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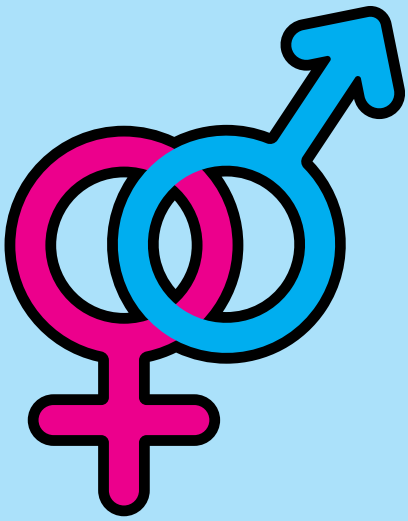

GENDER OPERATIONAL PLAN FOR HIV RESPONSE IN TANZANIA MAINLAND

2016 – 2018

Dar es Salaam, Tanzania
June 2016

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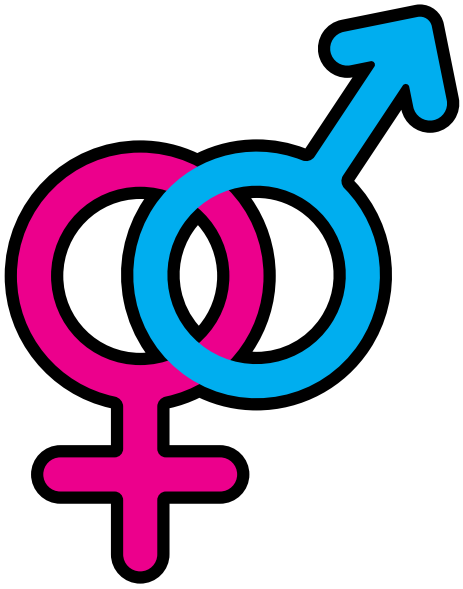

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Gender Operational Plan for HIV response in Tanzania Mainland

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Foreword

This Gender Operational Plan (GOP) 2016-2018 is a revised version of the 2010-2012 GOP. Its Priorities, approaches and principles are aligned to the Third National Multisectoral Framework for (NMSF III, 2013/14-2017/18) and Third Health Sector Strategic Plan (HSHSP III, 2013-2017) National HIV and AIDS Response. The Plan has also been aligned to other key national, regional and global instruments on HIV, gender and human rights.

The main objective of the GOP 2016-2018 is to guide HIV stakeholders in Tanzania mainland at all levels in the provision of strategic interventions on HIV with focus on gender issues. The purpose is to ensure gender perspectives permeate all national HIV interventions to address the gender disparities arising out of gender inequality. In view of this, the Operational Plan will be used as a tool to guide coordination and supervision of gender sensitive HIV interventions in all sectors at all levels in the country by integrating and implementing gender sensitive and human rights based approaches.

Evidence shows that women and girls are more vulnerable to HIV infection compared to their male counterparts due to their physiology and existing gender norms around masculinity and unequal power relations, which put them at high risk. According to the results of the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS, 2011-12), the overall HIV prevalence has declined to 5.1% of people aged 15-49 from 5.7% in 2007-08. However, despite the national decline of prevalence among males from 6.3% to 3.9%, prevalence among females is still high at 6%.

The high prevalence of HIV among women and girls is fuelled by unequal gender relations; gender based violence (GBV), stigma and discrimination. A lot of evidence exists that shows the link between GBV and HIV infection. GBV is a risk factor for HIV acquisition, and a consequence of being HIV infected. Some women and girls have become infected with HIV because of sexual violence. Women living with HIV are particularly vulnerable to violence especially after disclosing their HIV status. GBV and especially Intimate partner violence (IPV) is proven to be a cause and a consequence of HIV. A study in South Africa has found that young women who experienced IPV were 50% more likely to have acquired HIV than women who had not experienced violence (Jewkes et al, 2010). It was also found that women facing IPV have lower Anti-Retroviral Therapy (ART) use and worse viral load suppression as well as more mental health issues (Janet et al, 2015).

Gender norms and roles around masculinity and sexuality also put men and boys at the risk of HIV infection because of society expectations. Women are more impacted by HIV due to unequal gender relations and gender roles; and their limited or lack of decision making power, including not being able to negotiate for condom use and safe sex, resulting in the violation of their human rights and gender based violence (GBV). In this regard, the GOP is a significant instrument in addressing gender disparities in the national response to HIV. And it is our hope that all the stakeholders will use this GOP as a tool to mainstream gender perspectives in their HIV programmes to eliminate the pandemic. The GOP contains activities that are to be implemented by HIV stakeholders in Tanzania Mainland while taking into consideration all strategic gender issues, constraints and challenges that have the potential to increase the risk and vulnerability of women and men, girls and boys to HIV infection. It is our strong belief that the GOP will enable stakeholders to integrate gender perspectives in their HIV interventions to enable positive change in people's perception and equal access to HIV services.

Thank you.

Dr. Hamis Mwinyimvua
Permanent Secretary
Prime Minister's Office

Acknowledgement

On behalf of TACAIDS and myself, I would like to extend my appreciation to several individuals and institutions that contributed generously to the review and updating of the 2010-2012 GOP that led to the development of the GOP 2016-2018.

First, our gratitude goes to the United Nations Population Fund (UNFPA) Tanzania and The Global Fund to Fight AIDS, Tuberculosis and Malaria for their generous financial support, which made possible the review of the GOP 2010-2012 and coming up with the GOP 2016-2018. We are grateful to both UNAIDS and UN Women for their insightful technical support which have been a contributing factor for us to manage developing this document to its final stage.

We also thank all the Government Ministries, Departments, Agencies (MDAs), Local Government Authorities (LGAs), Civil Society Organizations (CSOs), Community Based Organizations (CBOs), Faith Based Organizations, Development Partners (DPs) and various Networks of PLHIV for their constructive comments and inputs. We recognize the contribution of individual representatives from various institutions and organizations. We have listed their names on appendix A.

Special acknowledgement goes to the Consultant, Mrs. Zuki Njalai Mihyo for reviewing and updating the 2010 -2012 GOP that led to production of GOP 2016- 2018. She worked very closely with the following TACAIDS' staff, Mr Jumanne Issango Director of Advocacy and Information, Mr. Jacob Kayombo the Gender Coordinator for National HIV Response, Judith Luande, Gender Officer and Mr. Elisha Mngale, Librarian and Documentarist.

Thank you.

Dr. Fatma Mrisho
Executive Director
Tanzania Commission for AIDS (TACAIDS)

Abbreviations

ANC	Antenatal Clinic
ART	Anti-Retroviral Therapy
ATE	Association of Tanzania Employee
BCC	Behaviour Change Communication
CCM	Country Coordinating Mechanism
CEDAW	Convention for Elimination of all forms of Discrimination against Women
CHACs	Council HIV and AIDS Coordinators
CMACs	Council Multisectoral AIDS Committees
CSOs	Civil Society Organizations
CT	Counselling and Testing
CTC	Counselling and Testing Centre
DBS	Dried Blood Sample
DGBV-FP	District GBV Focal persons on GBV
DMO	District Medical Officer
DPs	Development Partner's
DRC	Democratic Republic of Congo
DSW	District Social Workers
EAC	East Africa Community
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child Transmission
FBOs	Faith Based Organization
FGM	Female Genital Mutilation
FSWs	Female Sex Workers
GBV	Gender Based Violence
GOP	Gender Operational Plan
GOT	Government of Tanzania
GRB	Gender Responsive Budgeting
HAART	Highly Active Antiretroviral Therapy
HCM	Health Communication and Marketing
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSHSP	Health Sector HIV and AIDS Strategic Plan
HTC	HIV Testing and Counselling
ICCPR	International Covenant on Civil and Population Rights
ICE	Information Education and Communication
ICESCR	International Covenant on Economic, the Social and Culture Rights
ICPD	International Conference on Population and Development
ILO	International Labour Organization
IPV	Intimate Partner Violence
LGAs	Local Government Authorities
MCDGC	Ministry of Community Development, Gender and Children

MCH	Maternal and Child Health
MCP	Multi Concurrent Partner's
MDAs	Ministry Department and Agencies
MOEST	Ministry of Education Science and Technology
MOHA	Ministry of Home Affairs
MOHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Program
NMSF	National Multisectoral Strategic Frameworks
NSGRP	National Strategy for Growth and Reduction of Poverty
OMVC	Orphans and Most Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV and AIDS
PHDP	Positive Health Dignity and Prevention
PMTCT	Prevention of Mother to Child Transmission
PWID/PWUD	People who Inject Drugs/People who use Drugs
RCH	Reproductive Child Health
SMG	Social Monitoring Group
SOSPA	Sexual Offences Special Prevention Act
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TNBTS	Tanzania National Blood Transfusion Service
TOMSHA	Tanzania Output Monitoring System for HIV and AIDS
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nation General Assembly Special Session
URT	United Republic of Tanzania
VAC	Violence Against Children
VCT	Voluntary Counselling and Test
VMACs	Village Multisectoral AIDS Committees
VMMC	Voluntary Medical Male Circumcision
WLHIV	Women Living with HIV
WMACs	Ward Multisectoral AIDS Committees
WWID	Women who Inject Drugs
WWUD	Women who Use Drugs

Definition of Key Words Used in Operational Plan

Comprehensive HIV Prevention, Treatment, Care and Support includes tailored HIV strategies, including clinical care, adequate nutrition, psychological support, social and economic daily living support, involvement of people living with HIV and their families; respect for human rights and protective legal provisions and access to justice. HIV care and support require a comprehensive set of services including psychosocial, physical, social economic, nutritional and legal care and support, which are crucial to the wellbeing and survival of PLHIV and their care-givers, and general the population OVCs. Care and support services are needed from point of HIV diagnosis regardless of the ability to access ART.

Comprehensive Sexuality Education is an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality. The term comprehensive indicates that this approach to sexuality education encompasses the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality.

Discordant Couples are those where one partner is HIV-infected and the other is not, where a couple is defined as two persons in an ongoing sexual relationship and each of these persons is referred to as a 'partner' in the relationship.

Empowerment is an action taken by people to overcome obstacles of structural inequality that have put them in a disadvantaged position. Social and economic empowerment is a goal and a process aimed at mobilizing people to respond to discrimination and marginalization, to achieve equality of welfare and equal access to resources, services and decision-making.

Gender Analysis is a systematic way of looking at the different impacts of development, policies, programs and legislation on women and men that entails, first and foremost, collecting sex-disaggregated data and gender-sensitive information about the population concerned. Gender analysis can also include the examination of the multiple ways in which women and men, as social actors, engage in strategies to transform existing roles, relationships, and processes in their own interest and in the interest of others

Gender Discrimination is any distinction, exclusion to restriction women, men, girls and boys made on the basis of sex thereby hindering the recognition and enjoyment of their human rights and fundamental freedoms in the political, economic, social, cultural, and civil or any other field.

Gender Equality is the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles or prejudices. Gender equality means that the different behaviors, aspirations and needs of women and men are considered, valued and favored equally. It does not mean that women and men have to become the same, but that their rights, responsibilities and opportunities will not depend on whether they are born male or female.

Gender Equity means fairness of treatment for women and men, according to their respective needs. This may include equal treatment or treatment that is different but considered equivalent in terms of rights, benefits, obligations and opportunities. In the development context, a gender equity goal often requires built-in measures to compensate for the historical and social disadvantages of women.

Gender is a social and cultural construct, which distinguishes differences in the attributes of men and women, girls and boys, and accordingly refers to the roles and responsibilities of men and women. The definition and expectations of what it means to be a man or a woman, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, and age. Transgender individuals, whether they identify as men or women, are subject to the same set of expectations and sanctions

Gender Relations are the social relations between men and women that are based on the position they occupy in society and roles they perform in society, which can change. Gender relations refer to the social attributes and opportunities associated with being male and female and their relationships, most of which are based on inequalities in responsibilities and activities undertaken, as well as their access to, and control over resources, services and decision-making.

Gender Roles are roles, tasks, expectations and responsibilities of women and men, which have been defined and assigned or allocated to them by the society. Gender roles are not necessarily determined by biological make up and most of them can change with time and according to the situation Gender relations also include opportunities that women and men have values and cultural norms, beliefs and prejudices imposed on them, which sometimes limit women's mobility and full participation in economic and political activities.

Gender-Based Violence (GBV) is violence that establishes, maintains or attempts to reassert unequal power relations based on gender. The term was first defined to describe the gendered nature of men's violence against women and is often used interchangeably with the concept of violence against women (VAW). The definition has evolved to include violence perpetrated against some boys, men and transgender persons because they don't conform to or challenge prevailing gender norms and expectations or heterosexual norms (WHO). GBV may be physical, sexual, psychological and economic violence. GBV can be in the form of intimate partner violence (IPV), rape, sexual assault or harassment by a partner, stranger, acquaintance or family member at home, work or within the community.

Gender-Blindness is the failure to acknowledge the different roles, needs and interests of women and men, girls and boys in planning, programming/interventions, thereby reinforcing existing gender inequalities and social norms that reinforce gender inequality. For example the lack of disaggregated data or failure to acknowledge that programmes and policies have different effects/impacts on women and girls, men and boys.

Gender-Sensitiveness or Gender-Responsiveness recognizes the distinct roles and contribution of different people based on their gender differences and takes these into account to ensure women and girls, men and boys equitably benefit from the interventions

Gender-Transformative AIDS Response seeks not only to address the gender-specific aspects of HIV but also to change existing structures, institutions, and gender relations into ones based on gender equality. Policies and programs that seek to transform gender relations to promote equality and achieve program objectives. This approach attempts to promote gender equality by: 1) fostering critical examination of inequalities and gender roles, norms and dynamics, 2) recognizing and strengthening positive norms that support equality and an enabling environment, 3) promoting the relative position of women, girls and marginalized groups, and transforming the underlying social structures, policies and broadly held social norms that perpetuate gender inequalities.

