough understanding of their local communities; they know the local constraints and issues and can effectively prioritize problems within their context. Local NGOs and institutions know how HIV and AIDS is understood and viewed in a particular community or sub-set of a community, and they can communicate about it and initiate actions in ways that are understood by the community and deemed appropriate and acceptable.

Local NGOs often have a comparative advantage over governments, International NGOs, and donors in their ability to inspire behavioral change, shape public discourse, and draw local attention to HIV and AIDS and the actions needed to combat it. By utilizing their comprehensive understanding of social, political, religious, and economic circumstances, local NGOs and institutions are often best prepared to identify new approaches and design new activities to locally resolve specific problems. NGOs and institutions are often in a better position to pay close attention to ethical considerations raised by HIV/AIDS, such as the need to safeguard confidentiality and to ensure that informed consent is a priority.

3. PRIORITY MESSAGES

The second NHACAS builds on the NMSF-III endorsed commitment to eliminating HIV in Tanzania. Priority Messages are designed to contribute in long terms impacts of Zero New HIV Infections, Zero AIDS-Related Deaths, and Zero Stigma and Discrimination.

The NMSF III has adopted the three long-term impact results of ZERO New HIV Infections, ZERO HIV Related Deaths and ZERO HIV Related Stigma and Discrimination (known as the three ZEROs). NMSF III has also identified four strategic areas of primary investment, four supportive areas of secondary investment, and four cross-cutting programmatic principles to lead the nation towards the three ZEROs.

The NHACAS key messages are aligned to the three impact NMSF results, as summarized in the table below;

IMPACT RESULT	PRIORITY MESSAGES
Elimination of New HIV infection	HIV Transmission
	HIV testing and counseling
	Abstinence, delay of sexual debut and being faithful
	Correct and Consistency use of condoms
	Elimination of MTCT
	Preventive services • Male circumcision • STI
	Target key populations
Reduction of HIV Related death	Antiretroviral Therapy • Eligibility • Side effects • Adherence • Alternative medications • Treatment as Prevention • Access and Availability
Elimination of HIV related Stigma and Discrimination	Elimination of Stigma and Discrimination
	Positive Health Dignity and Prevention (PHDP)
Cross-cutting	Individual Response “play your part”
	Community Response and ownership
	Enabling environment

3.1 ZERO NEW HIV INFECTION

3.1.1 HIV transmission

Human Immunodeficiency Virus (HIV) is a virus that causes Acquired immunodeficiency syndrome, a disease that deteriorates human body's capacity to defend itself against illnesses. Everyone can be infected with HIV. The most common ways for adults to get infection is through heterosexual (80%). Most children are infected through parents to child transmission.

HIV can be detected in several fluids and tissue of a person living with HIV. Only specific fluids (blood, semen, vaginal secretions, and breast milk) from an HIV-infected person can transmit HIV. These specific fluids must come in contact with a mucous membrane or damaged tissue or be directly injected into the blood-stream (from a needle or syringe) for transmission to possibly occur. If a man with HIV has vaginal intercourse without a condom, infected fluid can pass into the woman's blood stream through a tiny cut or sore inside her body. Oral sex with an infected partner does carry some risk of infection. If a person sucks on the penis of an infected man, for example, infected fluid could get into the mouth. The virus could then get into the blood if you have bleeding gums or tiny sores or ulcers somewhere in the mouth.

If a couple has anal intercourse, the risk of infection is greater than with vaginal intercourse. The lining of the anus is more delicate than the lining of the vagina, so it's more likely to be damaged during intercourse, and any contact with blood during sex increases the risk of infection. An infected pregnant woman can pass the virus on to her unborn baby either before or during birth. HIV can also be passed on during breastfeeding. If a woman knows that she is infected with HIV, there are drugs that she can take to greatly reduce the chances of her child becoming infected. At the moment, scientific opinion is pretty clear that you cannot become infected with HIV through kissing. To become infected with HIV you must get a sufficient quantity of HIV into the bloodstream. Saliva does contain HIV, but the virus is only present in very small quantities and as such, cannot cause HIV infection. Unless both partners have large open sores in their mouths, or severely bleeding gums, there is no transmission risk from mouth-to-mouth kissing. HIV does not survive well in the open air, and this makes the possibility of this type of environmental transmission remote. This means that HIV cannot be transmitted through spitting, sneezing, sharing glasses or musical instruments. Studies conducted by many researchers have shown no evidence of HIV transmission through insects, such as mosquitoes. HIV only lives for a short time and does not reproduce in an insect. So, even if the virus enters a mosquito or another sucking or biting insect, the insect does not become infected and therefore cannot transmit HIV to the next human it feeds on or bites.

3.1.2 HIV Testing and Counseling

HIV testing and counseling (HTC) is the first and fundamental step for HIV response in Tanzania. HC refers to the process by which an individual, couple, or family receives HIV testing and counseling on HIV prevention, treatment, care, and support. There are many approaches to HTC, but generally, the intervention includes three activities:

- Pretest counseling on the testing process;
- risk-behavior assessment; informed consent; and
- post-test counseling based on the test result(s).

HTC is the entry point to treatment, care, support, and prevention interventions for those who have HIV. People living with HIV are less likely to transmit the virus to others if they know they are infected and if they have received counseling about safer behavior. For example, a pregnant woman who has HIV will not be able to benefit from interventions to protect her child unless her infection is diagnosed. Those who discover they are not infected will benefit, by receiving counseling on how to remain uninfected. Every Tanzanian has a responsibility to take action and go for HIV testing. HTC allows making realistic plans and choices in life. It is not recommended to make assumptions about HIV status by making reference to the HIV status of sexual contacts. There is a possibility that a person is infected with HIV even when their partner is not This phenomenon is called discordance.

HIV is tested by using HIV antibody tests that are most appropriate test for routine diagnosis of HIV among adults. The test looks for HIV antibodies in a person's blood. These antibodies can take up to three months from the time of infection to appear, and so for an accurate HIV test, a person should wait at least three months since the time of suspected infection. Antibody tests are very accurate. In Tanzania HIV testing is provided in a number of places, such as health clinics, government hospitals and in HIV testing and counseling (HTC) centers. When someone attends a testing site they will usually see a health care provider such as a doctor, trained counselor, nurse or other health professional in private. The health care provider will explain what the test involves and what the result means.

If the HIV test is positive, there are services including ARV treatment available throughout the country. A person who tests positive will at some point need to take ARV to slow down the virus and maintain a healthy immune system. The longer a person remains unaware of their infection, the less likely it is that the treatment will work efficiently. Doctors can monitor an HIV positive person's health in order to provide the right treatment regimen at the right time. If a person is aware of their HIV infection they can take steps to protect other people. Those who test positive are thinking of starting a family can learn about ways to protect their child from becoming infected with HIV through mother to child transmission.

For those who test negative, counseling focuses on prevention messages tailored to the client's or patient's risk behavior(s) and provides referrals to prevention interventions, such as male circumcision clinics and support groups.

Given testing is an important step to treatment and care this means that many people may be missing out on treatment and care because they do not know their status. This calls for advocacy for good-quality, voluntary and confidential testing and counselling to be made available and accessible to all cadres of the society and advocacy to shift people's attitudes towards HIV testing.

3.1.3 Abstinence, Delay of Sexual Debut and Being Faithful

Both abstinence (not engaging in sex) or delaying onset of first sex are proven HIV prevention methods aimed at preventing spread of HIV among young people. An intervention that promotes primary or secondary abstinence and delayed onset of sexual debut reduces an individual's risk of being exposed to HIV. Youth who abstain from sexual activity avoid the consequences that directly result from a non-marital pregnancy, as well as the potential lifelong implications of STDs. Delaying onset of sexual debut has a considerable impact on the physical health outcomes of young people. The indirect complications of early sexual debut include other negative health outcomes, such as increased vulnerability to partner violence, elevated risks of HIV and AIDS, and a higher probability for other risk behaviors.

When young people and adolescence choose to wait to avoid premarital sexual bonds with other partners they are less likely to get involved in cohabitations, which is a major risk factor for future marital infidelity and divorce. Most faith-based groups generally view delayed sexual initiation as a commitment to refrain from sex until marriage. Others view delayed sexual debut as delaying sex until some future time, for example, when entering into a committed relationship before marriage. In general it is proposed to delay sexual initiation until you are ready.

Faithfulness is only protective when both partners are not infected with HIV and both are consistently faithful. It is a known factor that marriage itself does not necessarily protect people from HIV infection but unless both parties involved are faithful. Avoiding being infected with HIV is of more benefits to a person. A society free from HIV is ultimate goal of HIV prevention campaigns. Faithfulness does not only protect oneself from HIV infection but also it shows that one care for the other involved in a relationship. Because you care about your partner you need to protect yourself from transmitting HIV. People living with HIV should also remain faithful if are in a relation to avoid worsening of their own health status as well as prevent their communities from HIV. Being faithful not only help prevention from HIV and other STDs but also it is a moral advantage ensuring ultimate happiness and satisfaction. Being faithful will ensure a healthy and a happy relationship. Religious bodies still have a role in advocating for abstinence and faithfulness to its members. Families should maintain message of delay in sexual debut.

3.1.4 Correct and Consistency use of condoms

Numerous studies have shown that condoms, if used consistently and correctly, are highly effective at preventing HIV infection. Condom effectiveness for STIs and HIV prevention has been demonstrated by both laboratory and epidemiologic studies. Evidence of condom effectiveness is also based on theoretical and empirical data regarding the transmission of different STIs, the physical properties of condoms, and the anatomic coverage or protection provided by condoms. Studies that compare rates of HIV infection between condom users and nonusers who have HIV-infected sex partners demonstrate that consistent condom use is highly effective in preventing transmission of HIV.

It is imperative to ensure that one has sex education and knows how to use condoms and making sure one uses one condom for each sexual act that he or she engages in. Consistent and correct use of condoms means the use of a new condom for and throughout every act of vaginal or anal sex. It is recommended to ensure adequate lubrication is used during vaginal and anal sex

which might require water based lubricants. Oil based lubricants e.g. petroleum jelly, should not be used because they can weaken latex, and cause breakage. Correct use of condoms for each sexual act ensures peace of mind and avoiding acquiring HIV. It will prevent you from sexually transmitting diseases, pregnancy and plays in role in preventing cervical cancer.

Condoms have helped to reduce HIV infection rates where AIDS has already taken hold, curtailing the broader spread of HIV in settings where the epidemic is still concentrated in specific populations. In populations at the highest risk of HIV infection, significant reduction of HIV transmission has been reported even when condoms are used less consistently. Condoms may also indirectly slow the spread of HIV by preventing the transmission of other STIs that act as co-factors for HIV transmission.

Supply of condoms as a preventive tool to most at risk population groups such as sex workers have achieved major progress in reducing associated HIV infection. There is no evidence that promoting condoms leads to increased sexual activity among young people. Therefore condoms should be made readily and consistently available to all those who need them.

HIV prevention education and condom promotion need to also address the challenges of complex gender and cultural factors, ensuring that gender issues are not a barrier to information about and access to condoms. In many social contexts, females do not have the power to negotiate the use of condoms, and males are resistant to the use of condoms. This lack of power needs to be recognized in designing condom promotion programs. Young girls and women are regularly and repeatedly denied information about, and access to, condoms. Female condoms can provide women with more control in protecting themselves.

3.1.5 Targeting Key population

Tanzania has adopted the international definition of Key Populations, a term referring to populations that may be key to the epidemic's dynamics and therefore key to the national response. In Tanzania mainland, groups which have been documented to be at a higher risk of HIV infection include MSMs, FSWs, PWIDs, prisoners and other mobile population groups including among others, fishermen, miners, plantation labourers and trackers. Other groups include people in conflict and post – conflict situations, refugees and internally displaced persons, mining and other groups include fishing communities in high risk situations.

Members of key populations are at a significantly higher risk of HIV infection than other groups. KPs are also at a higher risk of acquiring other infections such as syphilis, Hepatitis B and Hepatitis C and others, due to the high risk behaviour among them. KPs are not only the populations that are at higher risk of being infected or affected by HIV, but also who play a key role in the way HIV spreads, and vital for an effective and sustainable response to HIV.

Stigma and discrimination experienced by PLHIVs, as well as by population groups perceived to be most at risk for infection, are major obstacles to the provision of accessible services for both prevention and treatment. Moreover, legal frameworks in many countries hinder efforts to combat stigma and discrimination against PLHIVs. There are structural barriers at the policy, cultural, and institutional level including criminalization, high levels of stigma and discrimination, homophobia in health care systems, and poverty which need to be addressed. These barriers create an environment where extortion, discrimination, and violence against members of key populations are common occurrences.

Advocacy for the integration of health services for KPs aimed at fostering non-judgmental, inclusive, and responsive health services for all is crucial. Availability of a full range of health services utilizing a primary health care approach is a critical condition to ensure access by all. Ensuring integration of HIV and sexual/reproductive health services in primary care service delivery is particularly important to overcome stigma and discrimination. It is also important to prioritize on building the capacity of health care workers in order to enhance their knowledge and skills so that they can effectively address and integrate these issues in service delivery utilizing a human rights perspective and gender-responsive approaches. Capacity building should also increase health workers' knowledge and understanding of the physical and psychosexual health issues and concerns relevant to specific groups.