HIV Testing, Counselling (HTC) in Reproductive and Child Health (RCH) settings refer to a confidential dialogue between a client and a health care worker (HCW) aimed at enabling the client to make an informed personal decision about HIV testing in order to know their serostatus. HTC is the gateway to HIV care and treatment including PMTCT interventions and a fundamental part of good clinical management. HTC should be accessible to all women of childbearing age and their partners.

Key Populations are those populations that have significantly higher levels of risk of acquiring and transmitting HIV, and those with higher rates of mortality and/or morbidity within a defined epidemiological context. Key populations often have significantly lower access to or uptake of relevant services than the rest of the population.

Multi-sectoral means inclusion of all sectors in the national HIV response (government ministries, department and agencies (MDAs); CSOs, Private Sector, FBOs, DPs, multilateral organizations for health, legal, protection, psychosocial and other services including economic empowerment sectors/microfinance so as create a multi-sectoral synergy to promote human rights for all, equitable gender norms to address GBV, VAC and harmful traditional practices in line with the NMSF III.

Patriarchy is as a system of male domination and female subordination. It has gender and power hierarchy where people are organized into different levels of importance from the highest to lowest, which tend to discriminate women and girls and benefit men and boys. These relations are also in several gendered practices including in the division of labour, economic resources and basic services between men and women.

Post-exposure Prophylaxis (PEP) is the immediate provision of medication following an exposure to potentially infected blood or other body fluids in order to minimize the risk of acquiring HIV infection.

Strategic Gender Needs (SGN) and Interests are related to the status of men and women in society in terms of access to resources and services, employment and income, inheritance, mobility, decision-making, and political/social participation – all of which are related to issues of control and power of women and men in relation to each other involving e.g. decision-making power or control over resources. Strategic gender needs are related to changing the situation of marginalised people, especially women and girls to reach social equality. These include leadership and control over resources. Addressing SGN has the potential to transform gender inequality, and the roles of men and women to achieve equality in access to resources, services and decision making.

Practical Gender Needs are those related to the day to day practical basic needs aimed at satisfying the basic material needs of men and women, boys and girls for their day to day survival. These include food, water, clothing and shelter. These needs relate to responsibilities and tasks of women or men that are associated with their traditional gender roles. Responding to practical needs can improve quality of life but does not *challenge the gender divisions or men's and women's position in society.*

Sex refers to biologically determined differences which define humans as female or male. These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics tend to differentiate humans as males and females.

Sexual and Reproductive Health Programmes and Policies include services for family planning; infertility services; maternal and new-born health services; prevention of unsafe abortion and post-abortion care; prevention of mother-to-child transmission of HIV; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer, and other gynecological morbidities; promotion of sexual health, including sexuality counselling; and prevention and management of gender-based violence.

Executive Summary

The overall objective of the GOP 2016-2018 is to provide guidance to all HIV stakeholders to mainstream gender perspectives in their HIV interventions to support the national HIV response. Integrating gender issues in the national response is essential to the reduction of vulnerability and risk of HIV infection. It is within this context that the GOP 2016- 2018 addresses issues of gender inequalities including gender-based violence, stigma and discrimination in order to protect the rights of all peoples , women and men, boys and girls to access services for HIV prevention, treatment, care and support.

This GOP is aligned to the Third National Multi-Sectoral Strategic Framework (NMSF III) for HIV and AIDS (2013/14 – 2017/18) and the National Third Health Sector Strategic Plan (HSHSP III) 2013-2017, whose guiding principles include gender equality and protection of the human rights of women and men, girls and boys in Tanzania.

The GOP 2016-2018 is organised around eleven sections, and starts with the definitions of key concepts on gender and HIV.

Section one is the introduction. It provides information about country profile including geographic, demographic, political and socio-economic characteristics of the United Republic of Tanzania Mainland. Section two exposes a situation analysis of HIV in Tanzania Mainland. This section also provides information on HIV variations according to sex, age and marital status. It also discusses the main drivers and key determinants of HIV, which include individual behaviours as well as socio-cultural factors, biomedical and structural factors.

The third section discusses about policy and legal framework for addressing the AIDS epidemic; promotion of gender equality and protection of human rights. In the light of the national, regional and international policy.

Section four gives a flash back on the overall review of the GOP 2010 – 2012, it discusses the emerging issues from the National Gender Assessment and from other aspects of the review process.

The fifth section highlights the key achievements and challenges in HIV prevention care, treatment and support in the national HIV response under the GOP of 2010 – 2012. The section as well indicates achievements and gaps based on implementation of the GOP of 2010 – 2012.

The sixth section discusses priorities, approaches and the guiding principles of the GOP 2016-2018.

Section seven contains the strategic gender issues, results and gender strategies for women and girls, men and boys, according to the eleven investment areas of the NMSF III. The section also presents the gender sensitive activities to implement the Operational Plan to achieve desired results. Generally the Investment Framework, which the NMSF III and HSHSP III have adopted are aiming towards achievement of the Three Zeros: Zero New HIV Infections; Zero AIDS-Related Deaths; and Zero Stigma and Discrimination. Both NMSF III and HSHSP III have adopted the Investment Framework for the elimination of the AIDS epidemic by 2030.

Section eight provides the management and institutional framework for implementing the GOP as aligned to the existing structures of the national HIV response, with TACAIDS main role of coordination and implementation of the Operational Plan in close collaboration with different national stakeholders, at various levels from development partners level, to national, regional, council, community and health facility levels.

Section nine discusses monitoring and evaluation arrangements of the Operational Plan whose activities will be monitored, evaluated and reported within the National Investment Framework of the NMSF M&E System.

Section ten, which is the last, discusses the anticipated risks, assumptions and mitigation strategies for implementing the GOP, which may include inadequate resources and leadership support, limited implementation capacity, insufficient cooperation from stakeholders and delays in funding the interventions. TACAIDS and other stakeholders have planned actions to mitigate these risks. Then the section concludes by providing recommendations for the way forward.

Section eleven is the conclusion part which summarizes the overall mechanism for coordination of implementation of the GOP 2016 - 2018. It points out the role of TACAIDS as the mobilizer of stakeholders who are vital for implementation of activities contained in this Operational Plan. This section has also emphasized on the necessity for TACAIDS to organize and coordinate stakeholder's annual meetings for review of activities in this Plan.

1.0 Country Profile

The United Republic of Tanzania (URT) is made up of the Mainland Union Government and the Revolutionary Government of the islands of Zanzibar (i.e. Unguja and Pemba) in the Indian Ocean. Tanzania shares its borders with Kenya to the north, Uganda to the northwest, Rwanda and Burundi to the west, Democratic Republic of Congo (DRC) to the southwest, Zambia, Malawi and Mozambique to the south. Tanzania is member of the East African Community (EAC) and the Southern Africa Development Community (SADC). Tanzania Mainland is divided into twenty six regions and 145 districts. The district authority (or council) is the most important administrative and implementation unit for public services. Each council is divided into divisions, wards and villages.

1.1 Population

The current population of Tanzania is estimated to be 49,639,138, According to (NBS, 2014), this is an increase from 43,625,354 in 2012.Tanzania sex ratio stands at 95 males per 100 females. The population of Tanzania is projected to increase by 1,015,230 people and reach 51,726,028 in the beginning of 2016. The crude birth rate is 41.6 per 1,000 populations and life expectancy at birth is 52 years for men, and 55 years for women. With the population growth rate of 2.7%, Tanzania is considered as among the fastest growing populations as 1.2 million people are born annually (HDR, 2014). Almost half of the population (48%) is below 15 years of age; 49% are aged 15-64 years and 4% are over 65 years. Life expectancy has risen from 51 years in 2002 to 60.76 years in 2012; 62.09 years for females and 59.48 years for males (an increase from 56 years for females and 53 years for males (THDR, 2014), Infant mortality has declined from 68 deaths to 2007/08 1,000 live births to 51 per in 2009/10 per 1000 live births and to 45 in 2010 with the likelihood of reaching the MDG target of reducing infant mortality down to 38 deaths per 1000 live births by 2015. Under-5 mortality has declined from 91 per 1 000 live births to 81 per 1 000 live births during the same period (NBS, 2011).

1.2 Social Economic Background

Agriculture is the backbone of Tanzania with more than 75% of people living in rural areas working on the land as smallholder self-employed farmers depending on the hand hoe and rain-fed agriculture for subsistence (Kiyondo, 2011). Despite the high economic growth of between 6% and 7% over the past ten years, about one third of the people still live in poverty, which has declined to marginally to 28.2% from 33.3% in 2007, (THDR, 2014). Women produce more than 70% of the food crops and also bear substantial responsibilities for many aspects of export crops. The impact of HIV has been felt in some of the social and economic sectors such as agriculture, education, health and tourism, most of which are female dominated, (ESRF, 2009). The impact has included reduction of labour productivity due to ill-health, work absenteeism and financial costs for caring PLHIV.

2.0 Situation of HIV in Tanzania Mainland

Currently, it is estimated that there are 1.5 million people living with HIV out of whom 28% are children aged 0-14; and 11.2% are young people aged 15-24 (Spectrum Estimate, 2013). HIV transmission in Tanzania is predominantly by heterosexual mode, which is 80%, followed by vertical transmission at 18%. An estimated 78,843 new HIV infections were occurring annually as of December 2013, the 45.1% of whom were males and 54.9% females; and a total of 79,338 deaths (40,523 males and 38,815 females) occurred in this reporting period, (Spectrum estimate, 2013). Although HIV prevalence has declined from 7.0% to 5.3% (THIS, 2003 to THMIS III, 2013) among adults aged 15-49, and from 6.3% to 3.9% among men in the same age group, women's HIV prevalence has not declined significantly as it is at 6.3%. Surveys have also identified some regions with increased prevalence despite the decline in the national prevalence. Regional variation in HIV prevalence ranges from 1.5% in Manyara region to 14.8% in Njombe region (THMIS III, 2013).

2.1 Key Determinants in HIV Transmission

Various studies (NMSF III, 2013) have shown that, key drivers of HIV epidemic include promiscuous sexual behaviour, inter-generational sex and concurrent sexual partners, presence of other STIs, and inadequate comprehensive knowledge of HIV transmission. Several contextual factors that shape the HIV include poverty, having unprotected, transactional or commercial sex, men's irresponsible sexual behaviour due to social norms and gender inequality, harmful traditional practices such as widow inheritance and cleansing, violence against women and children; and cultural patterns of virility. Others are alcohol and substance abuse, mobility which leads to separation of spouses and increased establishment of temporary sexual relationships.

Gender related gaps in some national laws and policies also act as barriers to the national HIV response. Current gaps include, among others, lack of amendment of the Marriage Act, lack of laws addressing GBV and the lack of adequate shelters to house survivors of GBV especially from intimate partner violence. (Gender assessment, 2015).

Inspite of the emphasis of (The National HIV and AIDS Policy, 2001) on respect for gender equality and people's human rights and in spite of the various laws that were enacted to specifically deal with HIV and AIDS related matters. The HIV and AIDS Prevention and Control Act, (2008) is the main regulatory tool on HIV prevention and control in Tanzania Mainland. Part VIII of the Act provides for PLHIV rights and obligations. Section 24 of the Act provides for equality and non-discrimination to enable all people access to health facilities. Part VII of the Act addresses issues of stigma and discrimination. Article 33(1) section (a) and (b) provide for rights to access quality medical services and treatment for opportunistic diseases. Article 33(2) sections (a) and (b) provide for obligation of protection to others from re-introducing infections into the population; according to articles 28 to 32 of this Law, discrimination is a punishable offence.

Below is a summary of the main drivers and key determinants of HIV categorized in four main areas, namely: - individual behaviours, socio-cultural, biomedical and structural factors.

2.1.1 Individual Behaviours

These are individual behavioural factors that are normally inter-personal contexts in which sexual behaviour and sexual HIV transmission occur and include early sexual debut; substance and alcohol abuse; multiple sexual relations, inter or cross-generational sexual relations; and unprotected sex, low, infrequent and inconsistent condom use.

2.1.1.1 Early Sex Debut

Early sex debut is common among adolescents (i.e. girls/young women and boys), where about 9.7% of young women and 10.2% of young men aged 15-24 reported to have had sexual intercourse before age 15; 51.6% of young women and 43.9% of young men aged 18-24 had sexual intercourse before 18 years of age.

2.1.1.2 Substance and Alcohol Abuse

Substance and alcohol abuse are closely associated with decreased ability to practice safe sex, and therefore increases vulnerability to contracting STIs and HIV. The National Guideline for Comprehensive Package of HIV Interventions for Key Populations, (2014) shows that; the vulnerability of women who use and inject drugs (WWUD/WWID) is enhanced due to the selling of sex to secure drug supply. Meanwhile most men who use and inject drugs resort to stealing money or shoplifting and sell the stolen goods in order to buy drugs. According to the study investigating differences in drug use and sexual behaviors in a sample of injection drug users in Dar es Salaam between males and females, women had higher number of sex partners (trading sex for money or drugs) than men. More than four-fifths of women traded sex for money, and more than a fourth traded sex for drugs. There were significant differences between men and women in their relationship to the last sex partner. Most men's last sex partner was a spouse or someone like a spouse. Most women's last sex partner was a sex-for-money partner. (Williams, M., et al. 2007)

As of February, 2013 it was indicated that (the Bulletin of the World Health Organization, 2013) in Tanzania a total number of 319 males who inject drugs and 219 females who inject drugs, 33% traded sex for money, 49% did not use condoms during vaginal sex, 31% had injected with a needle used by someone else, 41% had given a used needle to another, and 42% were HIV-positive and almost none of those who tested HIV-positive knew their serostatus. The study also mentions the main HIV risks related to injecting drug as being: sharing contaminated needles - the one of the most direct transmission pathways for HIV transmission, exchanging sex for money or drugs, low condom use, and low levels of HIV testing and treatment.

2.1.1.3 Multiple Sexual Relations, Inter or Cross-generational Sexual Relations

Multiple, inter-generational and unprotected sexual relations are mostly driven by socio-cultural gender-based factors such as poverty, lack of productive resources, and frequent travels as well as working away from home, and sometimes due to peer pressure. Inter-or cross- generational sex also creates potentials for high vulnerability to HIV infection. It is estimated 7.6% of young women aged 15-19 in mainland Tanzania engage in cross-generational sex by 2010 with variations between urban (10.4%) and rural populations (6.7%). In both cases young women and men engage in cross-generational sex in search of material benefits and cash money or social standing aspirations (NMSF III, 2013).

In Tanzania HIV is particularly high among sex workers and their clients, who are vulnerable to HIV infection because of multiple or high numbers of sexual partners and frequency of sexual contacts coupled with their limited power to negotiate condom use or resist violent or coercive sex by clients.

2.1.1.4 Unprotected sex, low, Infrequent and Inconsistent Condom Use

Unprotected sex is practiced by people in heterosexual relationships, men who have sex with other men, and women who practice anal sex, all of which put them in a great risk of contracting STIs and HIV. The risk of women contracting HIV through anal sex is much higher than through vaginal sex (NMSF III, 2013) as indicated in a study on FSWs (NACP, 2010). Vulnerability to STIs and HIV increases with low, lack or inconsistent use of condoms increases by both males and females of all categories. In 2013, a total of 109,480,995 male condoms and 1,717,560 female condoms were distributed by PSI and Tanzania Marketing and Communications Company Limited (T-MARC), additionally a total of 490,188 male and 35,521 female condoms were distributed by HIV implementers reporting through TOMSHA. Reported condom use at last sex among those with more than one partner in 15–24 year olds was 33.9% for females; and 40.6% for males (NRR, 2013). Other key HIV determinants under this category are incorrect use of condoms, wrong information, attitude and beliefs, and inadequate negotiation of condom use during sex encounters, especially on the part of women and girls due to gender inequality. Factors accounting for low, lack or inconsistent use of condoms include unequal power and gender relations; poverty and lack of money to buy or non-availability of condoms, especially female condoms. Low condom use, especially of the female condom, is an issue that needs to be addressed. The National Gender Assessment report (2015) indicates that the female condom is not readily available despite its promotion and free distribution. According to TOMSHA (2015) a total of 428,834 female condoms and 8,216,984 male condoms were distributed in 2013/14. More condoms were distributed through social marketing schemes by organisations such as T-MARC. The T-MARC distributes a brand of female condom known as *'Lady Pepeta'*, which is distributed to sex workers, bar maids and women engaged in transactional sex, who are being reached through interpersonal communications, condom demonstrations, peer educators trained as T-MARC sales agents. One of the advantages of the female condom is that it is inserted in advance thereby allowing a woman to initiate protected and safe sex.

HIV prevention measures are addressing the low use of condoms, especially the female condoms by addressing gender issues, which undermine condom use through several channels in order to increase condom availability, remove barriers to use, and increase negotiation skills for vulnerable groups so the use of both male and female condoms is enhanced. In National HIV Response (2013) this has been attributed to lack or limited power towards negotiating safe sex among couples. Data from Tanzania HIV and AIDS Indicator surveys of 2003/04, 2007/08 and 2011/2012 show that, the negotiating power among women was as low at 68.1% in 2004, increased to 90.7% in 2008 and slightly declined to 79.4% in 2012. This decline is a cause of high concern for women's empowerment specifically, and the national response towards HIV in general.

2.1.2 Socio-Cultural Factors

Socio-cultural factors are the broader population-level contexts in which HIV transmission occur and includes stigma, discrimination, mobility, migration, gender inequalities and wealth disparity and gender based violence; as well as multiple unprotected sexual relations and cross-generational sexual relations (NMSF III, 2013).Socio-cultural factors trigger discrimination and stigmatization in society, including to PLHIV within the community and also a breach of confidentiality through health delivery systems against PLHIV and KPs. Stigma and discrimination are linked to increased risks of increased infection of HIV and transmission among on PLHIV, and especially women living with HIV and female sex workers (FSW) most of whom fear to go for HIV testing and treatment thereby putting themselves and their sexual partners at high risk of contracting HIV. Stigma and discrimination at various levels even in the health facilities delivery systems affect access to HIV services.

According to studies, stigma is still high within local communities with low acceptance towards PLHIV. Available data according to THMIS (2012) indicate that, about, 15% of the PLHIV felt that health care providers did not keep information confidential, 5.4% had their serostatus disclosed without their consent; 13% were advised not to bear children. 44% were denied access to reproductive health information, 14% were forced in accepting particualr infant feeding options, and 9% were compelled to use family planning methods. According to the NRR (2015), a total of 63,868 pregnant women which is equivalent to 72.09% (63,868/88,583) of the total HIV positive pregnant women received anti-retroviral to reduce the risk of mother to child transmission. The number includes pregnant women who received combined regimen (Prophylaxis) which was 33,909 and those who were on ART 29,959. (NRR, 2015).

The People Living with HIV Stigma Index (2012), reported that, there have been some women living with HIV[1] who were forced into sterilization and pregnancy termination by health service providers. As a result of stigma, about 44% of PLHIV said they felt a sense of shame and 63.4% reported to be blaming themselves and 85% felt worthless, 10% said they deserved to be punished. As a result most PLHIV reported to have isolated themselves from work places they felt they would be stigmatized for fear of gossip (45%) and harrassment (30%). Studies reveal that very few PLHIV are aware of their human rights, national policies and laws or regional and international instruments on the human rights of PLHIV. As a result, very few PLHIV look for assistance when their human righs are violated.

The Stigma Index reports that 25% females ad 40% of males in Tanzania accept interacting with PLHIV. The situation is critical in rural areas where only 21% of females and 35% of males accept interacting with PLHIV. In the urban areas acceptance of PLHIV is better and stands at 36% females and 54% males have positive attitudes towards PLHIV. (NMSF III , 2013).

1 2% in regions and 3.4% in Dar Es Salaam.

2.1.2.1 Income Inequality and Poverty

Inequality in income and poverty are key determinants in the transmission of HIV as indicated in various studies. HIV prevalence has been found to be higher among the employed (6%) than the unemployed (3%); poverty pushes young girls to engage in commercial sex in exchange for cash or presents; wealth men and women that engage in cross-generational transaction sex with younger and poor vulnerable young people; inability to buy condoms due to poverty is also a barrier to negotiate safe sex and use of condom. Some women who are not sex workers engage in risky sexual behaviours in order to earn money to buy food for their children; and poverty increases chances of the AIDS epidemic progression due to poor immunity by not having enough money to buy nutritious food (NMSF III, 2013). Poverty aggravates the intensity of HIV impact on poor people, women, OVCs and disabled. Tanzania National HIV and AIDS Policy (2013).

2.1.2.2 Gender Inequality

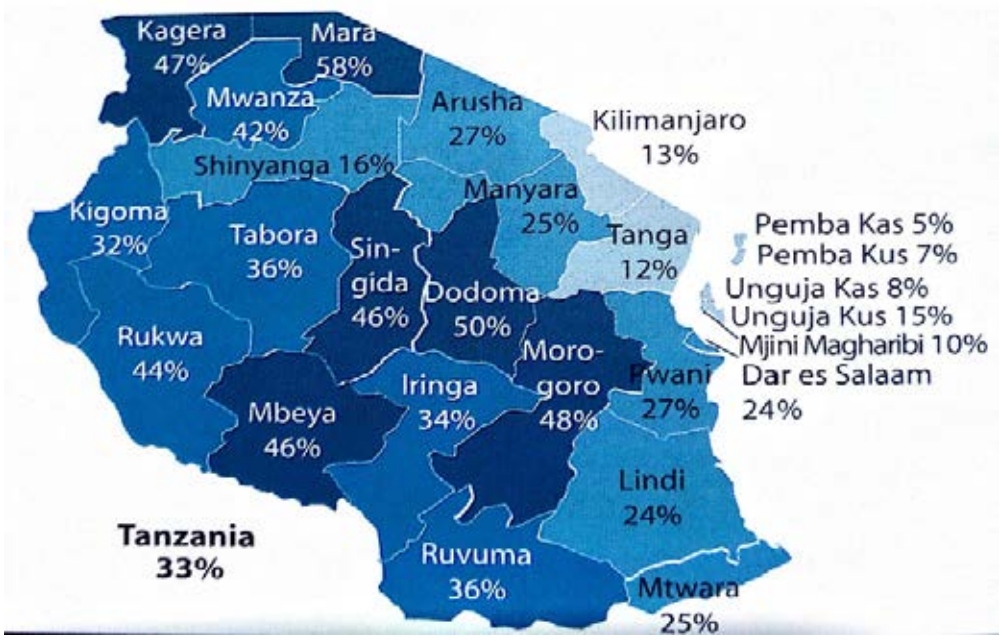
Gender inequality is a big hindrance to women's meaningful participation and decision making at all levels of society, including in negotiating for safe sex and condom use. Gender inequality is rooted in the patriarchal system that breeds gender based violence (GBV), which is reinforced and perpetuated by negative traditional practices that continue to undermine the promotion of gender equality, and the well-being of women, girls and boys thereby making them vulnerable to HIV infection. Such practices include FGM for girls and women; traditional circumcision for boys and sometimes men; traditional initiation dances taking place at night and increasing the risk of sexual abuse; arranged early marriages to older partners; and widow inheritance. These harmful traditional practices perpetuate attitudes of masculinity among men and dictate upon their multi-sexual partnerships and polygamous tendencies, and other sexual irresponsible behaviours. In turn, GBV impacts on women's productivity, access to economic resources and services including HIV and reproductive health services. Gender inequality and harmful gender norms encourage the notion of masculinity that allows men to have multiple partners, and prevent women from discussing sexuality and to accept partner infidelity. The fear of violence also prevents women from disclosing their HIV status to their partners and family members for fear that they may be divorced or stigmatized.

Due to gender inequality, most women lack or have limited knowledge on the procedures of how and where to access services for social and legal services for GBV incidences. In other areas, social and legal services for GBV don't often exist, this makes difficult for the GBV survivors to know how to access the services as such services are not known to them. Apart from GBV delimiting survivor's confidence and courage to report the incidents; survivors are very often stigmatized and shamed when they report to local authorities and police. GBV survivors also fear revenge by their perpetrators[2]. This fear results in women and girls not accessing PEP and HTC services[3].

2 TAWLA (2013) Need Assessment Report on Gender Based Violence Among Women Living With HIV Project: Gender Transformative HIV Response In Dar-Es-Salaam, Pwani, Iringa, Njombe, Mbeya And Katavi

3 HSHSP III.

Figure 1: Percentage of women aged 15 - 49 faced physical violence include biting or injured 12 months before research. Data by regions



Source: TDHS 2010

2.1.3 Biomedical Factors

Biomedical factors affecting HIV transmission include low levels of male circumcision in regions of low circumcision level; low coverage of quality assured blood transfusions, non-sterile medical injections and high prevalence of STIs including Human Papilloma Virus (HPV), high levels of HIV couple discordance, transmission of infection from parent to child and low levels of self-knowledge about HIV serostatus.

2.1.3.1 Low Levels of Male Circumcision

Voluntary Medical Male Circumcision is being implemented in regions (Njombe, Iringa, Mbeya, Rukwa, Katavi, Tabora, Shinyanga, Geita, Simiyu, Mwanza, Mara and Kagera) that have high HIV prevalence and low male circumcision. As of December 2013, a total of 676,225 males of the targeted 2,102,252 males by 2017 had been circumcised. NRR (2013). There are demographic and regional variations in male circumcision. However, more than 70% of men in Tanzania have been circumcised; the level of circumcision is higher in urban areas with 94% compared to rural areas, which is 64.2%. Male circumcision is lowest in Rukwa region with 28%, Simiyu 30%, Shinyanga 32%, all of which correspond with their high HIV prevalence rates. NMSF III (2013).

2.1.3.2 Low Coverage of High Quality Assured Blood Transfusion

According to Tanzania Country Progress Report, (2010), Tanzania has not yet achieved universal 100% blood screening of donated blood for HIV infection. As of to date, only 35.7% of the donated blood is screened for HIV.

Therefore, blood that has not been screened for HIV puts the recipient at the risk of HIV infection. NMSF III (2013) · subsequently this has a negative gender outcome, due to the fact that, more women are likely to receive blood transfusions due to labor/delivery/ caesarean section.

2.1.3.3 Prevalence of Sexually Transmitted Diseases

Studies indicate that STIs increase chances of individuals to get infected with HIV during unprotected sex. A survey of Tanzania Mainland revealed that 3.1% of women and 6.9% of men reported having STI. Evidence has also been established increased vulnerability of PLHIV to Human Papilloma Virus (HPV), which causes cancer. HPV is one of the most common sexually transmitted diseases worldwide and about half of all sexually active men and women will be infected with any given type of HPV at some point during their lifetimes and some may be repeatedly infected[4]. A systematic review and meta-analysis in 2012 showed that the overall risk of HIV acquisition in women doubled when they had a prevalent HPV infection with any genotype. HPV is a common virus that can be passed from one person to another during sexual intercourse. It can be prevented by either primary prevention, through abstinence and HPV vaccination or secondary prevention by way of screening and treating pre-cancerous lesions. Being HIV positive increases the risk of developing cervical cancer by at least 50%, as well as contributes to an earlier onset of the disease by 10 years.