Substance use is increasing and is of great concern because of the alarming levels of HIV infection among members of KP. The link between substance use and sex work is related to both female and male sex workers. Female substance users use sex work and lover sponsorship as key coping strategies to support their drug habits. Male sex workers who inject drugs, especially MSM, are more likely to be infected with HIV, compared to those who do not use any drugs, as they are less likely to use condoms. On the other hand, IDUs (mostly male) tend to avoid condoms when paying for sex. If they are infected with HIV, they are likely to transmit HIV to sex workers, who can then pass it on through other sexual networks. The illegal, stigmatized and hidden nature of substance use means that it is very difficult to reach this group with information on demand reduction and safer sex practices.

There is strong and consistent evidence that a package of harm reduction interventions significantly reduces IDU and associated risk behaviours and therefore prevents, halts and reverses HIV epidemics associated with this practice. Conversely, there is no convincing evidence of major negative consequences of such interventions. A core package of interventions should include:

- Outreach to IDUs; sterile needle and syringe access and disposal;
- VCT services;
- prevention of sexual transmission including male and female condoms/microbicides plus treatment of STI; Hepatitis B vaccination;
- vein care; and
- antiretroviral therapy (ART).

Drug dependence treatment, particularly substitution treatment, can be delivered from a primary care clinic and can be integrated into HIV treatment. Additionally, introducing comprehensive rehabilitation centers with vocational training schemes, plus enforcing laws against the infiltration of drugs is necessary. Ultimately, only supportive legislation that is in place can prevent the marginalization, discrimination and stigmatization of drug users to ensure their human rights.

3.1.6 Elimination of Mother to Child transmission of HIV (eMTCT)

HIV can be transmitted from a mother to her baby during pregnancy, labor and delivery and later through breastfeeding. Mother-to-child transmission (MTCT) is when an HIV-infected woman passes the virus to her baby. Without any intervention, around 15-30 percent of babies born to HIV-infected women will become infected with HIV during pregnancy and delivery. A further 5-20 percent will become infected through breastfeeding.

The first step toward reducing the number of babies infected in this way is to prevent HIV infection in women, and to prevent unwanted pregnancies. When a HIV infected woman becomes pregnant, there are a number of strategies that can help to avoid passing HIV to her child. A course of antiretroviral drugs given to her as well as to her newborn baby can greatly reduce the chances of the child becoming infected. The most effective treatment may involve taking life-long ARVs.

When expecting couples go to RCH clinic, they will receive routine HIV testing and counseling. The results are confidential. If the mother is found to be HIV positive, she will have the option to join PMTCT programme free of charge. The Health care worker will advise on treatment depending on national guidelines. She will be advised on the best to time to start medications that will reduce the chance of passing the virus in the mother's body to the baby during delivery. After delivery, the baby will also receive medications to prevent HIV.

Couples will also be counseled on a choice to either exclusively breastfeed for six months or exclusively formula feed. Exclusive breastfeeding means that the baby must only be given breast milk, no tea, no water, no juice or solids. This reduces the chance of the virus in the breast milk being passed on to the baby. The baby will receive an HIV test at six weeks, which coincides with the immunization visit. Elimination of mother to child transmission is important as a platform for ensuring HIV free future society. It is also important to note that HIV can live for a long time (three to ten years) in the body whilst the mother feels healthy and well. For this reason mothers are encouraged to go to the clinic regularly to get medicine for opportunistic infections to keep healthy for longer. She is encouraged to use condoms every time she has sex so that she can protect herself and her partner from contracting the virus, or from getting more of the virus if both partners are HIV positive.

The woman will also be given counselling about contraception options after the birth. The health worker will encourage the mother to tell the father of the baby that she is HIV positive so that he can also be tested. This can happen with the aid of the counsellor or health worker. It is important for the mother to join a group that will support her and give her information on eating nutritiously and how to look after herself and the baby. Formal support groups are available and can be contacted through the local clinic. Efforts should be made to make PMTCT services available even to those delivering at home and/or through traditional birth attendants. Traditional birth attendants should be educated on HIV transmission and linked to care and treatment centers (CTC) to ensure all pregnant women are provided with an opportunity to prevent their children from transmitting HIV. Males should also be educated on importance of PMTCT so they act as advocates for PMTCT as well.

3.1.7 HIV Preventive services

Male circumcision (MC): Evidence from several studies demonstrates that adult male circumcision significantly reduces the likelihood of uninfected men acquiring HIV from an HIV-infected female sex partner by 60%. Tanzania is implementing a Medical Male Circumcision for HIV prevention strategy guided by messages that outline the partial protection benefits of medical MC are clearly explained to clients, and that clients understand the need to continue to use the full range of HIV prevention strategies (abstinence, partner reduction, faithfulness to one partner, and/or condom use) after their healing period is complete. Before circumcision clients will be offered Opt-out HIV testing and counselling. Clients opting out, as well as clients testing HIV-positive, should be further counselled on the lack of HIV prevention benefits for HIV-positive men and the extra importance of adhering to the post-operative abstinence period. After counselling, clients still wishing to be circumcised should be provided with the service.

It should be noted that resumption of sexual relations before complete wound healing may increase the risk of acquisition of HIV infection among recently circumcised HIV-negative men. Men who undergo circumcision should abstain from sexual activity for at least six weeks. Voluntary Medical Male Circumcision (VMMC) services are provided as part of a comprehensive HIV prevention package along with provision of HIV Testing and Counselling (HTC), treatment for STIs, promotion of safer sex (including counselling of men and their sexual partners to prevent them developing a false sense of security), and provision of condoms (including instructions about how to use them correctly).

Post circumcision messages should include detecting and reporting adverse effects, temporary abstinence while wound heals and emphasize that MC does not eliminate the risk of HIV but complements other HIV prevention methods.

VMMC client counseling and education provide an important opportunity to increase understanding of the procedure and its benefits (which may support secondary discussion and demand creation through social networks), provide risk reduction counseling as part of HTC, and promote safe after care practices. It may also offer an entry point for discussion of gender as it relates to health-seeking behaviors and sexual risk-taking. BCC in this area will include flexible and efficient counseling procedures (including offsite counseling and group counseling when appropriate), provider job aids, client materials, and activities targeting clients' partners and caregivers. Careful monitoring and evaluation, and supportive supervision, of the program should be in place to quickly address any increase in adverse events or other problems with service delivery.

STI treatment: STI treatment interventions have an impact on HIV transmission at the population level, but the effects differ according to the stages of HIV and STI epidemics. In low--level or concentrated HIV epidemics a considerable impact of STI treatment can be expected on HIV incidence at the population level. Early detection and prompt treatment of STDs is critical to reducing rates of HIV and other STDs serious complications. Self-medication practices should be discouraged while expanding access to friendly services. Appropriate STI management is one of the few evidence-based and cost-effective interventions in reducing HIV transmission, especially in early, concentrated HIV epidemics in order to reach high-risk groups who are most likely to

have multiple sex partners, such as sex workers and their clients. To control the spread of STI people must know the signs and symptoms, be able to access prompt treatment, complete the treatment regime, return for a follow-up visit, and encourage partner referral. Comprehensive STI management services would include:

- Either medical personnel trained in physical examination or trained in syndromic management;
- the correct quantity and quality of drugs available;
- counselling on correct adherence to drug schedule and condom use;
- partner notification; and a referral system for related services.

Post exposure prophylaxis: Post exposure prophylaxis is a short term provision of ARV to reduce chances of HIV infection after exposure to the virus whether through accident at work or sexual intercourse e.g rape. Post exposure prophylaxis is currently provided as a package in health care settings since most accidents happens in this sector and poses potential risks for infection. Post exposure prophylaxis is usually given as combination of medications depending on degree of exposure and HIV status of the source

3.2 ZERO DEATH RELATED TO AIDS

3.2.1 Antiretroviral Therapy (ART)

Currently there is no cure for AIDS. However, there are drugs that can slow down the progress of HIV and thus slow down the damage to the immune system. These drugs are called antiretroviral (ARV's). ARV's slow down the reproduction rate of HIV. Once the virus is reproducing at a slower rate, it is less able to harm your immune system. If the immune system is functioning properly, then a person living with HIV is less likely to become sick. The immune system is the main defense system against infection. Since ARV's slow down the damage to your immune system, if they are used properly, they allow a person living with HIV to live a longer, and healthier life.

Eligibility: Once a person is diagnosed of HIV, they might not start ARV treatment immediately. In addition they will be referred to a Care and Treatment (CTC) clinic where, special counselling aiming at preparations to start ARV treatment will be provided. Antiretroviral therapy (ART) has been shown to be effective in slowing down the progression of AIDS and in reducing HIV-related illnesses and death. Normally, therapy is administered based on a patient's CD4 cell count, where the number of CD4 cells reflects the body's immune (defense) system. An HIV-infected individual with a CD4 cell count of 500 cells/μL or more is considered healthy enough not to need ART. When a patient's cell count reaches 350 cells/ μL, however, the immune system is severely weakened and ART is necessary. A patient with advanced symptoms for illnesses categorized as AIDS defined illnesses such as Tuberculosis receives treatment regardless of CD4 count.

Antiretroviral drugs: Standard antiretroviral therapy (ART) consists of the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. Huge reductions have been seen in rates of death and suffering when use is

made of a potent antiretroviral regimen, particularly in early stages of the disease. Furthermore, expanded access to ART can also reduce the HIV transmission at population level, impact orphan hood and preserve families. Unlike most medications ARV's need to be taken strictly as prescribed, under medical supervision, for the rest of your life. Provision of ARV is through more than 1000 clinics known as Care and Treatment Clinics which are available in a number of Health centers and all district hospitals throughout the country. ART also assist in saving money that would otherwise have been used for treatment of opportunistic infections that would present if immunity is lowered as well as other palliative care services. The use of ARV helps keeping households and families together. It helps HIV prevention by increasing access to prevention education during health care services (Behavioral) and it also decreases HIV transmission due to lowered viral load (Biological).

Side effects: ARV's can cause side effects such as diarrhea, tiredness and headaches etc., even if they are taken correctly. This does not mean that the drugs are not working. If this happens the health care provider will help to manage the side-effects.

Adherence to ART: The benefits of ART to patients and their families are enormous. Patients should not start ART only to stop because they cannot cope with the complex regimen. Some need a great deal of social support, including food supply to be able to adhere to their regimen. Even when patients feel better after ART use, they should not stop ARVs. ART is a life-long therapy and its continued success depends very much on appropriate use as recommended.

Alternative medications: Alternative medicines have shown potential in supporting health status. It is recommended that, patients who opt for alternative medication consult their doctors and continue to use ARVs. Providers of alternative medications including faith healers are to be sensitized over the investment committed and potential of ART in prolonging lives. In essence, programs should discourage any alternative medication practices that promote discontinuation of ARVs.

Treatment as Prevention: The preventative effect of antiretroviral treatment is another reason for scaling up access to HIV treatment. A recent study has suggested that if an HIV-positive person adheres to an effective antiretroviral therapy regime, the risk of transmitting the virus to their uninfected sexual partner may be reduced by 96 per cent. ARVs reduce viral load and higher viral loads have been linked to increased risk of passing HIV to sexual partners. HIV prevention efforts focused on people living with HIV make sense from an individual and public health perspective, and there is high-quality evidence supporting the use of ART to prevent HIV transmission.

Access and availability: The availability and accessibility of antiretroviral treatment is crucial; it enables people living with HIV to enjoy longer, healthier lives, and as such acts as an incentive for HIV testing. Continued contact with health care workers also provides further opportunities for prevention messages and interventions. Studies suggest that HIV-positive people may be less likely to engage in risky behaviour if they are enrolled in treatment programmes. Availability of ARV has increased uptake of voluntary testing and counseling. Its availability has increased awareness of HIV as well as increased motivation of health care workers. ARV should be scaled up to not only to CTCs at districts level but also to community health centers and dispensaries as well.

3.3 ZERO STIGMA AND DISCRIMINATION

3.3.1 Eliminating Stigma and Discrimination

Because of its association with sex particularly the association with "immoral" sex and death, HIV and AIDS is a highly sensitive topic. In both the private and the public sphere, silence, social stigma and denial are commonplace. At the individual level, denial of risk prevents many men and women from protecting themselves from infection. Denial also prevents those who believe or know they are HIV-positive from seeking counselling and treatment. At the community and national level, denial prevents many leaders from speaking out on the issue; those who do speak out may do so infrequently and restrict their remarks to generalizations that do not address the reality of the disease.

A need to catalyze an expanded response to the HIV and AIDS epidemic in order to contain the spread of infection; reduce people's vulnerability to HIV; and promote community and family based care to HIV and AIDS cases in an enabling environment without any stigmatization and discrimination has been recognized globally. Special attention is required to support vulnerable populations that include the women, the youth, the specific groups with sexually transmitted infections, the men who have sex with men and the intravenous drug users.

In today's world, HIV is a chronic disease like many others and no longer a death sentence as it was perceived during the early years of the epidemic. It has been proven that HIV drugs taken in combination restrict HIV from duplicating itself, and keeps HIV infection from turning into AIDS. The medicines available to treat HIV have gotten better, more effective, and easier to take. The currently available treatments can reduce the amount of HIV to the point that it is "undetectable."

3.3.2 Positive Health, Prevention and Dignity (PHPD)

Positive Health, Dignity and Prevention highlight the importance of placing the person living with HIV at the center of managing their health and wellbeing. PHDP stresses the importance of addressing prevention and treatment simultaneously and holistically. It also emphasizes the leadership roles of people living with HIV in responding to policy and legal barriers within the socio-cultural and legal contexts in which they live, and in driving the agenda forward towards better health and dignity.

PHDP aims at increasing the self-esteem, confidence and ability of PLHIV to protect their own health and avoid passing on the infection to others. PLHIV are part of the solution to the impact of the disease on communities and that PLHIV should be included in prevention efforts.

Prevention interventions with PLHIV should include both behavioral and biomedical interventions aimed at reducing the morbidity and mortality experienced by PLHIV and reducing the risk of transmission to HIV-negative partners and infants. Implementation of comprehensive

PHDP interventions, including practical integration of prevention into care and treatment settings, is an important HIV prevention approach. This should include provision of a continuum of consistent and reinforcing messages and services across settings. By addressing prevention with HIV-positive patients in care and treatment, providers can impact the HIV epidemic in their communities. The important HIV prevention components of a comprehensive package for the community and clinical setting are:

- Condom promotion and provision
- Messaging and counselling support for health behaviors including: sexual risk reduction; retention in care, adherence to medications, and partner HIV testing and counselling
- Screening and treatment of STI
- Safer pregnancy counselling and family planning service integration
- Identification of social needs and referral for community-based services

Patients may not be ready to adopt new practices immediately, and sustaining safer sexual behaviors can be difficult. Adopting and maintaining provider-recommended practices can be a slow and challenging process that requires continual reminders and support from providers. However, studies have shown that PLHIV will adopt many recommendations on risk reduction when health care providers are committed to delivering prevention messages and counselling at every visit. Specific risk reduction messages providers can promote include partner reduction, condom use, disclosure and knowledge of your partner's status, and reduced alcohol consumption.

PHDP interventions contribute to the identification of HIV-positive individuals and sero-discordant couples and partnerships. Partners who are newly identified as HIV-positive can then be linked into HIV prevention, care, and treatment services. Identification of discordant couples and partnerships represents an opportunity to prevent new infections of the negative spouse or partner(s) through provision of prevention services, including routine re-testing and counseling of the HIV-negative partner. To help ensure that the couple is able to maintain their HIV discordance, the HIV-negative partner in discordant partnerships should be offered HTC at least annually or in line with WHO re-testing recommendation.

Finally, ongoing adherence counseling and support services maximize the care and prevention benefits of ART by supporting optimal adherence among patients on treatment.

Considering the ongoing challenges of HIV prevention, people living with HIV should be recognized as a part of the solution. The public health and human rights goal of preventing new HIV infections can only be achieved when:

- The human, sexual, and reproductive rights of people living with HIV are protected and supported;
- the broader health and dignity needs of people living with HIV including special needs of groups such as CSW, MSM and IDUs are met;
- access to timely and uninterrupted treatment and care encourages greater uptake of confidential HIV testing and counseling.

Communities should be educated on their responsibilities towards people living with HIV as well as rights and responsibilities of those living with HIV. Through support groups PLHIV can be supported to organize income generating activities.

3.4 CROSS-CUTTING MESSAGES

3.4.1 Community Response and Ownership

Community based activities have been the cornerstone of many health initiatives, such as vaccination and sanitation campaigns. The HIV movement has built on experiences such as these, and since the beginning of the HIV epidemic, civil society organizations have been in the vanguard of the community response to HIV and AIDS.

The emergence of the AIDS epidemic has simultaneously affected communities at many levels: sickness and death is combined with deepening poverty and widespread orphaning. The challenge was initially perceived as a health problem requiring a public health approach. But health services, and communities for that matter, were ill prepared to deal with a problem that encompasses the complex issues of sex, terminal illness and death - all three raised to astonishing levels by HIV and AIDS. Innovative ways of working with communities to generate an effective and structured response is now in place. In Tanzania village and ward AIDS committee have been formed in most areas but their roles and responsibilities are limited to meetings that are often organized by partners. There is a need for communities to take their own action in responding to HIV. The process of mobilization must start with a community identifying their own concerns. Community leaders have a role to play regarding community initiated activities. A recurring theme among communities affected by HIV and AIDS is the growing number of orphans and vulnerable children and the circumstances in which they live. The motivation that energizes their efforts comes from a variety of sources: compassion, religious commitment and recognition that unless they support each other while they are able, they will have no one to depend on if their own families someday need help.

Community response initiatives need to recognize internal community resources and knowledge, individual skills and talents that are already available within the communities. Thereafter, it is important for members of the communities to take lead in planning and managing activities using their internal resources; and increasing capacity of community members to continue carrying out their chosen activities, to access external resources once internal means are exhausted, and to sustain their efforts over the long term. It is recommended to engage every community member and create a space for mutual learning and help reshape relationships in line with transformed values. These include processes for enhancing the capacity of all groups in the community including people living with HIV. Throughout this process, the dignity of individuals and families is preserved and enhanced in an environment that encourages compassion, acceptance and accountability. Stigmatization, coercion and violence are avoided.

The enhancement of community capacity through Community Conversations is a methodology based on the recognition that communities have the capacity to prevent the spread of HIV, care for those affected, change harmful attitudes and behaviors and sustain hope in the midst of the epidemic.

It integrates the principles of diversity, respect of differences and non-discrimination into the tools and practices used to address issues critical to HIV and AIDS. These include issues related to stigma, discrimination and the violation of the rights and dignity of people living with HIV, along with issues related to voluntary counselling and testing, prevention of parent-to-child transmission, and access to treatment, including antiretroviral therapy.

Coordinated Community response provides an opportunity for NGOs, community-based organizations and faith based organizations to work more effectively by reinforcing social networks and coalitions. Communities can play a leading or supporting role: they could provide goods and services directly to the beneficiaries, or they could be facilitators for those services. Community responses tend to play a leading role where face to face interaction, knowledge of the community, and peer influence and support are important, such as in care and support or in reaching populations that are at elevated risk. Community responses tend to play a supporting or complementary role when they facilitate services such as food, HCT, or treatment provided by others groups or the private or public sectors. Communities need to rally around activities designed to provide care for such children and support to their guardian households.

3.4.2 Enabling Environment

Despite increased reporting on protective laws, countries and other stakeholders should establish effective enforcement mechanisms and provide people living with HIV and other key populations with access to justice and redress through HIV-related legal services and legal literacy programmes.

Although progress has been noted, HIV-related stigma and discrimination are still highly prevalent globally and are not yet being sufficiently addressed. Countries and other stakeholders should urgently scale up comprehensive programmes that build capacities of HIV-related service providers, address stigma and discrimination in laws, institutions and communities, and empower those affected by HIV.

To help to realize human rights in the context of HIV, there must be more meaningful involvement of people living with and those vulnerable to HIV in national HIV responses, as well as meaningful coverage of all affected populations. The Greater Involvement of People Living with HIV and AIDS (GIPA) principles must be fully implemented.

It is very important to involve PLHIV in design, planning and implementation of AIDS related work. Doing this will increase the relevance of such work; reduce discrimination; help the needs of people with HIV and AIDS to be recognised; assist in the process of de-stigmatisation; enable a greater understanding of the impact of HIV and AIDS; and present a human face to AIDS.

PLHIV also have a key role to play in education and prevention. Discrimination against them is widespread, and involving them is vital element in changing attitudes.

To achieve universal access goals towards HIV prevention, treatment, care and support, the AIDS response needs to be women and girls centered and include a dedicated budget to address their needs.

Given that violence is widespread and that there is a clear association between violence against women and the spread of HIV, national HIV responses must include specific interventions to address violence. All countries need to ensure that women have access to integrated quality HIV and sexual and reproductive health services that enable women to exercise their rights.

Men and boys need to be engaged in innovative approaches to change harmful social and cultural practices and norms, as part of HIV prevention.

In response, districts need to invest in innovative strategies to expand the capacity of health systems to address HIV and other challenges. These include increasing the use of civil society partners to manage health care facilities, other forms of task-shifting in clinical settings. The health care response should focus on the extension of basic services to marginalized subgroups such as CSWs, MSM, IDUs and GBV survivors, as well as on improving the quality and scope of services provided by investing in better social services and protection system.

Perhaps the greatest constraint to an effective response to HIV/AIDS is the lack of resources. Not only do countries lack the resources but, across the continent, international development partners, including bilateral agencies, also face resource constraints. There is also under increasing pressure to streamline their programmes to focus resources on core competencies and mandates. Despite their goodwill, many are obliged to assign HIV/AIDS to a lower order of priority.

One of the most frustrating aspects of the fight against HIV/AIDS is the shortage of financial resources to carry out programmes and actions that are known to be beneficial.

Due to inadequate funding, HIV/AIDS is becoming a disease of poor people, poor communities and poor countries. Funds are short at all levels and among all partners.

Due to resource constrains, there is an increasing pressure to streamline programmes to focus resources on need, best science, core competencies and mandates. Under these circumstances, key implementers at all level tare urged to:

- Explore new sources of funds;
- Encourage central and local governments, civil society groups, private sector and development partners to provide more funds for HIV/AIDS prevention and control.
- Ensure that scarce resources are utilized in the most cost-efficient manner. This should include efforts to target key population and use equity scale in funds distribution.
- Promote equity in the allocation of resources, ensuring that women's and youth groups obtain a fair share.

3.4.3. Roles and responsiveness

Individual Response: Everyone has a role to play in HIV response. The first and fundamental step in prevention of HIV infections is through getting an HIV test. Knowing HIV status can keep one from accidentally passing the virus to someone else. Many people who are infected do not realize they are infected. They may not even realize they are at risk. Early treatment is another important part of prevention. If a person finds himself/herself to be HIV positive, he or she can get medical care to keep him/her healthy for a long time. Treatment will make them less infectious to others, and help to protect their partner(s).

The second individual level response is to practice safe sex. This means using a condom correctly and consistently for anal, vaginal or oral penetration. For those who are at practicing high risk behaviors such as IDUs, sharing needles is highly discouraged. It is also highly recommended

to use medical latex or non-latex gloves if you will be coming into contact with another person's blood, urine, or semen. Health care workers should consider this practice as a "universal precaution" which means they wear protective equipment regardless of the client's HIV/AIDS status.

Reduce Sexual partners: People who engage in sexual relationship with multiple partners are at a greater risk of getting HIV, or passing it to someone else. For sexually active individuals, mutual monogamy with uninfected partner is the safest way to go. That means: 1) You are in a sexual relationship with only one person, and 2) Both of you are having sex only with each other. In addition, both of you need to be tested for HIV and other STIs before you have sex without a condom. Having unprotected sex with a sex worker, having anal sex, group sex only increase chances for you to get HIV infection. You should avoid these activities so that you improve your chances of staying healthy and happy. It is also important to remember that abstinence from sexual activity outside of a committed monogamous relationship is one of the best ways to be protected from HIV/AIDS.

Sexual activity with more than one partner plays a central role in all sexually-driven HIV epidemics. In many settings; intergenerational sex and transactional sex are closely related. Both practices are driven by economic needs or wants, as well as deeply-entrenched norms not discouraging age differences between partners and male dominance in relationships. Many people find it difficult to change their behaviors, especially around sexual practices. Changes surrounding sexual behaviors are particularly challenging, as the issues are considered private, often require the participation of both partners, and are typically shaped by gender dynamics. Activities such as anal sex, having unprotected sex, engaging in trans-generational sexual relations, are known to increase chances of being infected with HIV. It is hence advised to address the behavioral and social norms challenges related to supportive environment that will enable individuals to avoid such activities.

People engage in concurrent multiple partner sexual relationships for many reasons but the desire for heightened excitement and sexual pleasure and perceived peer norms are paramount. This motivation for sexual pleasure and show-off needs to be acknowledged, and people should be given the skills for making sexual relations in monogamous and faithful relationships highly pleasurable instead of being boring. Preference for unprotected sex is often driven by the desire for deeper sexual satisfaction. It is therefore important to promote couples open communication about sexual needs and exhaust safer practices that meet satisfaction needs of each partner.

Responsible Drinking: Alcohol use plays a critical role in sexual risk behavior that can lead to HIV transmission. Multiple studies have found that persons who use alcohol in sexual situations are more likely to have unprotected sex, casual sex, and multiple partners, than persons who do not use alcohol in sexual situations. Alcohol consumption is linked with increased risk of STI and HIV infection, gender-based violence, and non-adherence to ART.