Tanzania has one of the highest cervical cancer burdens in the world with the incidence of 50.9 cases per 100,000 women; cervical cancer is the leading cause of cancer-related morbidity and mortality in Tanzania [5]. This burden is 50% higher than the East African average and nine times higher than Europe and North America. High illiteracy rates among women, traditional beliefs, lack of information finances, especially in rural areas, make it difficult for women to go for HPV screening and vaccination. As a result, the majority of patients go to the hospital at the late stages of the disease, which reduces their chances of survival. The main barriers to cancer screening and treatment include social and gender norms, stigma, lack of information and awareness, and high transport and accommodation costs at the health centers, Tanzania Country Progress Report (2010). In this regard, education, communication and integrated service delivery system is among the key determinants of HPV and cervical cancer screening. If pre -cancerous lesions are detected and treated early, cervical cancer is almost 100% curable.

2.1.3.4 Mother to Child Transmission of HIV

The TDHS (2011),found that Mother to Child Transmission (MTCT) is the second most common cause of HIV transmission in the country due to low levels (out of the recommended 4 visits) of attendance to ante-natal clinics (ANC) and lack of full integration of PMTCT services in maternal and child health (MCH) services. This is one of the reasons that about 24% of HIV positive pregnant women that attended ANC were not reached by PMTCT; and 43% of HIV exposed infants who needed ARVs to prevent MTCT did not get it due to limited access to treatment or stock out of commodities.

According to Tanzania GARPR Report 2014, 77% of pregnant women living with HIV in Tanzania received effective antiretroviral drugs for PMTCT in 2013, an increase from 71.7% in 2012. However, there are many challenges including ensuring that high proportions of women and children in need of ART can access it. But to achieve this goal, all partners will need to redouble their efforts in order to reach the hardest-to-reach women and children with ART. This calls for among others, broader maternal, neonatal and child health (MNCH) HIV programs services that maximize cost-effectiveness and the benefits for other health programs. It also calls for simple and better and new PMTCT approaches, called 'Option B+', which has started to show good results.

4 Centres for Disease C, Prevention, FDA licensure of quadrivalent human papillomavirus vaccine (HPV4, Gardasil) for use in males and guidance from the Advisory Committee on Immunization Practices (ACIP), MMWR Morbidity and mortality weekly report, 2010; 59(20): 630-2

5 World Health Organization, Tanzania: Human Papillomavirus and Related Cancers, Fact Sheet 2010, http://apps.who.int/hpvcentre/statistics

Current PMTCT statistics in Tanzania indicate that, about: 97% of health facilities with RCH services provide PMTCT services; 98% of pregnant women attend ANC clinic at least once while only about 47% make at least 4 visits to ANC clinic during their pregnancy. According to THMIS 2011-2012, of all women attending ANC in a RCH facility providing PMTCT services 90% are tested for HIV. The prevalence of HIV among women who attend ANC is 6.9%; 26% of pregnant women male partners test for HIV; 93% of women who test positive for HIV receive ARV prophylaxis. Action needed to reach zero mother to child HIV transmission, include strengthening efforts to reduce unmet need for family planning; increasing coverage of prophylaxis during breastfeeding; ensure eligible children receive ART; increasing early infant diagnosis from 35% to higher levels will improve ART uptake; and integrating PMTCT into maternal and child health services.

2.1.4 Structural Factors

Structural factors such as inadequate quality HIV services that are accessible, affordable, discrimination free and sensitive to specific needs of different population groups, produce and re-produce HIV risk and undermine the effectiveness of HIV interventions among women, especially adolescent and young women, and key populations including PWIDs, FSWs and OVCs. These structural drivers of HIV and STI transmission need to be addressed through structural interventions promoting health-based policies and practices that are accessible, non-discriminatory and sensitive to the needs of different population groups and effective at improving population level sexual health outcomes. These interventions call for innovative interventions that promote legal reforms, behavioural change, non-coercive policing practices, and street-based outreach and sexual health services to reduce the prevalence of HIV and other STIs among women and key populations[6].

Institutional, socio-cultural, as well as systemic and political factors prepare people for gendered lives and livelihoods. The way structures of power, production, distribution and services are organized determines who gets what, how, when and where. The powerlessness of women and girls and their limited negotiation capacity in sexual and marital relations is a product of these structures and promotes their perpetuation. To reduce gender power imbalances that perpetuate dependence and vulnerability among women and girls there is need to address these structural, institutional and systemic issues through total enfranchisement of women by constitutional and legal reforms, intensive education of gender equality for all and political leadership to enforce new norms and practices geared towards equal rights for all.

2.2 HIV Prevalence by Region, Urban and Rural Areas according to different Categories of Females and Males

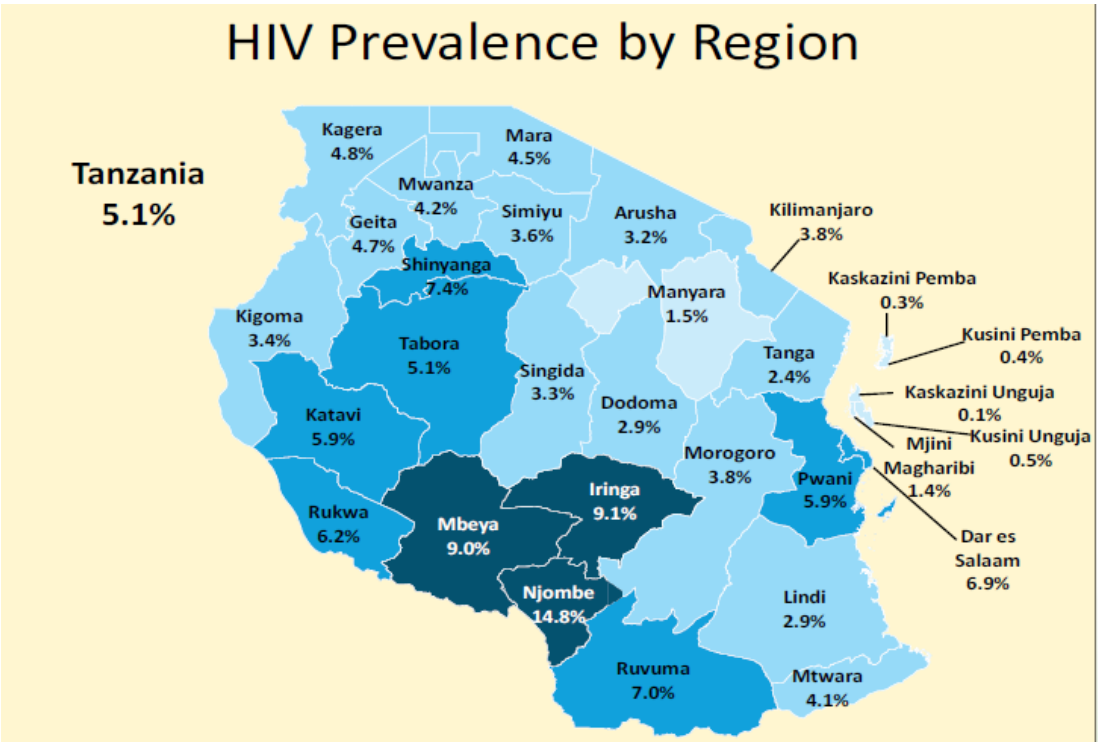
For 33 years since the first HIV case was recorded in Tanzania, the virus have spread rapidly, leading to a generalized epidemic, with pockets of a concentrated epidemic, and a devastating impact on social and economic development. Regional variation, coupled with age and sex differentials has been documented to dominate HIV prevalence thus resulted into various vulnerabilities to specific populations in Tanzania (NMSF III, 2013).

6 BMC Public Health, Structural factors associated with an increased risk of HIV and sexually transmitted infection transmission among street-involved youth by Brandon DL Marshall, Thomas Kerr, Jean A Shoveller, Julio SG Montaner and Evan Wood

2.2.1 HIV Prevalence by Region

Despite the general decline in HIV prevalence between 2008 and 2012, HIV prevalence has increased in Ruvuma, Rukwa, Kagera, Mtwara, Kilimanjaro, Kigoma, Singida and Arusha regions. Six regions have HIV prevalence rates above the national average. These are Njombe, Iringa, Mbeya, Ruvuma, Rukwa and Katavi in the Southern Highlands; as well as the Coastal region/Dar es Salaam and Shinyanga in the Lake Zone. Variations among regions with high prevalence has attracted NMSF III (2013) to focus on regions with high prevalence in order to control and reduce the infections. This makes it crucial for a strategic focus and understanding the key factors that increase HIV prevalence in such regions. The map below shows HIV prevalence rates by regions.

Figure 2: Prevalence of HIV and AIDS by sex and by urban and rural Areas



Source: (THMIS 2011/2012)

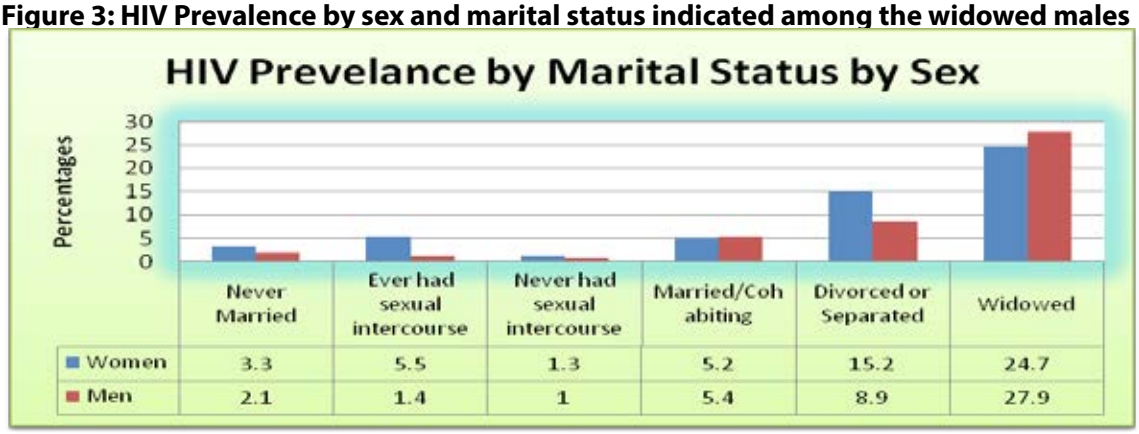
2.2.2 HIV Prevalence by Sex, Age and Marital Status

HIV prevalence varies clearly between sexes and age groups. Despite the general decline of HIV prevalence in the general public, women and girls of all age groups tend to have higher prevalence rates than males. While the overall prevalence is 6.2% among women aged 15-49, the prevalence varies from 1.3% among women aged 15-19 years up to 10.2% among women aged 45-49[7]. Prevalence among females aged 25-29 years is three times higher compared to young men of the same age. It is also important to note that in the whole Eastern and Southern Africa, more than one third of new infections are among those aged 24 or younger – grand majority of them being among females. AIDS is currently the leading cause of deaths among adolescents (10-19 years) in the region.

7 Compare: HIV prevalence is 7% among men aged 30-49 (THMIS, 2012).

HIV prevalence is also associated with marital status; it is higher among widowed, divorced or separated people, with much higher rates among women than men (THMIS III, 2013). The high prevalence of HIV transmission and infections among married couples is normally related to multiple sexual partners in the marriage. While widowed females and males are more vulnerable to HIV than married couples, males have a higher prevalence of 28% compared to the divorced or female widows, which is 25% THMIS, 2011/2012(2013) as can be seen from the graph below.

Figure 3: HIV Prevalence by sex and marital status indicated among the widowed males



Source: THMIS 2011/12

2.2.3 HIV Prevalence among Key Populations

Despite the fact that HIV transmission in Tanzania is predominantly by heterosexual (80%), recent studies show high prevalence rates among the Key Populations (KPs) including people who use and inject drugs (16%), female sex workers (31.4%), and mobile or migrant workers, vulnerable children that include orphans and street children, and prisoners, (Global AIDS Response Country Progress Report, 2014).

2.2.3.1 People Who Inject Drugs (PWID)

The prevalence of HIV infection among PWID is significantly higher than in the general population because of sharing needles, unsafe injecting practices and the re-use of contaminated needles and their risky sexual behaviours. Research indicates an increase of PWID with new HIV infections. The gender assessment (2015) shows unequal gender relations as one of the key determinants in HIV infection among PWID as the HIV prevalence among the Dar es Salaam female PWID is very high (68%), which is the highest of any key population group . Studies also show that females PWID are more likely to sell sex or have a higher number of sex partners thereby increasing their vulnerability to HIV infection. Risk Practices among PWID in Temeke (2011). It also indicates that, females finance their drug use through selling sex; with others engaging in transactional sex for protection, housing, food, or other kinds of support. Most women who use or inject drugs WWUD/WWID experience gender based violence, sexual harassment and exploitation. Stigma and discrimination against PWID is very high, which as mentioned earlier is a big challenge for the delivery of quality friendly HIV and other health services. However, women who use drugs (WWUD) and women who inject drugs (WWID) face more stigma, discrimination and marginalization than their male counterparts because of their gender.

2.2.3.2 Sex Workers

Sex workers include men and women, young and old who exchange sexual services for cash or goods, or a regular, occasional or full-time basis or as a short-term measure. Studies indicate high HIV prevalence among female sex workers (FSWs) than that of the general population. About 69.7% of the female sex workers interviewed in Dar es Salaam said sex work was their main source of income (NMSF III, 2013) Out of the 537 female sex workers interviewed in Dar es Salaam, one-third reported to be divorced or separated, and more than half were not married, and 72.6% three-quarters reported to have a steady non-paying partner.