Change Gender norms: Social norms play a critical role in sexual risk behavior that can lead to HIV transmission. Multiple studies have found that accepted social norms like multiple sexual partnerships are more likely to have unprotected sex, casual sex, with partner of unknown HIV

status. Social norms are also linked with gender-based violence, and non-adherence to ART. Women's ability to refuse sex or negotiate condom use, which may already be limited, may be further compromised by age differences between partners or exchange of money or gifts. These factors, in combination with young women's biological vulnerability to HIV infection, contribute to heightened risk for both young women and their male partners. Moreover, some cultural traditions are seen to be perpetrators of such violence. Practices such as initiation, widow cleansing and forced school drop outs which deny most girls/women the opportunity to develop skills that will facilitate their economic independence have often driven them towards transactional sex and early marriages exposing them to the risk of HIV infection, since victims are usually not in the position to discuss the use of condom and thereafter are likely to engage in risky behavior.

At family level this strategy recommends constructive, informed, and collective action within the family unit for successful HIV and AIDS scale up. The family unit can be a seat of both caring behavior and stigma and a powerful source of correct information or misinformation. In most cases the family unit is the only source of home based care for PLHIVs. To harness the potential for the family unit education is needed to discourage attitudes and behavior that fuel hopelessness and fatalism and act as an impetus for HIV prevention and community based care for those infected by HIV and also for the orphans and vulnerable children (OVC). This advocacy strategy places a strong emphasis on the family unit. The family is seen both as a channel of information and as an audience. It can act as a channel to infected people bringing important information about testing and health living practices. It can also be a target for advocacy interventions because their own knowledge and attitudes influence the outcomes for those infected or affected.

4. IMPLEMENTATION OF THE NHACAS

The NHACAS will be implemented for five years under the coordination of TACAIDS, The implementation of the plan will involve systematic preparation, planning and coordination of activities at national, regional and District level building on the National Multisectoral Framework III.

To ensure effective coordination, TACAIDS steering committee and regional stakeholders will conduct quarterly meetings to analyze, coordinate and plan the strategy at regional and national levels. The meetings will review progress and challenges and take appropriate actions. Achievements and challenges for implementation of this strategy will be assessed and reported every year.

Implementation at National level

At national level, the first year of implementation (2013) will focus on dissemination of the NHACAS to national, regional and district stakeholders. TACAIDS, in collaboration with national stakeholders including development partners, will support the regional stake holders to adapt and implement regional NHACAS plan by actively participating in the regional multi-sectoral planning meeting and regularly attend regional review meetings.

Implementation at Regional Level

TACAIDS Regional offices under the Regional Administrative Secretary offices will coordinate the adaptation and implementation of this strategy at regional level. Quarterly review of the NHACAS will be organized by the regional office with all stakeholders included.

Implementation at District level

The DAC and CHAC will provide technical support at this level to ensure implementation of the strategy at district level. DAC and CHAC will support development and implementation of the strategy working hand in hand with civil society organization including NGOs and religious organizations. CHAC will also plan and coordinate integrated supportive supervision, mentoring, monitoring and evaluation of activities within communities to ensure successful implementation of the strategy.

5. MONITORING AND EVALUATION

Monitoring and evaluation (M&E) are key instruments to encourage on-going learning for the improvement of advocacy and communication interventions. The benefits of conducting good M&E include improvement in management and performance in terms of effectiveness, efficiency and value for money, and an increase in accountability and transparency. It involves the collection, synthesis and analysis related to the measurement of inputs, outputs, outcomes and impacts as well as of parameters that affect outputs and outcomes in the programming framework. Advocacy and Communication interventions are more effective when they are planned using data and assessed using good monitoring and evaluation tools to achieve intended results.

The Monitoring and Evaluation of NHACAS will continue to be in line with the existing M&E systems, procedures and mechanisms of the NMSF III and the NHACAS II. TOMSHA, the Health sector's Health Management Information systems concurrently, and routine information systems of other sectors will be the main avenues for collection and reporting of data on HIV prevention activities based on the priority monitoring indicators. The frequency of reporting will depend on the type of information and the systems used to collect the information. The MoHSW NACP and other line ministries will also continue to obtain, analyse and prepare reports of sectoral HIV/AIDS advocacy and communication activities and provide regular reports to TACAIDS according to technical areas under their mandate. Horizontal linkages with TACAIDS will facilitate reporting of priority information to TACAIDS as well as sharing of their sector reports. In addition, partners implementing various programmes will be encouraged to document best practices in HIV prevention for consideration by stakeholders. Furthermore, information from research will be reported to the Information Centre that will be established, and their findings disseminated and used in planning and policy making.

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

- Input Indicators: Measure the quantity, quality and timeliness of resources provided for a project or programme for example funding, human resources, equipment; or communication materials
- Output Indicators: Measure quantity; quality and timeliness of products or services created or provided through use of the inputs. They measure immediate results, for example number of people exposed to a message or participating in community action
- Outcome Indicators: Measure short-term effects of a project or programme. They are often changes in behaviour following an intervention, for example number of couples who say that they used a condom after watching a TV spot on condom
- Impact Indicators: Measure long-term effects on the people and their surroundings. For example increase in the percentage of couples testing routinely for HIV in a district or region.

NHACAS II will contribute to achieving NMSF III indicators. Some key indicators have been recommended below.

In addition, evaluation of Advocacy and communication is necessary to understand causality and whether or not the advocacy and communication strategy has yielded behavior and social change results. Evaluation is defined as an assessment of a planned, ongoing or completed intervention to determine its relevance, efficiency, effectiveness, impact and sustainability. The purpose is to learn lessons for enhancing the quality of the communication intervention.

Strategic communication must lead to behavior and social changes, however, the impact cannot be demonstrated within a short span of time. In this context, indicators can be proxy signposts or progress markers; measures that inform us not about the ultimate outcome or impact, but that we are on the right track. For instance, in the case of an HIV prevention effort focused on young people, the decrease in number of in-school pregnancies can be a good proxy for safer sex behaviors.

Key indicators

No	KEY INDICATOR	BASELINE 2010/12 (%/N)	TARGET 2016 /17 (%/N)	DATA SOURCE
Prevalence of HIV				
	Among males between 15 – 49 years	3.8	2	THMIS
	Among females between 15 – 49 years	6.2	3	THMIS
	Injecting Drug users	35		Surveys
	Pregnant women	5.5	3	ANC Surveillance
	Female Sex Workers	31		Surveys
	Men who have sex with men	42		Surveys
Knowledge on HIV				
1.	Proportion of males with comprehensive knowledge on HIV	71	90	THMIS, TDHS
2.	Proportion of females with comprehensive knowledge on HIV	60	90	THMIS, THDS
3.	Proportion of People who inject Drugs with comprehensive knowledge on HIV			Surveys
4.	Proportion of MSM with comprehensive knowledge on HIV			Surveys
5.	Proportion of FSW with comprehensive knowledge on HIV			Surveys

Rate of condom use				
1.	Proportion of males with more than one partner who used a condom the last time they had sex	26.8	90	THMIS, TDHS
2.	Proportion of females with more than one partner who used a condom the last time they had sex	27.3	90	THMIS, TDHS
3	Proportion of MSM who used a condom the last time they had sex	43.2	90	Surveys
4	Proportion of FSW who used a condom the last time they had sex	69.3	90	Surveys
Elimination of MTCT				
1	Prevalence of pregnant women with HIV	5.5	2	ANC Surveillance
2	Prevalence of HIV exposed infants who did not receive ART to prevent from acquiring HIV from mother	43	90	HMIS
3	Rate of transmission of HIV from Mother to child	23	<5	Spectrum
4	Knowledge on transmission of HIV from mother to child among men	63	99	THIMS, TDHS
5	Knowledge on HIV transmission from mother to child among females	68	99	THMIS, TDHS
6	Percentage of HIV- positive pregnant women assessed With CD4 testing	15	90	HMIS
7	Percentage of infants born to HIV positive mothers tested for HIV within a short period of time since birth	22	90	HMIS, Spectrums
Sexually Transmitted Infections (STIs)				
1	Prevalence of sexually transmitted disease among sexually active males	4	2	THMIS
2	Prevalence of sexually transmitted diseases among sexually active females	3	1.5	THMIS
3	Percentage of male STI patients seeking treatment from a qualified health provider	62	75	Surveys
4	Percentage of female STI patients seeking treatment from a qualified health provider	50	75	Surveys

Male circumcision				
1	Prevalence of male circumcision (vary with regions)	72	80	THMIS
Gender Based Violence				
1	Proportion of women reported to experience any form of violence during past 12 months	33	0	THDS
HIV Testing and Counseling				
1	Proportion of males ever tested for HIV	47	65	THMIS, TDHS
2	Proportion of females ever tested for HIV	62	80	THMIS, TDHS
3	Proportion of males who know where to get HIV test	91	99	THMIS, TDHS
4	Proportion of females who know where to get HIV test	91	99	THMIS, TDHS
5	Percentage of health centers offering Provider Initiated Testing and Counseling	50	100	HMIS
Stigma and Discrimination ``				
1	Proportion of males who admit to stigmatize people living with HIV	25	50	THMIS
2	Proportion of females who admit to stigmatize people living with HIV	40	60	THMIS
Care, Treatment and Support				
1	Number of health facilities providing Voluntary Counseling and Testing for HIV	2,134		HMIS, NACP
2	Number of health facilities providing treatment services (ART)	1,404 (22%)	100%	HMIS, NACP
3	Number of health facilities providing PMTCT Services	4,914		HMIS, NACP
4	Clients on anti-retroviral therapy (ART)	626,444		HMIS, NACP

6 SUMMARY OF PRIORITY FOCUS AREAS FOR ADVOCACY AND COMMUNICATION STRATEGY MATRICES

The following matrices are provided to help guide communication planners in their communication strategies at the organizational and project level. Specifically, the matrices identify the following:

1. **Focus areas in three zeros** , which should be the focus of HIV and AIDS communication between 2013 and 2017
2. **Strategic Areas** under each focus area, where organizations and projects are encouraged to concentrate their efforts.
3. **Key issues** which should be addressed when developing and implementing strategic communication plans within a strategic area.
4. **Suggested objectives** for HIV and AIDS communication in the particular strategic area.
5. **Strategies** as per the National MultiSectoral Strategic Framework on HIV and AIDS 2013-2017.
6. **Key Audiences** that communicators should make efforts to reach. Priority audiences are suggested.
7. **Suggested approaches** for each strategic area.
8. **Expected outcomes** for each strategic area.

Focus Area 1 of 4: Enabling Environment for Zero Stigma and Discrimination

Objective(s):

- **HIV /AIDS is an issue which society accepts and openly discusses.**
- **People infected with/ affected by HIV / AIDS are met with tolerance and compassion.**

Expected Outcome:

- **Decision makers and core people at national and local levels are providing sustained leadership in the fight against HIV/AIDS.**
- **AIDS remains a priority issue in society's mind and perception.**

Strategy 1: Develop and implement, with important public decision makers, continuous plans for advocacy including leadership roles and role models (personal responsibility of leaders to live what they preach).

Strategy 2: Deliver responsible and appropriate information, reporting and educating on HIV and AIDS issues of the population.

Strategy 3: Include networks and individuals of Persons Living with HIV and AIDS (PLWHA) to take part in advocacy work.

Strategy 4: Develop communication strategies for specific population groups.

Strategy 5: Ensure that HIV and AIDS plans and campaigns include measures to reduce stigma and discrimination

Key Issue(s):

- Continuing stigma and discrimination is based on then perception of HIV transmission as primarily the result of immoral sexual behaviour.
- The hesitancy to engage in more difficult cultural change advocacy for gender equity and equality.

Priority Audience(s):

- Government officials
- Business leaders
- Community leaders
- Traditional leaders
- Media leaders

Additional Key Audience(s):

- Donors

Positioning

- Address the evolving HIV/ AIDS epidemic as a Human Rights issue. Note that in the beginning of the epidemic, transmission and infection was concentrated among certain groups practicing higher risk behaviours more frequently than others.
- In today's epidemic, a new pattern has emerged where transmission and infection has been occurring throughout the general population of sexually active persons. Therefore, infection should no longer be associated with the stigma of casual sex or commercial sex work. It is now important to protect the rights of workers, women and children affected by the epidemic.

Communication Strategy:

- Form or mobilize existing working groups around specific policy and advocacy issues.
- Develop specific plans of activities to address each policy and advocacy issue.
- Identify specific policy change objectives.
- Specify desired actions clearly.
- Identify primary and secondary audiences according to their position (pro, undecided, and competition)
- Positions issues clearly, and offer key decision-makers a unique and compelling benefit or advantage to support the position.
- Give the proposed policies or policy change an appealing name, easily understood and designed to mobilize support.
- Compile data/documentation which supports position and which shows importance of taking action.
- Present information in a brief, dramatic, and memorable fashion.
- Incorporate human interest and anecdotes into advocacy messages.
- Emphasize urgency and priority of recommended action.
- Organize training and practice in advocacy.
- Build coalitions with and mobilize support from appropriate partners, coalition advocates, spokespeople, and the media.
- Identify any organized competition, and seek reconciliation where possible. Network to enlarge coalitions and to keep them together.
- Plan for and organize news media coverage to publicize appropriate events, present new data, and credit key players.
- Rally visible grassroots support.
- Plan for and combine multiple channels of communication, including personal contacts, community media, mass media (print, radio, TV), and new information technologies such as Email and the Internet.
- Develop intermediate and final indicators to monitor the process and evaluate the impact.
- Refine positions to achieve a broader consensus. Minimize the opposition or find areas of common interest as often as possible. Link position to the interests of policy makers.

Objective(s):

- **Create widespread positive attitudes towards people living with HIV/AIDS and safeguard their Human Rights.**

Expected Outcome(s):

- **HIV and AIDS and related issues are accepted and dealt with understanding and tolerance in society.**
- **Attitudes and behaviours have changed in certain professional groups (e.g. health workers) with regard to the infection and disease, and to people who are infected / affected.**
- **Laws and regulations have been reviewed and adapted.**

Strategy 6: Promote greater involvement of PLHIV and their networks in HIV and AIDS interventions, and public promotion by political leaders.

Strategy 7: Establish hotline for human rights violations and acts discrimination.

Strategy 8: Review national laws and regulations (inheritance rights, workplace regulations etc.) to protect the Human Rights of PLHIV.

Strategy 9: Strengthen VCT facilities to reduce stigma and discrimination.

Key Issue(s):

- Perpetuated stereotype of the type of person who has HIV and AIDS as morally defective.

Priority Policy Changes to protect the Human Rights of PLHIV.

- Review and possible revision of workplace regulations to prevent discrimination of PLHIV.
- Review and possible revision of broadcasting regulations to ensure protection and encouragement of widespread condom promotion.

Priority Audience(s):

- Legislators
- Religious leaders
- Faith Based organizations
- Program managers

Additional Key Audience(s):

- Technical assistants

Positioning

- People with HIV and AIDS as indistinguishable from others, morally as well as physically.
- Reaching out to people with HIV and AIDS as a demonstration of good moral character.

Communication Strategy:

- Build awareness of underlying societal issues and their profound effect on (the likelihood of) success of all HIV and AIDS prevention and treatment interventions.
- Increase knowledge about continuing stigmatization of and discrimination against PLHIV.
- Increase knowledge about how campaign implementers often unconsciously perpetuate stereotypes and archetypes of PLHIV.
- Provide skills in non-stigmatizing advocacy.
- Monitor public events and media appearances by key moral leaders to ensure moral neutrality.

Examples of Communication Activities:

- Pre-event briefings by personnel trained to recognize potentially stigmatizing and discriminatory language and modelling.
- Reviews of campaign materials by TACAIDS communication specialists trained in recognizing potentially stigmatizing and discriminatory language and modelling.
- Awareness-building message development workshops with campaign implementers and planners on stigma and discrimination.

Key Messages: When developing messages and materials, think about how a person with HIV and AIDS would feel to look at it.

Key Issue(s): Reluctance of PLHIV to publicly disclose their status.

Priority Audience(s):

- PLHIV
- Voluntary Counseling and Testing counsellors
- Campaign planners and funders

Additional Key Audience(s):

- Families of PLHIV.

Positioning

- People who disclose their HIV and AIDS status as pioneers and advocates.
- People who disclose their HIV status as people who demonstrate good moral character.

Communication Strategy:

- Train VCT counsellors to refer PLHIV to groups seeking assistance with communication efforts.
- Establish anonymous ways for PLHIV to participate in HIV/AIDS prevention.
- Train PLHIV in pretesting skills, message development skills, and other communication skills

- Establish a PLHIV communication assistance group.
- Include PLHIV in quality circles and district level AIDS Action planning and review groups.

Key Messages:

- Pretest messages and materials with PLHIV
- PLHIV are the best resource for communication planning.

Key Issue(s):

- Violations of Human Rights of persons living with HIV /AIDS are frequent. Countries that have been successful in containing the epidemic have undertaken great strides in reducing stigma and discrimination.

Priority Audience(s):

- PLHIV and their families in areas with telephone service.

Additional Key Audience(s):

- Care providers and counsellors of PLHIV
- Human rights advocates
- Law Enforcement agency members
- Employers
- Insurance companies

Positioning

- Rights of PLHIV as a priority to the government.

Communication Strategy:

- Establish 24/7 hotline for human rights violations and acts of discrimination in established organization.
- Establish protocol for documenting and responding to human rights violations.
- Publicize telephone number and address on all HIV and AIDS education materials.
- Notify care providers, human rights advocates, law enforcement agency members, employers, and insurance companies of hotline and response team.
- Arrange for hotline director and members to be interviewed on radio and television to publicize availability.

Key Messages:

- All people have the right to privacy of their medical condition, regardless of its nature.
- All people have the right to be treated with respect and consideration, regardless of their medical condition.
- All persons have the responsibility to protect the rights of others.
- Call or write the hotline to report any human rights violations

Objective(s):

- **Mobilize and support the community to develop their own responses to HIV and AIDS.**
- **District and Municipalities to establish new partnerships and effectively plan and coordinate the local responses to HIV and AIDS under the leadership of local government councils.**

Expected Outcome:

- **Increase in the number of communities that are competent to develop their own responses to the epidemic.**
- **By 2017, 100 per cent of districts and municipalities in the country are developing and implementing their own comprehensive plans and contributing to the sustainability of the HIV and AIDS related programmes.**

Strategy 10: Promote, facilitate and expand models of Community Mobilisation for HIV and AIDS in all districts of the country.

Strategy 11: Rely on the strength, creativity and determination of Communities to find their own solutions to reduce their vulnerability to HIV and AIDS.

Strategy 12: Strengthen and accelerate District Responses:

- Promote and improve the comprehensive planning including all sectors.
- Promote and improve coordination of the various actors under the anchor of the local government councils.
- Develop and promote participatory Monitoring and Accounting systems.
- Improve mechanisms for disbursing funds to the civil society (NGOs, CBOs) and faith-based organisations through the councils.

Strategy 13: Strengthen the capacities of dispensaries, health centres and hospitals (both private and public), which are close to communities to provide effective HIV/AIDS interventions in areas such as STI management, condom promotion and distribution, VCT, health care and supports.

Strategy 14: Strengthen the involvement of Faith-Based Organization leaders, CBOs, NGOs as well as political and community leaders in advocacy, implementation and mobilization of communities.

Strategy 15: Mobilize increased local financial resources to sustain activities.

Strategy 16: Identify and address the needs for capacity building of the various actors in districts, municipalities and communities.

Strategy 17: Attach special importance to including the informal sector,unemployed and rural poor in the activities.

Key Issue(s):

- Lack of experience in maintaining an ongoing information, education, and communication intervention at the district and community level.
- Lack of feeling of responsibility on the part of any particular organizations or individuals to undertake regular organizing and coordinating activities in most districts.

Priority Audience(s):

- District and regional level ministry supervisory level workers (agriculture, education, health, etc.)
- NGO, FBO and CBO representatives working at district and regional levels

Additional Key Audience(s):

- National level supervisors of district and regional level workers.

Positioning

- Importance of decentralisation for appropriate and effective communication.
- You are responsible for your own community.
- The national and regional programmes are here to assist

Communication Strategy:

- Mobilise AIDS Response committees of public and private sector leaders through District Councils and TACAIDS
- Identify key information problems and needs of community.
- Develop or adapt messages and materials to meet these needs.
- Develop and execute dissemination plans for materials and activities.
- Develop a system of Circuit Riders (travelling communication specialists) through TACAIDS to assist with organisation and initial planning exercises by committees, share lessons learned from other districts in the country, and facilitate access to needed support for activities.
- Require letters of endorsement and involvement from local community leaders for HIV and AIDS education activities.
- Report and evaluate district and community responses

Key Messages:

- Adapted to the particular community need, but around the main theme of Human Rights and Responsibilities in a time of HIV and AIDS.

Objective(s):

- **The National Response to HIV and AIDS will be expanded and intensified in major sectors of society through mainstreaming plans and implementation.**

Expected Outcome:

- **HIV and AIDS responses have been expanded in public, private and other sectors**

Strategy 18: Develop mainstreaming plans in health, education, agriculture, and industry sectors among the uniformed services including partnerships between public, private and civil institutions.

Strategy 19: Provide guidance to the sectors on how to mainstream, including prevention and care programmes for their own human resources, as well as how to adjust the technical components (core business) of the sector to the impact of AIDS.

Strategy 20: Develop human capacity and resources to implement the mainstreaming plan.

Strategy 21: Develop monitoring and evaluation systems and review strategies to follow up on achievements and improve performances.

Key Issue(s):

- Mainstreaming requires prerequisite positioning of HIV and AIDS epidemic as affecting everyone, regardless of their serostatus.
- Communication efforts, when mainstreamed without involvement of specialists, may inadvertently stigmatise, enhance discrimination, or provide wrong or incomplete information.

Priority Audience(s):

- Leaders of organizations in key sectors.

Additional Key Audience(s):

- Communication specialists of programs and agencies.
- Public relations/ communication officers of organizations in key industry sectors.

Communication Strategy:

- Sensitize leaders to the benefits of mainstreaming HIV and AIDS activities into their organizations.
- Assist with development of peer education and advocacy groups in key organizations.
- Hold quarterly meetings to share information on ongoing, planned, and completed initiatives and to develop cooperative materials and activity sharing.
- Annual strategic communication program review and development workshop.

Key Messages:

- Benefits of mainstreaming HIV and AIDS into organization.
- Need for a strategic approach to communication
- Need to integrate HIV and AIDS communication into ongoing communication.
- Concept of power of singular message repeated through many sources and channels.

Objective(s):

- **The country's major long-term development plans and policies have fully incorporated and addressed the challenges of the HIV /AIDS epidemic**

Expected Outcome:

- **The long-term national development plans and policies are addressing the root-causes and the social – economic impact of the epidemic and providing the framework for long-term successful responses to AIDS.**

Strategy 22: Continuous assessment of the major country documents for their analysis of the HIV and AIDS impact and their development of concepts and policies to mitigate those effects and contribute successfully to the control of the epidemic.

Key Issue(s):

- Efforts have started to factor in the HIV and AIDS issues in the development strategy of Tanzania. However, more analytical work, research and professional imagination are needed to fully address the impact of the epidemic on the country's long-term development and assistance plans.

Priority Audience(s):

- Legislative assistants.
- Policy advocates and

Additional Key Audience(s):

- Ministry of Finance
- Office of the Prime Minister

Communication Approach (es):

- Sensitization of leaders and planners to key domains and their effect on HIV and AIDS prevention and management efforts throughout society.

Key Messages:

- AIDS is about more than sex. It is about gender equity, culture,spirituality, government policy, and socioeconomic status.
- Development and poverty reduction cannot occur effectively until and unless the AIDS epidemic is halted.
- Development and poverty reduction strategies that incorporate HIV and AIDS risk and harm reduction components are more likely to succeed.

Focus Area 2 of 4: Prevention (includes Gender Equity and Equality) for the Zero new HIV infections.

Objective(s):

- **Increased effective control and management of reported STI cases.**

Expected Outcome:

- **By, 2017, 80 percent of health facilities correctly diagnose, treat and counsel 70 percent of patients with STIs**.

Strategy 23: Improve and maintain the quality of STI services through capacity building, training, supervision and quality circles.

Strategy 24: Involve the private medical sector (hospitals, practitioners, pharmacists) in training and quality control

Strategy 25: Make quality STI services available to specific vulnerable groups like Commercial Sex Workers, Military and Miners

Key Issue(s):

- Potential clients lack the ability to recognize STI symptoms
- Adolescents perceive health facilities providing services as stigmatizing and discriminatory.
- Service providers are reported to shame and embarrass STI clients, especially youth.
- Youth reportedly resorting to veterinary treatments for STIs, or ignoring symptoms.

Priority Audience(s):

- STI service providers

Additional Key Audience(s):

- Adolescents (both boys and girls)
- Parents (as gatekeepers)
- Teachers (as collaborators)

Communication Approach(es):

- Reorient (provide counseling training for) all STI service providers as part of capacity building and training strategy.
- Identify and train one youth counselor for each service outlet.
- Create youth-friendly treatment service provider brand.
- Emphasize non-judgmental attitude.
- Recruit youth ambassadors from local schools and work places to act as liaisons and advocates for referring peers to youth friendly outlets

Key Messages:

- Early and complete treatment of STIs is vital to ensuring future fertility.
- Youth have a right to expect and receive courteous, confidential, and non-judgmental sexual counseling, services and commodities from professional health service providers.

Key Issue(s):

- Perception of private medical sector as having higher quality.

Priority Audience(s):

- Owners and managers of private health service outlets.
- Service providers in private health service outlets

Additional Key Audience(s):

- Youth

Communication Approach (es):

- Include private sector in counseling training for public sector providers.
- Extend branding of youth-friendly service providers to private sectors.