Gender based violence is also high among sex workers. Sexual and physical abuse including rape is estimated to be 51.7% among female sex workers (National Response Report on HIV, 2013). Apart from the HIV risk this poses to FSWs themselves, FSWs have multiple partners hence acting as a bridge for HIV transmission between FSWs, their partners, other high risk groups, and the general population. Power relations between sex workers and their clients play a big part in the not using condom during the exercise, even their own/female condom. The Gender Assessment (2015) indicates that, only 18.3% of FSWs of Dar es Salaam reported ever using a female condom. This could be partly due to lack of information, poverty, and lack of negotiation power or refusal by their clients, who usually pay more if they can have unprotected sex.

Related to sex work is sexual violence against children (VAC), which puts many young people, male and female, at the risk of HIV infection. Existing data of VAC shows 4% of Tanzanian girls received money or goods in exchange for sex at least once in their lifetime; of the 82% girls that reported receiving money or goods for sex also reported childhood sexual violence; 90% who received money or goods for sex reported experiencing childhood physical violence by a relative; while 50% of those that received money or goods for sex reported childhood emotional violence (Violence Against Children Report, 2011).

2.2.3.3 Mobile and Migrant Workers

Mobile or migrant workers, which include distance truck drivers, fishermen and miners, prisoners and OVCs and the communities that surround them, are vulnerable to HIV infection. These KPs tend to have high HIV prevalence rates because they stay far away from their spouses/partners for long period are exposed to sexual activities with non-marital or co-habiting partners. Another group of Migrant workers are girls and young women that are trafficked from rural areas to urban areas to work as cheap labour in the homes as domestic servants or maids, or sex workers in brothels or bar maids in the various entertainment industries.

2.2.3.4 Fishermen and Miners

The working conditions of fishermen, miners and other migrant workers takes them away from their home for long periods, which encourage them to engage in casual and multiple sexual activities with commercial sex workers, female small scale traders including fish and food vendors *'mama ntilie'*, all of which put them into the risk of contracting and transmitting HIV In addition, working away from home and staying in the mining and fishing camps for long periods of time, pushing some miners and fishermen into the practice of having sex with other men. Alcohol and substance abuse is also high in most mining and fishing camps. Both practices of MSM, alcohol and drugs abuse enhance the spread of HIV.

2.2.3.5 Prison Inmates

Prison conditions create grounds for unsafe sex and abuse of substances, including the sharing of needles and razor blades among the prison inmates leading to higher HIV prevalence rates, Hepatitis B and C, STIs and TB. And about 53.2% prisoners are exposed to substance and alcohol abuse, risky sexual practices including MSM that make them vulnerable to HIV .Legal environment assessment in response to HIV and AIDS within the United Republic of Tanzania, (2015). Studies indicate that about 2,546 prison inmates out of the estimated 38,000 prisoners in the country are living with HIV. HIV prevalence among prison inmates is twice as much than that of the general population. Although the overall prevalence is estimated to be 6.7% (THMIS III, 2013) but other sources indicate 9.2% prevalence rate, which is still very high compared to the general prevalence of 5.3%. Just like in the general public, gender is a key determinant of HIV transmission among the prisoners, with women bearing the heavy burden of the disease. HIV prevalence among female prisoners is higher at 14.7% than that of males, which stands at 5.2%. Legal environment assessment (2015). Drug use and injection is widespread among the prison inmates; and the scarcity of needles leads to the inmates sharing of needles, which increases the spread of blood borne HIV infections.

2.2.3.6 Orphans and Vulnerable Children

Orphans and vulnerable children (OVC) including street children are vulnerable to HIV transmission because of the conditions under which they live and work. Family related problems such us divorce or separation may lead to some children becoming homeless and resort to living in the streets under very difficult conditions, which makes them vulnerable to sexual abuse, violence, substance abuse and HIV infection. Research shows that, orphaned children head of households and those living with guardians, at times are obliged to work under harsh conditions to provide for their upkeep and that of their guardians (e.g. grandparents) and siblings. HIV/AIDS and Child Labour in Tanzania: A rapid Assessment (2003). Additionally, children that drop out of school due to poverty, pregnancy or exam failure are sometimes forced to work as child labourers or sex workers thereby risking their lives to violence, sexual abuse and HIV infection. There are some poor families that force their children to go into child labour or begging in the streets in order to earn some money for the family. This not only puts the children at the risk of their rights to education and care being violated, but also it makes children vulnerable to violence, sexual abuse, substance abuse and HIV. In view of the above concerns, it is therefore a great challenge for the government and other stakeholders to ensure equitable and friendly HIV and related services are easily accessible KPs regardless of their age, sex and sex orientation, education, social and regional/ethnic background. Gender and other issues of social inclusion need to be addressed strategically within the different contexts in which they live and work.

2.2.3.7 Key Populations

In order to address the plight of KPs, the government issued national guidelines for KPs aimed at standardizing the development and implementation of HIV interventions based on the best international evidence and good practice for what is effective. The goal of the guideline to guide all stakeholders in the delivery of cost-effective and comprehensive package of quality health and social services to all KPs in order to minimize the transmission of HIV and to reduce HIV-related mortality, morbidity, stigma and discrimination. In this way, the guideline also addresses the vulnerability, risk behaviours and associated adverse health consequences of KPs. It is expected that the implementation of the guideline will create and maintain an enabling environment for HIV and related interventions through multi-sectoral targeted dialogue for, targeted advocacy and community engagement to address the social, cultural, religious, political, structural legal and financial barriers that can impede upon a public health approach for KP;

and enhance and strengthen technical knowledge among the stakeholders to deliver the comprehensive package of evidence-based services in a more targeted, efficient, effective and cost-effective manner for KP thereby contribute to the attainment of the three Zeroes: Zero new HIV infections, Zero stigma and discrimination, and Zero AIDS-related deaths. The guideline, which is based on regional and global instruments, are being used as a reference for different KPs stakeholders, including those in research, learning institutions, health facilities, individuals and organisations working with the KPs.

3.0 Policy and Legal Framework for Gender and HIV

3.1 National framework

The Government of Tanzania (GOT) has put in place favourable policy and legal framework, institutional arrangements, and national guidelines and directives that provide an enabling environment to promote human rights, gender equality and social inclusion. In 2003, a community based strategic framework for protection of women and children against HIV and AIDS was developed; and a national public campaign to break the silence on the linkages between HIV and AIDS, resources and gender was launched. The Constitution of Tanzania (1997, Aricle.1) and various laws such as the Village and Land Acts (1999) and the Law of Inheritance (1999) in support of women's access to, and control over land to empower women economically and to increase food security and reduce poverty. Though gender sensitive, such laws are rarely being enforced because of customary laws. Nevertheless, customary laws and negative gender norms and socio-cultural practices undermine women's human, social, economic and political rights. It also enacted the Sexual Offences Special Provisions Act (1998) with special provisions related to sexual and other offences aimed at safeguarding the personal integrity, dignity, liberty and security of women and children.

Through the Ministry of Community, Gender and Children (MCDGC), in 2000, the government formulated the Tanzania National Women and Gender Development Policy (2000) and the Gender Strategic Plan to promote gender equality, diversity and social inclusion. The documents also address violence against women and children through its Community based Strategy for Prevention of Women and Children against HIV.

The first National AIDS Policy (2001), which has since been revised (2014), set the context for the first Multi-sectoral Strategic Frameworks I, II and III. The reviewed National AIDS Policy (2013) has incorporated new issues, which were not included in the 2001 Policy, which embrace: - different modes of sexual practices that contribute to HIV transmission such as heterosexual and concurrency partnerships, and the sharing of needles and syringes by people who inject drugs (PWID). Other Policy issues incorporated in it are risky practices related to concurrent multiple partnerships, early sexual debut, trans-generational sex and sexual exploitation and focusing on vulnerable populations such as prison inmates, orphans and vulnerable children including street children.

The Tanzania National Development Vision 2025 and National Strategy for Growth and Reduction of Poverty (NSGRP) or MKUKUTA in its Kiswahili acronym, contains specific targets for gender equality, elimination of HIV and gender based violence (GBV); and calls upon all Government Ministries, Agencies and Departments (MDAs) and other stakeholders including CSOs, CBOs, private sectors, international and development partners (DPs) to mainstream gender HIV and AIDS in their programmes. Others are the Third (NMSF; and its predecessors NMSF I 2003-2007, NMSF II 2008-2012 as well as the Third Health Sector HIV and AIDS Strategic Plans (HSHSP) III, and its previous versions of HSHSP I, and II National Guidelines for PMTCT, VCT, and CTC, National Guidelines for Voluntary Counselling and Testing 2005, National HIV and AIDS Advocacy and Communication Strategy 2013-2017, and the National Behaviour Change Communication Guidelines on HIV and AIDS Interventions, National Strategy for Scaling Up Male Circumcision for HIV Prevention 2010-2015, and National Guidelines for Management of Sexually Transmitted and Reproductive Tract Infections.

Both the NMSF III[8] and HSHSP III are implementing the global 90-90-90 strategy (2010) that includes increasing the number of HIV-positive individuals aware of their status to 90%, increasing to 90% the proportion of newly diagnosed individuals who are linked to care within three months, and increasing to 90% the proportion of HIV-diagnosed individuals whose virus are effectively suppressed. The 90-90-90 strategy is based on studies[9] that have revealed that ART, can preserve the health of PLHIV and also lower their risk of transmitting HIV to other people by reducing the amount of virus in the body. Therefore, by ensuring that everyone with HIV is aware of their infection and receiving the treatment they need, new infections can be reduced very dramatically. The 90-90-90 strategy and approach involves setting ambitious targets and accelerating the delivery of high-impact HIV prevention and treatment services, using innovation to expand services to better address HIV, focusing on the locations and populations with the highest HIV burden; it also addresses social and legal barriers and advances human rights and gender equality.

3.2 International Framework

Tanzania is party to several key international instruments on gender and human rights that are aimed at promoting gendered interventions of national responses to HIV. Key human rights international agreements signed and or ratified by Tanzania include the Universal Declaration of Human Rights (UDHR, 1948), the Covenant on Civil and Political Rights (ICCPR), International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, the Social and Cultural Rights (ICESCR), International Convention on the Rights of the Child (CRC, 1990), the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979), several International Labour Organization (ILO) Conventions, and commitments made in the Vienna Human Rights Declaration and Programme of Action (1994), the International Conference on Population and Development (ICPD, 1994), and the Programme for Action, the Copenhagen Declaration and the Beijing Platform for Action (1980).

Fundamental to all these human rights obligations is that of non-discrimination and equality. The UDHR (Article 2) states that 'everyone is entitled to all the rights and freedoms set forth in this Declaration without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'.

The United Nations General Assembly Special Session (UNGASS) on HIV and AIDS adopted a Declaration of Commitment on HIV/AIDS (2001), which reaffirmed its obligation to combat the epidemic. UN member states including Tanzania committed to develop strategies to promote and protect the human rights of PLHIV, eliminate gender inequalities, and review discriminatory policies and laws and address specific needs of most vulnerable populations. Core values related to these principles include the motivation for, and commitment to valuing human life, respecting the dignity of all people, respecting diversity and promoting the equality of all people without distinction of any kind, supporting community values that encourage respect for others and a willingness to work together to find solutions, in the spirit of compassion and mutual support, and addressing social and economic inequities and fostering social justice. Many of these same values also find expression in the Universal Declaration of Human Rights (The Declaration of the Paris AIDS Summit, 1994).

8 NMSF III specific impact-level results by 2017/18 are:- (a) the incidence of HIV in the general population is halved by 2018 from 0.32% (2012) to 0.16%; (b) a significant reduction in AIDS-related deaths among people living with HIV and AIDS from 74% (2011) to 80%; and (c) reduced stigma and discrimination among PLHIV from 31.9% (2012) to 40%.

9 See UNAIDS (2015). 90-90-90. http://www.unaids.org/en/resources/documents/2014/90-90-90.

In 2010, the UNAIDS launched an Agenda for Accelerated Country Actions for Women, Girls and Gender Equality and HIV and AIDS 2010-2014 (Operational plan for the UNAIDS action framework: (2010). In support of the UNAIDS Action Framework in response to the pressing need to address the persistent gender inequalities and human rights violations that make women and girls more vulnerable to HIV. The Agenda provides, among others, a set of strategic actions to support countries to foster social and gender transformation by addressing social norms and negative cultural practices that drive the AIDS epidemic, such as GBV and VAC. The UNAIDS Action Framework focuses on action in three main areas, namely: of strengthening strategic guidance and support to national partners to 'know their epidemic and response' in order to effectively meet the needs of women and girls; assisting countries to ensure that national HIV and development strategies, operational plans, monitoring and evaluation frameworks and associated budgets address the needs and rights of women and girls in the context of HIV; and advocacy, capacity strengthening and mobilization of resources to deliver a comprehensive set of measures to address the needs and rights of women and girls in the context of HIV. The Agenda also calls for increased accountability to gender equality interventions through gender responsive budgeting (GRB), which helps in prioritizing resources and monitoring programmes by tracking financial resources that are intended to address gender equality across budgets. The Agenda also recommends generating evidence to increase understanding of the specific needs of women and girls in the context of HIV to ensure their needs are prioritized and tailored to the national AIDS responses that protect and promote their human rights.

According to the Agenda education and information for young women and adolescent girls has the potential to lead to better health outcomes as it provides them with higher knowledge on HIV, sexual and reproductive health rights – as the longer a girl stays in school, the greater the chances that she will use modern contraception if she does have sex, and the lower her chances of giving birth as an adolescent. Education also has the potential to decrease women and girls exposure to GBV and to increase their chances of being employed and become financially secure and economically independent.