Key Messages:

- Youth-friendly private sector professionals are available for your convenience.
- Youth have a right to expect and receive courteous, confidential, and non-judgemental sexual counseling, services and commodities from professional health service providers.

Priority Audience(s):

- Brothel owners
- Bar owners
- Guest house owners
- Military leaders
- Mine owners

Additional Key Audience(s):

- Service providers

Communication Strategy (ies):

- Reorient (provide counseling training for) all STI service providers as part of capacity building and training strategy.
- Identify and train mobile STI service teams.
- Create high-risk-friendly treatment service provider brand for mobile units.

- Emphasize non-judgemental attitude.
- Recruit high-risk-friendly ambassadors from brothels, barracks, and to act as liaisons and advocates for referring peers to youth-friendly outlets. Include in supervision and quality circle programs.

Key Messages:

- Miners have a right to expect and receive courteous, confidential, and non-judgemental sexual counseling, services and commodities from professional health service providers.
- Military personnel have a right to expect and receive courteous, confidential, and non-judgemental sexual counseling, services and commodities from professional health service providers.
- All women, regardless of occupation, have a right to expect and receive courteous, confidential, and non-judgmental sexual counseling, services and commodities from professional health service providers.

Objective(s):

- **Increase the proportion of the sexually active population, especially in the rural areas, that use condoms consistently and correctly.**

Expected Outcome:

- **Increased percentage of young people aged 15 – 24 years reporting the use of a condom during sexual intercourse with a non-regular sexual partner.**

Strategy 26: Promote acceptance of condoms (male and female) in the general public consistently and throughout the country through private and public channels, and consistently counter misconceptions and misinformation.

Strategy 27: Promote the knowledge about condoms (male and female) in the general public consistently and throughout the country through private and public channels and counter consistently misconceptions and misinformation.

Strategy 28: Address gender and other barriers to using condoms.

Strategy 29: Address the need of correct and consistent condom use as an effective way of protection by condoms.

Strategy 30: Promote the introduction of the female condom as an alternative protection especially among groups of high vulnerability (e.g. female sex workers)

Key Issue(s):

- General acceptance and regular use of male condoms is still very limited.
- References to Condoms in the National Policy on HIV /AIDS are not sufficient to counter resistance from many quarters.
- Women are reluctant to introduce negotiation of condom use in relationships with regular partners.
- Couples are reluctant to use condoms in regular partnerships.
- Limited information and knowledge of female condoms among sexually active women.

Priority Audience(s):

- District-level gatekeepers to widespread promotion of condoms.

Additional Key Audience(s):

- Media producers
- Policymakers and legislators
- Pharmacists
- Refreshment distributors

Communication Approach(es):

- Train and dispatch peer educators/distributors of condoms (men and women) for vulnerable groups, including youth, transport workers, guest house workers, refugees, and others.Link peer educators
- Standard issue condom kits and education materials in all uniformed service kits, miner kits, employment packets, etc.

Key Messages:

- Condoms are protection.
- Protect yourself. Use a condom.

Objective(s):

- **Increase number of people in Tanzania who consult about their HIV status and adopt appropriate measures to responsibly protect themselves and others**

Expected Outcome:

- **By 2017, significant number of VCT facilities are established in each of the districts and increased percentage of the sexually active population know their HIV status.**

Strategy 31: Revise and disseminate national guidelines on the provision and management of VCT services.

Strategy 32: Promote VCT services through IEC measures, advocacy, social marketing etc.

Strategy 33: Establish, link and expand VCT services to existing reproductive health and MCH services and HIV/AIDS prevention, care and support programmes in the respective communities.

Key Issue(s)

- Despite related benefits, uptake for VCT is still low
- High levels of stigma and discrimination associated with HIV and AIDS as one of the major barrier for VCT uptake
- Poor accessibility of VCT services is now being addressed.
- Variable quality of VCT services

Priority Audience(s):

- Couples of Reproductive Age contemplating having a child.

Additional Key Audience(s):

- Families of priority audiences.
- Traditional midwives

Communication Approach (es):

- Peer recruitment.
- Support from mass media, community media, and interpersonal.

Key Messages:

- For your peace of mind and your long-term partners, get tested.
- The earlier you know about your infection, the longer you can live a normal and healthy life.

Objective(s):

- **Reduce the risk of mothers to transmit HIV to their children, during pregnancy, birth and / or breast-feeding**

Expected Outcome:

- **Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce risk of MTCT increased**

Strategy 34: Establish a comprehensive National Policy on PMTCT addressing all sensitive ethical and social / cultural issues.

Strategy 35: Build capacities among health and social workers to implement interventions.

Strategy 36: Advocate and sensitise the public at all levels on PMTCT.

Strategy 37: De-stigmatise HIV and AIDS and encourage partner involvement.

Strategy 38: Link PMTCT interventions to Access to Drugs initiatives and other treatment programmes.

Strategy 39: Monitor and evaluate PMTCT interventions and undertake research on long-term benefits of interventions.

Key Issue(s):

- Low public information and knowledge about PMTCT and the
- role of VCT
- High levels of stigma and discrimination associated with
- HIV/AIDS as one of the major barrier for VCT uptake
- Limited capacity among health care providers on counseling and provision of friendly services.

Priority Audience(s):

- Pregnant Women
- Partners of Pregnant Women

Additional Key Audience(s):

- Women of Reproductive Age
- Health Care providers
- Relatives of pregnant women
- Ministry, parastatal organization and business projects

Communication Strategy:

- Media campaign on PMTCT

Key Messages: ·

- Importance of knowing your serostatus before becoming pregnant
- Facts about transmission of HIV from mother to baby in utero, at birth, and during breast feeding
- Information on services that proving counseling and testing for HIV
- Services for prevention of mother to baby transmission
- Information regarding access of health care services providing anti retroviral treatment
- Importance of opting in for voluntary counseling and testing so that one is able to access services that prevent transmission to your unborn babies.
- Information regarding access of health care services providing anti retroviral treatment

Objective(s):

- **Increase the proportion of children and youth, girls and women, men and the disabled who feel adequately empowered to protect themselves against HIV infection**

Expected Outcome:

- **Different sections of the population are competent to deal with the challenges of HIV and AIDS by delaying onset of sexual activities, reducing the number of sexual partners and / or adopting safer sex measures as well as increasing understanding of gender issues.**

Strategy 40: Increase the number of quality Adolescent Sexual and Reproductive Health information sources.

Strategy 41: Intensify and expand competent youth centres providing friendly STI and VCT services and other interventions in the communities for out of school youth.

Strategy 42: Promote and expand programmes against drugs and substance abuse, especially excessive alcohol consumption.

Strategy 43: Strengthen and expand comprehensive to HIV and AIDS. interventions for primary, secondary and tertiary education.

Strategy 44: Promote open discussion and awareness about gender and culture related traditions and sexual behaviour that increase vulnerability of women/girls to HIV and AIDS.

Strategy 45: Empower girls and women to negotiate safer sex by strengthening their knowledge about the nature and impact of HIV and AIDS and how best to have effective control so as to protect themselves.

Strategy 46: Initiate programmes with and by men to promote male responsible behaviour in sexual and family relations (reduce machismo, irresponsible parenthood, domestic violence)

Strategy 47: Initiate programme with and by disabled people to promote effective HIV and AIDS transmission amongst this group.

Key Issue(s):

- Lack of continuity of communication efforts.
- Some communication stigmatises intended population groups.

Priority Audience(s):

- Children & Youth
- Girls and Women
- Disabled persons

Additional Key Audience(s):

- VCT centre providers
- Health centre providers
- Pharmacists

Communication Approach (es):

- Peer education groups and resource centres
- Peer advocacy groups
- Entertainment education

Key Messages:

- Your rights and responsibilities in a time of HIV/AIDS

Objective(s):

- **Primary and Secondary Schools provide education and opportunities for young people to develop and maintain orientations, values, attitudes and activities which safeguard their sexual and reproductive health.**

Expected Outcome:

- **Increased number of schools with teachers who have been trained in life-skills based HIV /AIDS education and who taught it during the last academic year**

Strategy 48: Develop, test, and integrate curricula related to sexual health matters of young people at primary and secondary school level and train teachers.

Strategy 49: Train sufficient numbers of teachers to achieve national coverage.

Strategy 50: Assure support of parents and parents associations in dealing with reproductive and sexual health matters.

Strategy 51: Encourage pupils to develop their own projects and interventions (school clubs, theatre groups, competitions etc.).

Strategy 52: Promote peer-education and guardian-centred projects.

Key Issue(s):

- Lack of continuity of communication efforts.
- Some communication stigmatizes intended groups.

Priority Audience(s):

- Children & Youth
- Girls and Women

Additional Key Audience(s):

- VCT centre providers
- Health centre providers
- Pharmacists
- Coaches

Communication Approach (es):

- Peer education groups and resource centres
- Peer advocacy groups
- Entertainment education
- Sports-related education for men and women

Key Messages.

- Your rights and responsibilities in a time of HIV/AIDS

Objective(s):

- **Increase sexual behaviour change and care and support and impact mitigation activities for key population groups like Commercial Sex Workers, Men Who Have Sex with Men, Bar Maids, Prisoners, Policemen, Soldiers and Mobile Populations, Refugees, and intravenous drug users.**

Expected Outcome:

- **Key population groups have increased capacities and competence to ascertain their own risks of HIV transmission and undertake appropriate measures to safeguard their well-being.**

Strategy 53: Develop in a participatory manner and promote increased access to services and interventions (IEC, condom access, peer education, friendly VCT and STIs services, care and support, mitigation of impact) for the key population

Strategy 54: Support NGOs, CBOs and other agencies working with Key population groups and stimulate documentation and exchange (learning) among the actors.

Key Issue(s):

- Lack of continuity of communication efforts.
- Some communication stigmatises intended groups.

Priority Audience(s):

- Commercial Sex Workers
- Men Who Have Sex with Men
- Bar Maids
- Prisoners
- Policemen
- Soldiers
- Mobile Populations
- Miners
- Refugees
- intravenous drug users
- Street children

Additional Key Audience(s):

- VCT centre providers
- Health centre providers
- Pharmacists

Communication Approach(es):

- Peer education groups and resource centres
- Peer advocacy groups
- Entertainment education

Key Messages:

- Your rights and responsibilities in a time of HIV/AIDS

Objective(s):

- **Increase the proportion of public/private sector enterprises and informal sector operators developing and implementing workplace interventions against HIV and AIDS**

Expected Outcome:

- **The percentage of (large) enterprises / companies that have workplace policies and programmes have increased. The proportion of operators in the informal sector reached by HIV and AIDS prevention and control programmes.**

Strategy 55: Promote the introduction and maintenance of adequate workplace interventions in the public and private sector focused on the protection, care and support for employees; and mainstreaming of HIV and AIDS activities in the core business of the respective establishments.

Strategy 56: Develop and disseminate replicable models of interventions.

Strategy 57: Review and ensure a legal environment (Protection of workers rights, ILO recommendations) that is conducive for promoting and facilitating effective workplace interventions.

Strategy 58: Strengthen labour and employment policies and regulation to incorporate HIV and AIDS / STDs and to discourage misconducts.

Strategy 59: Develop outreach programmes to include families and communities of the workers and employees in the activities.

Strategy 60: Develop special HIV and AIDS prevention and control programmes designed to reach the operators in the informal sector.

Key Issue(s):

- Stigma and discrimination result in silence about HIV/AIDS issue at work.
- Lack of open discussion leads to lack of preparedness on part of employers and employees.

Priority Audience(s):

- Workers

Additional Key Audience(s):

- Employers
- Business groups
- Labour leaders

Communication Approach(es):

- Peer education groups and resource centres
- Peer advocacy groups
- Workplace policy development

Key Messages:

- Your rights and responsibilities in a time of HIV/AIDS

Objective(s):

- **Reduce the risk of blood borne, health care and non-healthcare settings -induced HIV transmission by invasive procedures.**

Expected Outcome:

- **The population in general and health workers in particular are better protected against HIV transmission when donating blood or undergoing medical procedures.**
- **Traditional practices containing increased risk of HIV transmission are diminished.**

Strategy 61: Develop a National Blood Transfusion System covering all regions and districts.

Strategy 62: Provide quality screening for HIV anti-bodies, hepatitis and syphilis for people donating blood.

Strategy 63: Make Post-exposure prophylaxis available to professional groups at risk.

Strategy 64: Improve the supply and distribution of laboratory supplies for HIV and AIDS blood screening.

Strategy 65: Strengthen and enforce national hospital waste management guidelines

Strategy 66: Intensify advocacy and sensitize health workers on issues related to HIV transmission risks through discharged instruments and waste and reinforce the proper use of sterilization guidelines.

Strategy 67: Provide appropriate information to the public and the practitioners on the transmission risks through traditional practices like skin piercing.

Key Issue(s):

- Low risk perceptions for HIV infection through contaminated instruments or hospital waste product among health care workers

Priority Audience(s):

- Health Workers
- Traditional practitioners

Additional Key Audience(s):

- Medical schools
- Trade groups

Communication Approach (es):

- Peer education groups and resource centres
- Peer advocacy groups
- Workplace policy development

Key Messages:

- Don't be seen as part of the problem. Be seen as part of the solution.
- Your rights and responsibilities in a time of HIV/AIDS

Focus Area 3 of 4: Improved Care, Treatment and Support for Zero AIDS related deaths.

Objective(s):

- **Increase the proportion of PLHIV having access to adequate community-based care and support**

Expected Outcome:

- **Percentage of Persons with HIV and AIDS having access to best available treatment and medical care increased.**
- **Percentage of people with advanced HIV infection receiving antiretroviral combination therapy increaseda.**

Strategy 68: Expand the availability and affordability of quality service for prophylaxis and treatment of opportunistic infections and AIDS conditions in the public and private sector.

Strategy 69: Strengthen the National TB Control programme and its linkage with the HIV and AIDS programme.

Strategy 70: Develop a National Policy for Access to Drug in the context of the on-going health sector reform containing clear stipulations on eligibility, priority of access, financial support, equity in the overall health service provisions etc.

Strategy 71: Include the private medical sector (Hospitals, practitioners, pharmacies) in all aspects of policies, guidelines and training related to treatment issues.

Strategy 72: Link Access to Drug programme to other programmes like PMTCT.

Strategy 73: Provide appropriate public information and transparency in regard to equitable access to drugs for AIDS patients and equity in relation to other conditions of ill health of the population.

Strategy 74: Establish strong and effective regulatory measures to safeguard the health of the people against abuse and illicit use of drugs.

Strategy 75: Develop financial safety nets (health insurance schemes, social security packages etc.) to prevent the financial ruin of families and individuals due to treatment costs.

Strategy 76: Include the traditional medical healers and their organizations in developing appropriate guidelines and training for treatment and care, including the promotion of constructive use of traditional/home remedies that have proven to have potential in the treatment of opportunistic infections.

Strategy 77: Promote the application of new research findings on the clinical management of AIDS patients.

Strategy 78: Collaborate with international and national institutions in the search for HIV vaccine.

Key Issue(s):

- High levels of public stigma and discrimination against PLHIV
- Training needs for health care workers and family care takers on proper provision of services to PLHIV at the hospital and at home respectively.
- Lack of public awareness on the importance of VCT to care and treatment
- Lack of public awareness of and knowledge about care and treatment plan for PLHIV and accessibility to related services
- Training of health care workers needed for provision of friendly services to PLHIV
- Training of care takers needed for PLHIV on the proper administration of ART

Priority Audience(s):

- PLHIV

Additional Key Audience(s):

- MOHSW workers

Communication Approach(es):

- Peer education groups and resource centres
- Peer advocacy groups
- Treatment Literacy approach

Key Messages:

- Don't be part of the problem. Be seen as part of the solution.
- Your rights and responsibilities in a time of HIV/AIDS

Objective(s):

- **Increase the proportion of PLHIV having access to adequate community-based care and support.**

Expected Outcome:

- **Appropriate and sustainable community approaches for caring and supporting persons living with HIV and AIDS and their families have been developed and are expanded in the country.**

Strategy 79: Develop guidelines on provision of Home / Community care and support

Strategy 80: Promote and expand community and home-based care programmes.

Strategy 81: Support NGOs/CBOs and Faith-based organisations in care and support projects.

Strategy 82: Strengthen referral systems for patients in need to ascertain continuum of care from home - community - hospital level.

Strategy 83: Increase advocacy and education in communities to make them receptive and responsive to the needs of PLHIV and their families.

Strategy 84: Promote greater involvement of PLHIV in planning and implementation of Home / Community care and Support.

Key Issue(s):

- Lack of treatment literacy
- Stigma and discrimination at the community level

Priority Audience(s):

- Faith Based Organizations
- Community Based Organizations

Additional Key Audience(s):

- Community leaders
- Business leaders

Communication Approach (es):

- Peer education groups and resource centres
- Peer advocacy groups
- Workplace policy development
- Treatment Literacy approach

Key Messages:

- We have a social responsibility to provide economic and social support.

- Everyone is part of the AIDS continuum of care
- Your rights and responsibilities in a time of HIV and AIDS.

Focus Area 4 of 4: Social and Economic Impact Mitigation

Objective(s):

- **To secure the basic livelihood of persons, families and communities that are hardest hit by the impact of the epidemic.**

Expected Outcome:

- **A social policy framework for assisting persons living with HIV and AIDS and their affected families and communities has been developed and programmes / projects are in place to secure the basic livelihood of those affected by the impact of the epidemic.**

Strategy 85: Study the quantitative and qualitative issues related to the basic livelihood conditions of the affected persons and communities.

Strategy 86: Develop a social and economic policy framework to address the needs of the affected persons and communities.

Strategy 87: Study the possibility of creating special health insurance and social security plans for PLHIV.

Strategy 88: Promote and expand programmes in the communities supporting PLHIV. with legal, psychosocial, economic and material assistance

Strategy 89: Promote and strengthen the protection of legal, employment, economic and social rights of PLHIV..

Strategy 90: Develop and institutionalize a framework/system for continued monitoring and assessment of the social and economic needs of persons, families and communities hardest hit by the epidemic.

Strategy 91: Provide support to NGOs, CBOs, Faith-based organizations and other agencies providing economic, social and spiritual support to affected persons and communities.

Key Issue(s):

- Continuing stigma and discrimination against persons affected by HIV and AIDS prevents identification of needs and equitable direction of funding.

Priority Audience(s):

- Legislators and policy makers
- People and families affected by HIV and AIDS
- Insurance institutions (private and public)

Additional Key Audience(s):

- Department of Labour
- Business community

Communication Approach (es):

- Peer advocacy through accountants, human resource specialists, and economists.
- Peer education and counseling through FBOs, CBOs

Key Messages:

- We have a social responsibility to provide economic and social support.

Objective(s): **Increase the proportion of AIDS orphans having access to adequate integrated, community-based support.**

Expected Outcome:

- AIDS related and other orphans have developed their capacities to lead a productive life and are guided by social policy measures.

Strategy 92: Study the extent of the issue under different scenarios.

Strategy 93: Develop policy guidelines and co-ordination of interventions for orphans.

Strategy 94: Strengthen and expand integrated and innovative programmes for orphans especially at the district and community level (education, health care, shelter, psychosocial counseling, life skills training, etc).

Strategy 95: Support NGOs, CBOs and Faith-based organizations in developing and sustaining support activities wherever possible in close relation with existing traditional family and community systems.

Strategy 96: Address stigma and discrimination against HIV and AIDS orphans.

Key Issue(s):

- Low levels of awareness and knowledge about HIV and AIDS among OVC/MVCs
- Need for continuing public advocacy for support of OVC/MVCs
- Need for advocacy with policy makers for support of OVC/MVOs and their care takers

Priority Audience(s):

- Orphans
- Tribal representatives from which orphans come
- Business service groups (such as Rotary International)
- Faith-Based Organizations

Additional Key Audience(s):

- International adoption agencies
- International companies
- Major employers (such as mining sector)

Communication Approach (es):

- Orphan peer educators
- Outreach to street children
- Branded safe haven spots for orphans
- Investment briefings for employers facing labour shortages

Key Messages:

- Children are our future.
- Orphans are everyones sons and daughters.
- How would you want your child treated

APPENDIX 1: TARGET AUDIENCE, KEY ISSUE AND CHANNELS OF COMMUNICATION

TARGETED AUDIENCE	KEY ISSUES	DESIRED BEHAVIOR / ATTITUDE CHANGE	INTERVENTION STRATEGIES	CHANNELS OF COMMUNICATION
Youth in general **(10-29 years)**	HIV and AIDS Awareness. Multiple concurrent partnerships. Incorrect and Inconsistent condom use. Alcohol Abuse. Injection Drug Use. Cross generational Sexual relationships. Sexually transmitted illnesses. Male circumcision. Gender based violence. HIV testing and Counseling	Delayed sexual activities Increased partner referral Increased condom use Reduction of sexual partners Increased non-penetrative sex Improved knowledge on HIV/ AIDS Reduced alcohol/drug use Increased use of life skills Increased self perception of risk	Peer education Entertainment education Life skills promotion Involvement in planning and implementation Positive mentoring Active adult- youth partnership Use of multi-media strategy Drug prevention education Straight Talk Magazine Post Test Clubs Community Service/Outreach Youth friendly services Celebrities IEC materials Promotion of VCT Involvement in planning and implementation Group discussion Youth friendly services Training on positive deviance	**Interpersonal;** Peer education, life skills promotion, Involvement in planning and implementation, Mentoring, partnerships, Community gatherings, social networks. **Media: Small, Print, utility, Visual and Audio-Visual** Peer education, life skills promotion, involvement in planning and implementation, mentoring programs, Active adult-youths partnerships, Multimedia strategies, Straight talk media programs, Post test Clubs, Outreach youth friendly service, Celebrities involvement, IEC materials, Group discussions,

Youth in school (10-18 years)	HIV and AIDS Awareness. Incorrect and Inconsistent condom use. Cross generational sexual relationships. Sexually transmitted illnesses. Male circumcision. HIV testing and Counseling	Delayed sexual activities Increased non penetrative sex Reduced alcohol/drug use Increased condom use Increased self perception of risk Increased sense of self efficacy Reduced number of sexual partners Increased use of life skills	Peer education Entertainment education Life skills promotion Involvement in planning and implementation Positive mentoring Formation of Radio Listeners Clubs Post Test Clubs Community service/outreach Formation of Radio Listeners Clubs Active adult- youth partnership Training in positive deviance Group discussion School Clubs/associations Use of multi-media strategy Drug prevention education Youth friendly services Straight Talk Magazine Celebrities IEC materials	**Interpersonal;** peer education, life skills promotion, Involvement in planning and implementation, Mentoring, partnerships, Community gatherings, social networks. **Media: Small, Print, utility, Visual and Audio-Visual** Peer education, lifeskills promotion, involvement in planning and implementation, mentoring programs, Active adult-youths partnerships, Multimedia strategies, Straight talk media programs, Post test Clubs, Outreach youth friendly service, Celebrities involvement, IEC materials, Group discussions,

Youth in colleges/ university (18-29 years)	HIV and AIDS Awareness. Multiple concurrent partnerships. Incorrect and Inconsistent condom use. Alcohol Abuse. Injection Drug Use. Cross generational Sexual relationships. Sexually transmitted illnesses. Male circumcision. Gender based violence. HIV testing and Counseling	Increased non penetrative sex Reduced alcohol/drug use Increased condom use Increased self perception of risk Increased sense of self efficacy Reduced number of sexual partners Increased use of life skills	Peer education Focus group discussion Outreach services Post Test Clubs Community outreach/services Magazine Newspaper Launch Social marketing Youth friendly services Promotion of VCT Entertainment education Involvement in planning and implementation Use of positive celebrities Television IEC materials	**Interpersonal;** Peer education, life skills promotion, Involvement in planning and implementation, Mentoring, partnerships. Community gatherings, Small groups gatherings and discussions, school debates, essay competitions, social networks. **Media: Small, Print, utility, Visual and Audio-Visual** Peer education, lifeskills promotion, involvement in planning and implementation, mentoring programs, Active adult-youths partnerships, Multimedia strategies, Straight talk media programs, Pre test clubs, Post test Clubs, Outreach youth friendly service, Celebrities involvement, IEC materials, Group discussions, documentaries, magazines,

Youth out of school **(10-29 years)**	HIV and AIDS Awareness. Multiple concurrent partnerships. Incorrect and Inconsistent condom use. Alcohol Abuse. Injection Drug Use. Cross generational Sexual relationships. Trans-generational Sexual relationships Sexually transmitted illnesses. Male circumcision. Gender based violence. HIV testing and Counseling	Delayed sexual activities Increased non penetrative sex Reduced alcohol/drug use Increased condom use Reduced number of sexual partners Increased use of life skills	Peer education Post test Clubs Community media Launches Radio IEC materials Social marketing Community service/outreach Group discussions Formation of Radio Listeners Clubs Straight Talk Magazine IEC materials Entertainment education Life skills promotion Involvement in planning and implementation Positive mentoring Active adult- youth partnership Youth friendly services Use of multi-media strategy Drug prevention education Youth friendly services	**Interpersonal;** Peer education, life skills promotion, Involvement in planning and implementation, Mentoring, partnerships. Community gatherings, Small groups gatherings and discussions, school debates, essay competitions, community life skills meetings, social networks. **Media: Small, Print, utility, Visual and Audio-Visual** Peer education, lifeskills promotion, involvement in planning and implementation, mentoring programs, Active adult-youths partnerships, Multimedia strategies, Straight talk media programs, Pre test clubs, Post test Clubs, Outreach youth friendly service, Celebrities involvement, IEC materials, Group discussions, documentaries, magazines,

Adolescent boys (10-18 years)	HIV and AIDS Awareness. Incorrect and Inconsistent condom use. Injection Drug Use. Cross generational Sexual relationships. Sexually transmitted illnesses. Male circumcision. HIV testing and Counseling	Delayed sexual activities Increased non penetrative sex Reduced alcohol/drug use Increased condom use Reduced number of sexual partners Increased use of life skills	Peer education Post test clubs Community media Radio IEC materials VCT promotion Formation of Radio Listeners Clubs Youth Friendly Services Entertainment education Life skills promotion Involvement in planning and implementation Positive mentoring Active adult- youth partnership Life Skills Training Use of multi-media strategy Drug prevention education Youth friendly services	**Interpersonal;** Peer education, Involvement in planning and implementation, Mentoring, partnerships. Small groups gatherings and discussions within communities, school debates, essay competitions, Family meetings, social networks. **Media: Small, Print, utility, Visual and Audio-Visual** Peer education, lifeskills promotion, involvement in planning and implementation, mentoring programs, Active adolescents-youths partnerships, Multimedia strategies, Straight talk media programs, Celebrities involvement, Special adolescents directed media programs, IEC materials, Group discussions, documentaries, magazines, Drug prevention education, youth friendly services.