3.3 Regional Framework for Gender and HIV

Tanzania is party to the African Union Protocol on Human and Peoples Rights and the Rights of Women (Maputo Protocol, 2003) both of which call all African governments to review of discriminatory laws and amend them to accommodate the rights of women, and enforcement of legislative measures for women's rights in customary courts, to property, inheritance and access to productive resources including land, employment and credit. It is also party to the SADC[10] Gender Declaration and its Addendum on the Prevention and Eradication of Violence Against Women and Children to the Southern Africa (1997) and SADC Protocol, which provides for the need for HIV comprehensive testing, treatment and care for survivors of sexual offences in view of the danger of HIV transmission, emergency contraception, access to post-exposure prophylaxis, and social/psychological rehabilitation of perpetrators of gender-based violence.

10 Southern Africa Development Community (SDAC) has 14 member countries.

4.0 Review of the Gender Operational Plan 2010-2012

The overall objective of the review was to align the GOP 2010-2012 with the NMSF-III, 2013/14-2017/18 and HSHSP-III, 2013-2017 which are key national strategic instruments for HIV national response. NMSF III has adopted a new global 'Investment Framework' approach to AIDS (UNAIDS)[11] that is people centred and focuses on equity, evidence and efficiency by making smart decisions to produce results for people (UNAIDS, 2011). The NMSF III provides the national context for stakeholders[12] to work together in the national response to achieve the national impact-level results of elimination of new HIV infections, elimination of HIV-related deaths and eliminating HIV stigma and discrimination by 2030. Likewise the HSHSP III, which is designed to support universal access to preventative, care, treatment and support services, also aims to achieve the same impact results.

4.1 Emerging Issues from National Gender Assessment and Review of the Gop 2010-2012

Various issues have emerged in a course of doing Gender Assessment and most importantly the review of the GOP 2010-2012. The purpose of the processes all together sought to find out the status of gender mainstreaming in National HIV response. Below are some of the key issues, which significantly tell about the existing social situation but they can still be used as a touch base to explain significant factors regarding to outcomes of the outgone GOP 2010-2012. The issues will as well lay a ground for what the new GOP 2016-2018 attempts to emphasize.

i) Patriarchy and cultural norms and practices continue to breed gender inequality and GBV practices in Tanzania, which in turn fuel and increase prevalence and incidences of HIV infections and transmissions among women and girls note.

ii) GBV in the form of physical, sexual and psychological gender related violations and gender inequality including unequal access to opportunities for women's empowerment increase their vulnerability to HIV infection.

iii) The link between HIV and GBV in fuelling HIV infection for women and girls is made more apparent with regard to forced sexual intercourse through rape, in which women and girls are forced in sexual acts that make them vulnerable and at high risk for HIV infections. This includes marital rape and rape from partners which by law is not acknowledged as rape.

iv) GBV puts women, girls, and people with disabilities in compromising situations of fear and helplessness in which they cannot negotiate on the use of condoms (as prevention against HIV transmission and infection). The lack or limited of knowledge on legal procedures by GBV victims/ survivors or their families continue to prevail so that in most cases rapes and sexual assaults are settled out of court, letting most rapist go scot free.

v) Disparate sexual intercourse/relationships/marriage through early marriages continues to contribute to HIV infections and transmissions among disparate couples of older men and very young girls, sometimes below 14 years of age. Sexual relationships between older men/women and young girls/boys also promote early sexual debut among young persons, thus increasing their exposure to HIV infections and transmissions.

11 Investing for results - Results for people: A people-centered investment tool towards ending AIDS, UNAIDS Guide 2012

12 Government ministries, departments and agencies (MDAs); Local Government Authorities; CSOs, private sector, development partners, CBOs, FBOs, research and academic institutions, and local communities.

vi) A traditional practice in marriages between females of which 'Women marrying women' known as '*Nyumba Ntobhu*'[13] not mentioned or recognized in any national document may also have a considerable contribution on fueling the transmission of HIV.

vi) Inadequate laws and policies to address gender inequality; as well as inadequate law enforcement for addressing GBV cases using the Penal Code and SOSPA - are the most pressing issues that are related to the gender differentials within the national HIV response. Although most international and regional laws have been ratified, most policies and other frameworks on GBV and VAW such as the CEDAW are still not backed up by strong national laws and policies on GBV and gender equality.

vii) Emerging social factors and new civilizations result in new social factors and practices such as PWID, and OVC in the society which has brought in new outlooks on sexual behaviours and sexual orientations. Commercialization of sex, and the use of drugs through injections and sharing of needles have become the cause of increased HIV infections and transmission. These practices in the face of law are all illegal in Tanzania, hence making the groups of people with such practices not only at great risk of HIV infections and transmission, but also to be forced to operate secretly, which makes difficult for them to be identified and reached by the national HIV response – i.e. due to the illegality of such practices. In view of this therefore, these people are grouped as key to combating HIV transmissions and infections because they are more vulnerable and at high risk of HIV infections and transmissions.

viii) Key populations include people who inject drugs (PWIDs), female commercial sex workers (FSW, orphans and vulnerable children (OVC) including street children. Studies have found high rates of HIV infections among PWIDs (51%) and Dar es Salaam female sex workers at 31.4% (National HIV and AIDS Response Report: Tanzania Mainland 2012,2013) In this regard therefore, the Ministry of Health and Social Welfare and TACAIDS recognize that these groups very significant in the elimination of HIV.

ix) Increased migration of children and youth makes them vulnerable and puts them at great risk for HIV infections and transmissions. Household poverty and other factors at household level, deprive some children of parental support resulting in increased number of migrant and street children. The National Costed Plan of Action (NCPA) for Orphans and Vulnerable Children (OVC) notes that 5% (more than two million) of children in Tanzania are OVC. This population is considered to be vulnerable with poor or minimal access to care, protection, education, health care, nutrition and shelter[14]. The number of street and vulnerable children that require support has increased disproportionally to the possible national available support. HIV infections due to sex work among OVCs (for both girls and boys), increases through the vulnerability of living rough in the streets without proper care and support.

x) Despite the many initiatives being implemented to improve the economy in rural Tanzania, increased vulnerability and poverty continue to challenge the national response to the HIV epidemic due to youth migrations to the urban areas where in most cases they are then introduced to commercial sex; the girls to FSW[15].

13 *Nyumba Ntobhu* is a type of marriage that is contracted traditionally and is in force after the bride price is paid by a senior woman to marry another woman. The married woman is made available for sexual intercourse with men that the husband (i.e. senior woman) chooses for her/bride. This practice is very widely spread among the Kurias, even for those not residing in Tarime. The mere fact that the bride is made available to several men could be one major source of HIV infection and transmission. No study has been done; therefore the extent of impact has not been documented.

14 ibid

15 ibid

xi) Another area of concern for the national HIV response is the issue of working conditions of miners and fishermen, which also continue to fuel HIV infections and transmissions. There is great need for the national HIV response to address practices and behaviours that facilitate the spread of HIV in these sectors. Some miners and fishermen practice risky behaviours, substances and alcohol abuse and multiple sexual practices with female sex workers, other women from surrounding neighborhoods of such as women petty traders, food vendors known as *mama ntilie*, and fish vendors.

xii) Artists and 'stars' (e.g. musicians, actors, actresses, etc.) are also at great risk for HIV infection and transmission due to the nature of their work, which puts them in the risk of using drugs, engaging in multiple sexual partners, short marriages, etc., which need to be taken into consideration in the national HIV response. Being considered as role models, these artists and 'stars' also put their fans at great risk for HIV infection especially the youth who emulate these behaviours from them[16]; and the girls in particular, are at great risk from the male 'stars'.

4.2 Alignment the Gender Operation Plan to the NMSF III 2013/14-2017/18

NMSF III has adopted the Investment Framework as the global framework for addressing and eliminating HIV by 2030. In this regard, the NMSF III approach, which is also the global AIDS approach, focuses on: -

- Evidence-informed planning using selected priority interventions with high impact and targeting them to the locations and populations where they will make the most impact.
- Focusing on results which contribute to the attainment of desired national outcomes and investing in systems to monitor and evaluate achievements.
- Assessing the effectiveness and feasibility of interventions, focusing on the capacity and systems required for cost-effective, programme implementation and evaluation.
- Addressing the structural and behavioural aspects of the epidemic, situating evidenced-informed interventions in their proper context, while addressing key populations.
- Ensuring the sustainability of interventions, including financial, material and human resources, community ownership, organizational development, services availability, coverage and accountability.

Below are the NMSF III investment framework of five primary investment areas and six supporting areas of secondary investment, which the Gender Operational Plan 2015-2018 has adopted.

16 TACAIDS (March 2015) Validation Meeting of the Gender Assessment of the National HIV Response in Tanzania

4.2.1 NMSF III Primary Investment Areas

Comprehensive Antiretroviral Therapy (ART) Service Delivery - is considered the most important investment in the NMSF III, which involves among other things, scaling up, sustaining access to and retention in treatment, care and support interventions, along with investments in infrastructure, procurement and supply chain management, and continuous availability of ART for all PLHIV in the country.

HIV Counselling and Testing With Effective Linkages to Facility and Community-based services – centred on respect for human rights, informed consent, focusing on high disease burden areas, mobile, hard-to-reach populations, as well as KPs including discordant couples, sex workers, people who inject drugs, and others that are at highest risk.

Elimination of Mother to Child Transmission (eMTCT) including adoption and implementation of PMTCT Option B+ in the country, providing testing and counselling to all prospective mothers, and placing all HIV positive mothers on life saving ART.

Comprehensive sexuality, gender, and health education and services including investments in curricula and training for the provision of facility and community based interventions that deliver a comprehensive package of education and services relating to sexuality, gender, and health for the HIV national response.

Condom Provision and Programming in order to employ targeted and innovative strategies to increase the availability and access to male and female condoms and water-based lubricants, through both the private and public sectors.

4.2.2 NMSF III Supporting Areas of Secondary Investment

Voluntary medical male circumcision (VMMC) - is being expanded into geographic areas with low circumcision rates.

Provision of safe blood - requires quality assurance and effective screening of voluntary non-remunerated blood donors for 100% of the country's blood needs.

Treatment of sexually transmitted infections (STIs) - is being improved through the integration of STI services with other health services, with special attention to stigma-free services for key populations.

Targeted behaviour change communication (BCC) across the strategic programmes is designed to increase the demand for services, enhance knowledge, and lead to positive changes in risky behaviours at personal, community and national levels.

Community based care and support interventions - designed to improve referrals and linkages to services (e.g. health, social welfare, economic support, etc.) and addressing the stigmatization of PLHIV and KPs in communities –with a view to reduce the numbers of lost-to-follow-up (LTFU) clients and improve the overall social environment for PLHIV.

Mainstreaming of HIV interventions - in the routine activities of all sectors to ensure the demand for HIV services is created, the public is informed about the realities of the disease and its effective treatment; and that stigma and discrimination against PLHIV and KPs are addressed across all segments of society including workplace interventions in the public and private sectors.

The cross-cutting programmatic principles of NMSF IIII are integration[17], demand creation[18], human rights[19], gender[20]and programme strengthening[21].

4.2.3 The Investment Framework for HIV National Response

The NMSF-III Investment Framework for HIV has also been adopted by the Third Health Sector HIV and AIDS Strategic Plan (HSHSP III). Its objective is to facilitate a focused and strategic use of scarce resources by adopting a more strategic approach to investments, which offers a realistic and achievable road map to accelerate progress in the global HIV response. The Framework aims at maximizing the benefits of the HIV response, supporting more rational resource allocation based on country epidemiology and context, prioritizing and implementing the most effective programmatic activities, and to increase efficiency in HIV prevention, treatment, care and support programming. The Framework is based on *equity, evidence* and *efficiency; supported* by principles of *country ownership, community engagement, shared responsibility* and *global solidarity - grounded in the local epidemiological context*.

17 Integration in order to ensure segregation of duties and duplication of efforts is avoided. Examples of integrated programmes include integration of ART, PMTCT, and RCH clinics; and consolidation of trainings, supervision budgets, and human resources.

18 *Demand creation* so that all programme components are complemented by civil society efforts, public, private, and informal sectors in order to create demand for high quality services within the targeted communities.

19 *Human Rights* to ensure laws, policies, and education programmes safeguard the rights to health services, informed consent, and protection under the law, particularly for PLHIV and KPs.

20 *Gender as* a principle to ensure all programme activities address the disparities that result from gender discrimination and gender-based violence.

21 *Programme strengthening* in order to build the service platforms in the country by which HIV prevention, care, treatment, and multi-sectoral support services are performed.

To implement new Investment Framework approach, national governments are required to identify the key drivers of HIV; to focus on the relationship between the patterns, causes effects (epidemiology) of HIV infection, behaviours and social conditions that act as barriers in accessing and HIV information and services. The Framework requires clear understanding of the legal and socio-cultural environment, extent of stigma and discrimination, and prioritization of the national response by identifying, selecting and funding most appropriate and effective HIV prevention measures that are specific to epidemic situations and settings. Among the highest-priority interventions under the Investment Framework include: -

- Provision of ART to PLHIV and treating opportunistic infections;
- Treatment for prevention by providing ART for preventing HIV transmission among discordant couples;
- Provision of HIV prevention services for pregnant women and girls;
- Implementing behaviour change programmes, including condom promotion for the general population with special emphasis on people with multiple partners, those engaging in casual sex, and young people;
- Carrying out voluntary male circumcision in areas with high HIV prevalence and low rates of circumcision; and
- Focusing outreach on key populations such as people who use and inject drugs, sex workers and their clients, mobile and migrant workers such as long distance truck drivers, fishermen, miners, and construction workers.

In addition, the IF emphasizes behaviour change programmes for the general population to be combined with community dialogue, mass-media and information campaigns to bring about gender transformation i.e. change social/gender norms and individual behaviour – e.g. reducing the number of sexual partners, delaying sexual onset and using condoms, focusing on the geographical hotspots with high risk of HIV transmission; and to focus on KPs. Social enablers for behaviour change are conducting outreach for HIV testing, reducing stigma, advocating for human rights and community mobilization. Programme enablers include strategic planning, programme management and capacity-building for community based organizations (CBOs). Critical to achieving the new approach is strong national leadership and commitment to ensure investments made are integrated, and duplication is avoided[22]; to ensure resource allocation is equitably based and aligned to the social, cultural and epidemiological context; and that communities are the ones that guide the implementation, monitoring and accountability of the AIDS programmes. The new AIDS approach emphasizes community engagement for sustainability, advocacy and generating demand to ensure accountability for results; it also calls upon CSOs to play a central role as enablers.

22 The Investment Framework is aimed to reduce the vertical delivery of AIDS programmes by integrating them into health and community development systems in order to reduce costs and create a basis for sustainability. For example integrating ART with TB services; and integrating HIV into routine maternal and child health programmes, etc.

Another key strategic document to which the GOP is aligned to is HSHSP III, 2013/2017. While the vision of HSHSP III is guided by the vision of the NMSF III (2013/14-2017/18), its mission goals are guided by the National Health Policy and health sector priorities. The Vision of HSPHSP III is: *'An HIV free society where new infections are halted and those infected and affected by HIV and AIDS receive quality services';* and its mission is: - '*To lead and guide the health sector in the intensification, optimization and scaling up of quality HIV and AIDS prevention, care and treatment services to facilitate the attainment of the Three Zeros'.* HSHSP III is based on among others, the reviewed HSHSP II (2008-2012) and the Mid-term review (MTR). HSHSP III intends to achieve the similar impact like those of NMSF III within the new AIDS approach of Investment Framework approach, namely: - to achieve universal access to comprehensive HIV prevention, treatment, care and support services in order to significantly minimize the transmission of new HIV infections, reduce HIV-related mortality, stigma and discrimination, strengthen health system strengthening to support quality HIV interventions, and foster integration within the health sector. Just like with NMSF III, the HSHSP III investment areas for HIV interventions are those that have proved to be cost-effective for achieving results, which are: – HIV Testing and Counselling (HTC), Condom programming, Social and Behaviour Change Communication (SBCC), Sexually Transmitted Infections and Malignancies, Targeted Youth Services, Voluntary Medical male circumcision (VMMC), and Preventing Biomedical Transmission of HIV and blood born diseases. Interventions for HSHSP III result two are eMTCT and Keeping mothers alive, Early Infant Diagnosis of HIV, Paediatric HIV care and treatment, Decentralized and integrated HIV care and treatment services for adolescents and adults, and co-infections and co-morbidities[23] in PLHIV. Guiding principles of HSHSP III are equity, universal access, gender and rights based approach, decentralization; integration, public private partnership (PPP), meaningful involvement of PLHIV, accountability and sustainability.

23 In medicine, co-morbidity is the presence of one or more additional disorders (or diseases) co-occurring with a primary disease or disorder; or the effect of such additional disorders or diseases. The additional disorder may also be a behavioural or mental disorder.

5.0 Achievements and Challenges of the Gender Operational Plan 2010-2012

Some of the achievements gained and challenges experienced when the Gender Operational Plan 2010-2012 was in operation, have been obtained from the literature review, TACAIDS annual reports and evaluation report of NMSF II (2012) and Gender Assessment Report (2015) as outlined below:-

5.1 Achievements

Below are some of the achievements of Gender Operational Plan 2010-2012.

5.1.1 HIV Prevention

Many achievements have been made by the Government, which worked in collaboration with different stakeholders. Achievements have been particularly made in the following areas:-

- Scaling up of Prevention of Mother to Child Transmission
- Provision of integrated and comprehensive sexual and reproductive health services
- HIV Counseling and Testing
- Voluntary Medical Male Circumcision and Condom Distribution and Programming
- Implementing behavior change communication programs
- Safe blood transfusion and infection prevention and control in the hospital settings;
- Life skills education through peer education programs particularly for in-school and out-of-school youth, establishment and strengthening of youth friendly services (NRR, 2013)

Other main achievements in HIV prevention under the GOP 2010-2012 are: -

- Increased awareness of the link between HIV and GBV, which has been well mainstreamed in key national HIV frameworks (NMSF III, 2013 HSHSP III, 2013) of the Three Zeros aimed at eliminating HIV. This is in recognition of the need to address gender inequality and elimination of GBV through a multi-sector approach.
- Development of National Guidelines for Comprehensive Care Services for Prevention of Mother-to-Child Transmission of HIV and Keeping Mothers Alive in 2013, (MoHSW, 2013) under the Reproductive and Child Health Section and the NACP, in line with Options B and B+ of the United Nations Children's Fund (UNICEF) for eliminating new infections among children and keeping mothers living with HIV alive and well[24]. The Guidelines are aimed at promoting the delivery of quality HIV PMTCT prevention, care, treatment, and support services focusing on maternal, child and family health in the management of HIV and AIDS, tuberculosis (TB) and malaria.
- Increased percentage of pregnant women who tested for HIV and know their results from 29.6% (THMIS, 2007) to 42.7% for 15–19 age groups, (THMIS, 2012).
- Improvement in the health status of pregnant WLHIV and newly born children through improved PMTCT programme. In 2010 the PMTCT programme managed to provide ARVs to 70% of the estimated HIV positive pregnant women in the population. In 2013 there was 72.09% increase in a general reproductive and child health program offering PMTCT services, (NRR, 2013). This includes pregnant women who receive combined regimen (Prophylaxis)[25].

24 Option B and B+: Key considerations for countries to implement an equity-focused approach – 'Elimination New Infections among Children and Keeping Mothers Living with HIV Alive and Well'

25 ibid

- Increase in VMMC from 67% (2007-2008) to 72% (2011-2012) to reduce the risk of HIV acquisition (THMIS, 2012).

5.1.2 HIV Care, Treatment and Support

The main achievements in HIV care and treatment include:-

- Scaling up comprehensive care and treatment services in public and private facilities through facility based, community based and TB/HIV collaborative activities focusing on quality improvement.
- In 2013, enrolment of patients into care and treatment clinics increased to 1,366,402 from 1,135,390 in 2012, those on ART to 850,274 from 663,911 of which 512,555 were males, and females were 320,830, out of which 7.58% were children below 15years (NRR, 2013).
- Scaling up of community-based initiatives, including Mother Peer Support Groups, Male Involvement, and Follow-Up of Mother-Infant Pairs in the community to ensure timely delivery of dried blood sample (DBS) results to the mother and to provide outreach services.
- More support is given to initiatives related to couples counselling, GBV detection and care, and positive health and prevention (PHDP) activities are being supported; and scaling up of comprehensive services for PLHIV.
- Improved provision of ART to children; improvement in HBC services to ensure a continuum of care for HIV related services using a standard package of HBC services.
- Strengthening of referrals between the community and health facilities and improved information education and communication (IEC) materials, which were widely, disseminated thereby improving BCC and reduction of stigma.
- Introduction of collaborative TB/HIV services, and integration of HIV services in RCH to facilitate strong linkages between programs to ensure a continuum of care - within health facilities and from the health facility to the community, including the linkages of PMTCT, pediatrics care and HBC (HSHSP III, 2013).
- Increased involvement of women and girls living with HIV in HIV programming to enable them make decisions that address their concerns, and to fight stigma and discrimination.
- Promotion of women and girls human rights to education and economic opportunities to promote gender equality and women's reproductive rights.

5.1.3 Social and Impact Mitigation

HIV has a devastating economic impact not only at national level but this goes all the way to the family and individual levels. Mitigating the impact associated with HIV is very critical for the socio-economic development of the country. The Government of Tanzania in collaboration with other partners has embarked on financial arrangements to empower community members to access economic opportunities that would transform their financial positions and reduce the vulnerability to HIV in the context of poverty and also to improve access to HIV services including care and treatment services and nutrition. Financial arrangements available to support communities include micro financial institutions such as Savings and Credit Societies, Village Community Banks (VICOBA) which covers 19 regions in Tanzania Mainland, Women Development Fund and Tanzania Women's Bank. (NRR, 2013).

Other achievements in Social and impact mitigation are: -

- Increased gender awareness and sensitization that led to the reduction of gender related impediments[26], which in turn contributed to women and girls' improved social standing and economic empowerment.
- Establishment of women and girls empowerment programmes such as the women development fund (WDF), and AXIOS program of 'Comprehensive Community Based Palliative Care Program for HIV Positive Adults and Children in Lindi and Mtwara'[27] supported by USAID to improve the quality of life of adolescent girls and women living with HIV by providing training, referrals and counselling in order to help them overcome poverty, stigma and discrimination
- Support provided with various income generating programs was successfully promoted in 2013. A total of 8,707 individuals from group of OVC, elderly, widows/widowers, vulnerable households and other groups had benefited. (NRR, 2013)

5.1.4 Enabling Environment

- Promotion and development of national policies and guidelines in support gender equitable access to health services, gender equality in work opportunities, realization of gender equality in work place environment, protection against stigma and discriminatory practices, protection against VAW and GBV for women and girls[28].
- Increased political commitment and strong leadership resulting in the expansion of PMTCT, and introduction of Option B+ of Elimination of Mother to Child Transmission plan (e-MTCT) aimed at reducing vertical HIV transmission from 15% (2012) to below 5% in 2015, and to keep mothers alive through improved maternal, new born and child health and survival interventions by 2015. (NRR, 2013)
- Development of National Guidelines for Comprehensive Package of HIV Interventions for KPs to facilitate cost-effective comprehensive package delivery of quality health and social services to all KPs so as to significantly minimize HIV transmission reduce stigma and discrimination to achieve the Three Zeros of: Zero new HIV infections, Zero discrimination, and Zero AIDS-related deaths. (NRR, 2013)

5.2 Challenges

The sections below are going to address some of the main challenges and gaps in prevention based on implementation of the Gender Operational Plan 2010-2012.

5.2.1 Prevention

Major challenges and gaps in prevention that were encountered when the Gender Operational Plan 2010-2012 was in operation are: low knowledge and awareness of HIV, continuing gaps in PMTCT, HTC, blood transfusion, scaling up male circumcision, access to services by KPs, mainstreaming gender and HIV in various policies, programs and interventions.

26 such as lack of economic resources and poverty, limited access to HIV services, harmful traditional practices and gender norms of masculinity, femininity, patriarchy and female domination, stigma, discrimination and GBV

27 The AXIO Foundation (2014)Women and Girls Empowerment in Tanzania Camp 3T

28 TACAIDS (2015) Gender Assessment Validation Workshop

5.2.1.1 Comprehensive Knowledge of HIV

There is a huge difference between awareness of the epidemic and specific knowledge of how to prevent transmission and acquisition. Comprehensive knowledge and awareness of HIV prevention is low and has changed very little during recent years. According to THMIS 2011-12 (2013), 42% of adult women and 50% of men have comprehensive HIV knowledge. The figures are lower at 40% for young women and 47% for young men. Knowledge of HIV prevention methods is lowest among those who have never had sex; higher in the urban than rural areas; and lower among adolescents, especially females because of existing gender norms.

5.2.1.2 HIV Prevention of Mother to Child Transmission (PMTCT) Services

The (NMSF III, 2013), reports that in 2011, about 30% of all HIV positive pregnant women in need of ARV therapy to reduce the risk of mother to child transmission (MTCT) did not access PMTCT services. Moreover, about 44% of all children at risk of HIV infection from their mothers did not access ARV for PMTCT; and around 70% of health facilities did not provide Early Infant Diagnosis (EID) services; and 43% of HIV exposed infants did not receive any prophylaxis to prevent MTCT due to the long delays in specimen transport, testing and provision of results. It is worth mentioning that, PMTCT requires a reliable and consistent supply of high quality medications, HIV test kits, DBS kits, laboratory reagents, related medical and other supplies in order to effectively support service delivery.

5.2.1.3 HIV Testing and Counselling (HTC)

Some of the key challenges in the implementation of HTC services; includes low utilization of the HTC services especially in rural areas due to long distances; poverty and lack of transport, inadequate human resources; stigma and discrimination, gender inequalities and gender based violence; limited couple testing; and low disclosure of HIV test results to partners preventing efforts to make informed health decisions such as use of condoms.

5.2.1.4 Blood Transfusion

Transfusion of HIV contaminated blood is the surest way of transmitting HIV infection. An effective and well functioning National Blood Transfusion Service will ensure the regular availability of adequate Amounts of safe blood in all transfusing health facilities. (National Guideline for Management of HIV and AIDS, 2009). Gender stands as one of essential determinants of blood transfusion in HIV as it interact with sex in determining the probability of transfusion. Women and girls with pregnancy-related haemorrhage, anaemia or those who attend caesarean birth are among those who may highly need to benefit from blood transfusion services.[29] Unfortunately, according to NMSF III, (2013) only 35.7% of donated blood in Tanzania is screened according to universally accepted level and standards of the World Health Organization (WHO)**.** Due to the challenges raised by HIV pandemic, it may be true to raise an assumption that, women are likely to be at higher risk of HIV infection if there are no appropriate medical standards for blood transfusion[30].

29 www.jcafulltextonline.com/article, article by Shevde, K., "Gender is an essential determinant of blood transfusion in patients undergoing coronary artery bypass graft procedure. Presented in part at the Annual Meeting of the American Society of Anesthesiologist's, Orlando, FL, October 17–21, 1998.