Adolescent girls (10-18 years)	HIV and AIDS Awareness. Incorrect and Inconsistent condom use. Cross generational Sexual relationships. Sexually transmitted illnesses. Gender based Violence HIV testing and Counseling	Delayed sexual activities Increased non penetrative sex Reduced alcohol/drug use Increased condom use Reduced number of sexual partners Increased care and support Improved parent-child communication Improved mentoring Increased use of life skills	Peer education Crisis counseling Post Test Clubs Radio IEC materials VCT promotion Parent-child communication Training on Positive deviance Straight Talk Magazine Entertainment education Life skills promotion Youth friendly services Involvement in planning and implementation Positive Mentoring Training on Life skills Positive mentoring Active adult- youth partnership Use of multi-media strategy Drug prevention education Youth friendly services	**Interpersonal;** Peer education, Crisis counseling, Trainings on positive deviance, Involvement in planning and implementation, Mentoring, partnerships. Small groups gatherings and discussions within communities, school debates, essay competitions, Family meetings, social networks. **Media: Small, Print, utility, Visual and Audio-Visual** Peer education, lifeskills promotion, involvement in planning and implementation, mentoring programs, Active adolescents-youths partnerships, Multimedia strategies, Straight talk media programs, Celebrities involvement, Special adolescents directed media programs, IEC materials, Group discussions, documentaries, magazines, Drug prevention education, youth friendly services.

Key Population: Commercial Sex workers (15-45 years)	HIV and AIDS Awareness. Multiple concurrent partnerships. Incorrect and Inconsistent condom use. Alcohol Abuse. Injection Drug Use. Cross generational Sexual relationships. Sexually transmitted illnesses. Gender based violence. HIV testing and Counseling Increased risk- needle exchange and anal sex	Improved health care seeking behavior Partner notification and referral Improved condom use negotiation skills Increased self-perception of risk Increased sense of self efficacy Reduced drug/alcohol consumption Reduced sigma and discrimination Knowing HIV status Adherence to medication Increased health seeking behavior	Peer education VCT promotion IEC materials Radio Qualitative research on dynamics of commercial sex in the region Interpersonal communication Promotion of VCT	**Interpersonal;** Peer education, life skills promotion, Involvement in planning and implementation, Mentoring, partnerships. Community gatherings, Small groups gatherings and discussions, community life skills meetings, social networks, Legal consultations, Trainings on positive deviance, VCT and CTC interventions, Religious gatherings **Media; Small, Print, utility, Visual and Audio-Visual** Radio plays, Television plays, Trainings on positive deviance through media, Stories, Religious interventions, Social media, lifeskills promotion, involvement in planning and implementation, mentoring programs, Multimedia strategies, Straight talk media programs, Pre test clubs, Post test Clubs, Outreach youth friendly service, Celebrities involvement, IEC materials, Group discussions, documentaries.

Key population: People who Inject Drugs (PWID)	HIV and AIDS Awareness. Multiple concurrent partnerships. Incorrect and Inconsistent condom use. Alcohol Abuse. Injection Drug Abuse. Cross generational Sexual relationships. Sexually transmitted illnesses. Gender based violence. HIV testing and Counseling Increased risk -Needle exchange risk	Reduced alcohol/drug use Increased sense of self efficacy Increased health care seeking habits Improved safe sex practices Increased self perception of risk Reduced number of sexual partners Increased use of life skills Knowing one's HIV status Improved legal protection Increased adherence to medication Increased health seeking behavior	Peer Education Radio Mobilization VCT promotion IEC materials Research on the influence of alcohol/ drug on HIV infection	**Interpersonal;** Peer education, life skills promotion, Involvement in planning and implementation, Mentoring, partnerships. Community gatherings, Small groups gatherings and discussions, community life skills meetings, social networks, Legal consultations, Trainings on positive deviance, VCT and CTC interventions, Religious gatherings **Media; Small, Print, utility, Visual and Audio-Visual** Radio plays, Television plays, Trainings on positive deviance through media, Stories, Religious interventions, Social media, lifeskills promotion, involvement in planning and implementation, mentoring programs, Multimedia strategies, Straight talk media programs, Pre test clubs, Post test Clubs, Outreach friendly service, Celebrities involvement, IEC materials, Group discussions, documentaries.

Key Population (MSM)	HIV and AIDS Awareness. Undesirable traditional and cultural practices. Cross generational Sexual relationships. Sexually transmitted illnesses. Gender based Violence HIV testing and Counseling Increased risk-anal sex	Positive deviance Reduced sexual partners Knowing one's HIV status Legal protection Knowing one`s legal rights. Increased self perception of risk Increased sense of self efficacy through support Adherence to medication Improved health care seeking behavior Increased health seeking behavior	Legal rights education VCT Promotion Peer education Radio IEC materials Mobilization Advocacy Interpersonal communication Training on positive deviance	Interpersonal: Legal consultations, Peer education, Trainings on positive deviance, VCT and CTC interventions, community gatherings, Religious gatherings **Media; Small, Print, utility, Visual and Audio-Visual** Radio plays, IEC materials, Television plays, Trainings on positive deviance through media, Stories, Religious interventions, Social media,

Mobile population/ workers **Eg Fishermen**	HIV and AIDS Awareness. Multiple concurrent partnerships. Incorrect and Inconsistent condom use. Alcohol Abuse Injecting drug use Undesirable traditional beliefs Sexually transmitted illnesses. Gender based violence. HIV testing and Counseling	Consistent condom use Increased self perception of risk Increased sense of self efficacy Improved health care seeking habits Knowing one's HIV status Increased health seeking behavior	Peer education Radio IEC materials Interpersonal communication Mobilization Promotion of VCT Post test clubs Community media Community events	**Interpersonal;** Peer education, Mobile VCT interventions, life skills promotion, political interventions, Involvement in planning and implementation, Mentoring, partnerships. Community gatherings, Small groups gatherings and discussions, community life skills meetings, social networks, Trainings on positive deviance, VCT and CTC interventions, Religious interventions. **Media; Small, Print, utility, Visual and Audio-Visual** Radio plays, Television plays, drama, community plays, Trainings on positive deviance through media, Stories, Religious interventions, Social media, lifeskills promotion, involvement in planning and implementation, mentoring programs, Multimedia strategies, Straight talk media programs, Pre test clubs, Post test Clubs, Outreach youth friendly service, Celebrities involvement, IEC materials, Group discussions, documentaries, political interventions.

Key population: Prisoners	HIV and AIDS Awareness. Anal sex Sexually transmitted illnesses. HIV testing and Counseling	Awareness of HIV risks Increased self perception of risk Increased sense of self efficacy Improved health knowledge seeking habits Knowing one's HIV status	Peer education Radio IEC materials Interpersonal communication Mobilization Promotion of VCT Pretest clubs Post test clubs Religious events	**Interpersonal;** Peer education, Mobile VCT interventions, political interventions, family interventions, community interventions, Small groups gatherings and discussions, prison community life skills meetings, Trainings on positive deviance, VCT and CTC interventions, Religious interventions. **Media; Small, Print, utility, Visual and Audio-Visual** Radio plays, Television plays, drama, Trainings on positive deviance through media, Stories, Religious interventions, Straight talk media programs, Pre test clubs, Post test Clubs, IEC materials, Group discussions, documentaries, political interventions.

People Living with HIV/AIDS	HIV and AIDS Awareness. Multiple concurrent partnerships. Incorrect and Inconsistent condom use. Alcohol Abuse. Injection Drug Use. Sexually transmitted illnesses. Gender based violence.	Improved care and support Reduced self stigma Increased self perception of risk Increased sense of self efficacy through improved care and support Adherence to medication Reduced number of sexual partners Condom use negotiation skills Improved health care-seeking behavior	Peer education Promotion of VCT Radio IEC materials Community media Mobilization Advocacy Interpersonal communication Human rights education	**Interpersonal;** Peer education, life skills promotion, Involvement in planning and implementation, partnerships. Community gatherings, Small groups gatherings and discussions, school debates, post test groups, community life skills meetings, social networks, Legal consultations, Trainings on positive deviance, VCT and CTC interventions, Religious gatherings **Media; Small, Print, utility, Visual and Audio-Visual** Radio plays, Television plays, Trainings on positive deviance through media, Stories, Religious interventions, Social media, lifeskills promotion, involvement in planning and implementation, mentoring programs, Active adult-youths partnerships, Multimedia strategies, Straight talk media programs, Pre test clubs, Post test Clubs, Outreach youth friendly service, Celebrities involvement, IEC materials, Group discussions, documentaries.

Pregnant women and their partners (couples)	HIV and AIDS Awareness. Incorrect and Inconsistent condom use. Sexually transmitted illnesses. Gender based violence. Prevention of mother to child transmission of HIV (PMTCT) HIV Testing and counseling.	Increased self perception of risk Increased safer sex practices Increased health seeking behavior	Radio Clinics IEC materials PMTCT promotion Interpersonal Communication	**Interpersonal;** Peer education, life skills promotion, Community gatherings, Small groups gatherings and discussions, post test groups, community life skills meetings, social networks, Legal consultations, Trainings on positive deviance, VCT and CTC interventions, Antenatal clinic teachings, Antenatal clinic visits. **Media; Small, Print, utility, Visual and Audio-Visual** Radio plays, Television plays, Trainings on PMTCT through media, Social media, Multimedia strategies, Straight talk media programs, Pre test clubs, Post test Clubs, Antenatal attendees groups, Celebrities involvement with focus on PMTCT, IEC materials, Group discussions, documentaries.

Influence Leaders e.g Politicians (Members of parliament and Political Party) and religious leaders	HIV and AIDS Awareness. Undesirable traditional and cultural practices. Cross generational Sexual relationships. Sexually transmitted illnesses. Gender based Violence HIV testing and Counseling HIV resources constrains	Positive deviance Reduced sexual partners Knowing one's HIV status Legal protection Knowing one`s legal rights. Increased self perception of risk Increased sense of self efficacy through support Adherence to medication Improved health care seeking behavior Increased HIV funding and equitable allocation	Legal rights education VCT Promotion Peer education Radio IEC materials Mobilization Advocacy Interpersonal communication Training on positive deviance	Interpersonal: Legal consultations, Peer education, Trainings on positive deviance, VCT and CTC interventions, community gatherings, Religious gatherings **Media; Small, Print, utility, Visual and Audio-Visual** Radio plays, IEC materials, Television plays, Trainings on positive deviance through media, Stories, Religious interventions, Social media,

General Population	HIV and AIDS Awareness. Multiple concurrent partnerships. Incorrect and Inconsistent condom use. Alcohol Abuse. Injection Drug Use. Cross generational Sexual relationships. Sexually transmitted illnesses. Gender based violence. HIV testing and Counseling	Improved sense of self efficacy through support Reduced number of sexual partners Improved health care seeking habits Increased positive deviance Increased use of life skills	Peer Education Radio Mobilization Interpersonal Communication Promotion of CVT Promotion of PMTCT Training on Life Skills IEC materials	**Interpersonal;** Peer education, life skills promotion, Involvement in planning and implementation, Mentoring, partnerships. Community gatherings, Small groups gatherings and discussions, community life skills meetings, social networks, Legal consultations, Trainings on positive deviance, VCT and CTC interventions, Religious gatherings **Media; Small, Print, utility, Visual and Audio-Visual** Radio plays, Television plays, Trainings on positive deviance through media, Stories, Religious interventions, Social media, lifeskills promotion, involvement in planning and implementation, mentoring programs, Multimedia strategies, Straight talk media programs, Pre test clubs, Post test Clubs, Outreach friendly service, Celebrities involvement, IEC materials, Group discussions, documentaries.

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TANZANIA COMMISSION FOR AIDS (TACAIDS)
Sokoine Drive / Luthuli Street
P.O Box 76987, Dar es Salaam, Tanzania
Tel: +255 22 2122651/2125127
Fax: +255 22 2122427
Email: ec@tacaids.go.tz
www.tacaids.go.tz