30 http//.www. Science direct.com /science/artice/ the article by Fleming, A., entitled as "HIV and blood transfusion in sub-Saharan Africa" published in the Volume 18, Issue 2, June 1997, Pages 167–179.

5.2.1.5. Scaling up Male Circumcision

The target for scaling up VMMC was not met as planned by the National Strategy on Voluntary Medical Male Circumcision. Only 415, 398 (15 %) out of the targeted 2, 800,000 adult males in 12 priority regions (Rukwa, Mbeya, Iringa, Kagera, Mwanza, Tabora, Shinyanga, Njombe, Geita, Simiyu, Katavi and Mara region,) were circumcised by December, 2012.

5.2.1.6 Access to Services by Key Populations

According to the NMSF II Evaluation Report (2012), challenges faced by key populations include limited and or lack of access to services and interventions due to discrimination, stigma, and criminalization; limited or and lack of adequate data on key populations (except Dar es Salaam; limited coordination of implementers working with key populations; lack of a friendly environment and national strategies for interventions targeting key populations; programmatic gaps include not knowing the magnitude of key populations; and lack of and inadequate user friendly services for key populations and comprehensive services for effective interventions, which resulted in insufficient service coverage/utilization of HIV prevention and treatment for key populations.

5.2.1.7 Mainstreaming HIV Interventions

Challenges related to mainstreaming HIV interventions in workplaces include limited awareness and HIV interventions in the private and informal sectors compared to the public sector. The low level of awareness sometimes results in high level of stigma and discrimination to PLHIV, including health workers and school teachers in these sectors. Other challenges on mainstreaming HIV are: - limited skills and expertise to mainstream, limited information on the rights and services of PLHIV (prevention, care and treatment, mitigation and enabling environment).

5.2.2 HIV Care, Treatment and Support

Challenges under this thematic area included low enrolment in care and treatment, inadequate trained human resources in health care and inadequate home base care givers.

5.2.2.1 Enrolment in Care and Treatment

The target of 2010 national HIV response was to enrol 90% of PLHIV on ART of which 18% of the enrolled to be children by 2012. (NNR, 2013). According to the National Response Report on HIV and AIDS (NNR, 2013), a total of 512,555 (152,877 males, 320,830 females, and 38,848 children below 15 years) eligible HIV infected people were on ART treatment. Women accounted for 63% of all the people on care and treatment and children below 15 years accounted for 8%. Mbeya, Dar es Salaam, Iringa and Mwanza accounted for more than 50% of all the HIV infected people on ART. The low levels of enrolment are due to stigma and discrimination, weak referral and networking system and inadequate supervision and support to counsellors, and non-adherence to national HIC guidelines; limited or and lack of mechanism to track clients on ART at another facility resulting in the Loss to Follow-up (LTF); poor integration of HIV care and treatment with other general services of TB, RCH and Immunization; limited collaboration and coordination between facility and community activities and poor linkage of HBC, care and family treatment; and inadequate infrastructure and resources for ARVs.

5.2.2.2 Skilled Human Resources for Health

Staffing is another challenge that was experienced during the period of GOP 2010-2012. About 40% of the staff positions in health facilities are unfilled and the burden of HIV is stressing the already overburdened system (NRR, 2012).

5.2.3 Social and Economic Impact Mitigation

The main challenges and gaps under impact mitigation include inadequate support to community based support systems, limited provision of services to OVCs and not reaching out to PLHIV and their networks. Below are the summarised details of these challenges.

5.2.3.1 Support to Community Based Support Systems

Poverty and lack of well-developed national and community supporting systems are some of the barriers for PLHIV and OVC to access good quality HIV care and support services. Generally, community based care programs increase access to important interventions for PLHIV and those affected by HIV. Community programs that mobilize and create awareness against harmful practices and provision of community and home-based care services, facilitate linkage and referral to health facilities are not well recognized, supported or well-funded. Some of the community-based models (e.g. mobile care services, ARV refills, distribution, etc.) serve as a link by bridging the gap of distance and service provision between health facilities and households by providing clinical care services .NMSF II Evaluation Report (2012).

5.2.3.2 Services for PLHIV , Orphans and Vulnerable Children

Gaps in services for OVCs include limited support to community based programmes for HIV care and treatment. Community programmes are the ones that are able to mobilize support against negative gender norms and harmful traditional practices such as denial of property inheritance by women, gender based violence, violence against children, early marriages, wife inheritance and female genital mutilation, just to mention a view. Studies indicate that many community based programmes on HIV are not well recognized and receive very little financial support – i.e. in spite of the critical role they play in combating HIV. According to the NMSF II Evaluation II Report (2012), other challenges related to PLHIV and OVCs limited universal access to adequate and quality care and treatment services for PLHIV, Reproductive Health, TB/HIV, STIs and Opportunistic Infections (OI); limited capacity building of CSOs and community structures to facilitate the work of caregivers of different ages and gender groups; inadequate allocation of resources and poor coordination of activities undertaken by different stakeholders at regional and district levels as well as limited coordination among stakeholders working with elderly taking care of PLHIV. Low involvement of PLHIV in joint planning, reporting and monitoring forum at district level has also been a big challenge.

6.0 Priorities, Approaches and Guiding Principles of the GOP 2016-2018

The purpose of the Gender Operational Plan for the HIV Response in Tanzania Mainland is to guide HIV stakeholders at all levels in the provision of strategic interventions on HIV with focus on gender issues.

6.1 Approaches of the Gender Operational Plan

The following approaches will be applied in the implementation of this Operational Plan: -

a) Using the Operational Plan as a tool to guide coordination and supervision of gender sensitive HIV interventions in all sectors at all levels of society.
b) Integrating and implementing gender sensitive and a human rights based approaches as cross cutting issues within the NMSF III areas of investment.
c) Implementing activities contained in this Operational Plan through the existing structures.
d) Mainstreaming Gender, Human Rights and HIV issues into national and sub-national level plans, policies, strategies, budgets and training packages.

6.2 Guiding Principles

The following guiding principles govern the planning and implementation of the activities contained in this Gender Operational Plan for the HIV Response in Tanzania Mainland:

A: Upholding Human Rights and Ethics: This operational plan is aligned to global and regional commitments to human rights. Violations of human rights and ethical standards facilitate the spread of HIV and its negative impacts. The Operational Plan provides for structures, processes, policies and activities that uphold human rights, non-discrimination and participation. Stakeholders are held accountable and responsible for protecting and promoting the rights of women, men, girls and boys while recognizing their unique needs and levels of HIV risk and vulnerability.

B: Enhancing Universal Access: Limited access to HIV services and information facilitates the spread of HIV in communities. This operational plan facilitates the achievement of universal access to timely and high quality HIV services and information which meet the unique needs of women, men, girls and boys. The services are user-friendly, affordable, easily reachable and appropriate to reduce the spread and impact of HIV.

C: Strengthening Participation: Isolation of the most affected marginalized and/or at risk groups constrains the achievement of a gender sensitive national HIV response. This Gender Operational plan ensures social inclusion, equal participation and meaningful involvement of all groups of key stakeholders to contribute their experience and expertise in the national HIV response. These constituency groups include PLHIV, men and women prisoners, male and female drug users, male and female Sex Workers (SWs), girl and boy child labourers, OMVC, women employees in informal sector, women and child survivors of Sexual and Gender Based Violence SGBV, and women and men with disabilities and other marginalized groups.

D: Meaningful Involvement of PLHIV: It is critical to ensure that women, men, girls and boys who are living with or affected by the epidemic are in the forefront in participating meaningfully in making decisions and implementing activities of the GOP 2016-2018. Some actions and strategies in this plan fulfil the realization of the commitment to Greater Involvement of People Living with HIV (GIPA), which was agreed to by UN Member States at the Paris AIDS Summit in 1994 - as a critical principle to ethical and effective national responses to the epidemic.

E: Sustaining Partnerships: HIV cannot be effectively addressed without Government partnership with stakeholders from all sectors and disciplines. Therefore, this GOP 2016-2018 proposes strategies that build networks and working relationships among various government and non-government stakeholders such as development partners, PLHIV support organizations, human rights organizations, various MDAs and private sector. The diverse stakeholders pull in experiences, technical expertise and needed resources to address the spread and impact of HIV in a gender sensitive manner.

F: Supporting Bold and Committed Leadership: Realizing the aim of a gender sensitive national HIV response would be futile without a bold and committed leadership at all levels. This operational plan therefore commits to strengthen commitment of leaders through: Advocating with leaders so that they make gender central and address unique gender related needs in everything they do, convincing leaders to allocate adequate resources for gender sensitive interventions at all levels, Enhancing knowledge and skills of leaders to design and implement activities then make decisions which respond to unique needs and circumstances of women, men, girls and boys.

G: Engaging Men and Boys: Some harmful traditional roles and norms, at times, limit the meaningful engagement of men and boys in controlling the spread and mitigating impact of HIV in communities. This operational plan is committed to facilitate: Increased male involvement in HIV prevention and impact mitigation programs; more men seeking and accessing treatment, care and support services; Changing men's attitudes, practices and behaviour to eradicate harmful definitions of masculinity which increase HIV risk.

H: Applying Evidence in Decision-Making: The vision to plan and implement a gender sensitive national HIV response cannot be achieved without recognizing that HIV related needs of women, men, girls and boys are unique, different and context specific. This operational plan promotes the generation of strategic information on epidemiological, economic, social, cultural and political contexts together with the extent to which these influence the spread and impact of HIV among women, men, girls and boys. The strategic information is obtained in an ethical manner that does no harm to anyone and is applied in making decisions relating to programming, policy, resource allocation and learning.

I: Strengthening Institutional Capacity: It is critical that all institutions charged with responsibilities of ensuring a gender sensitive national HIV response have adequate knowledge, skills, systems, policies and resources. This operational plan therefore proposes activities to strengthen institutional capacity of key organizations involved in managing, coordinating and implementing gender sensitive HIV interventions.

7.0 Strategic Gender Issues, Results and Gender Strategies

This section contains updated strategic gender issues for women and girls, men and boys, expected results, and proposed strategies to address them according to the investment areas in line with the NMSF III. The duration of the Gender Operational Plan is three years 2016 – 2018 and will coincide with the ending period of NMSF III (2013/14-2017/18).

INVESTMENT AREA 1: ANTIRETROVIRAL THERAPY (ART)

Strategic gender issues for men and women, boys and girls

1.1 There is still a considerable number of women in need of HIV treatment that are not on treatment in rural and urban areas. Some of them face GBV at home and are forced to share drugs with their partners who do not go for treatment.

1.2 Adolescents and young people (particularly females) and KPs are among those with special challenges to access treatment: The challenges include stigma, discrimination and lack of support to remain on treatment.

1.3 More women than men are on ART mainly because women visit health facilities more than men for RCH services and therefore are promptly diagnosed and placed on ART.

1.4 Some women and men who take care for PLHIV patients do not have adequate knowledge and skills for protecting themselves from HIV infection.

1.5 Both women and men face challenges when diagnosed HIV positive on disclosure of their status. However, women are more vulnerable to psychological and physical violence than men.

1.6 Lack of transparency among couples on HIV status can result in PLHIV not being free to use ARVs openly.

1.7 The misuse of ARVs among couples/partners can result into ineffectiveness of ARVs. (E.g. when a partner who has not disclosed his/her status or uses the dose prescribed to his/her partner).

Results

R1: Equitable access for women, men, girls and boys as well as key populations living with HIV to a continuum of care, treatment and support increased.

R2: Morbidity and mortality among women and men, girls and boys as well as KPs due to gender HIV related factors reduced

R3: HBC service provision and resource mobilization strengthened, women and girls' burden of care for PLHIV reduced.

R4: Number of men caring for PLHIV increased.

Strategies

S1: Enhance gender sensitive and friendly HIV treatment and care which promote uptake particularly by males, young people and KPs.

S2: Promote greater enrolment of HIV positive men and women, boys and girls as well as KPs for HIV care and treatment services.

S3: Improve capacity of women and men including the elderly women and men who provide HBC services at community and household settings.

S4: Increase awareness on the importance of couple/partners to disclose their HIV status to each other, consistent use of ARVs and regular HIV testing

S5: Promote greater involvement of men and young people in planning and providing HBC services.

Gender Sensitive Indicators to Measure Performance and Desired Results	Data Source
General Population Desired Result and Target: By 2017, 95% of ART eligible adults (15+) and 80% of ART eligible Children (below15) receiving ART. **Indicator:** Percentage of adults and children currently receiving ART among all adults and children living with HIV.	CTC Database Spectrum
Pregnant Women Desired Result and Target: 100% of all estimated HIV-infected pregnant women receiving ART by 2018. **Indicator:** Percentage of HIV positive pregnant women who receive ARVs to reduce risk of eMTCT and keeping mothers alive	THMIS Census Projections HMIS CTC Database
KPs Desired Result and Target: KPs (sex workers, PWIDs) identified and reached for ART services.	Programme M&E

INVESTMENT AREA 2: HIV TESTING AND COUNSELLING

Strategic Gender Issues for Men and Women, Boys and Girls

1.1 There is a lower HTC coverage for men and boys compared to women and girls, coupled with men's and boys' reluctance to undertake HTC. 47% of men compared to 62% of women in Tanzania have tested for HIV and received their result.

1.2 HTC is significantly lower for KPs and adolescents compared to the overall population and adults due to challenges such as disclosure, stigma and discrimination, and lack of KPs, adolescent- and youth-friendly HTC.

Result

R5: Available HTC services improved and the number of men, adolescent, youth- and KPs-friendly HTC centers in urban and rural areas increased.

Strategy

S6: Strengthen and build capacity for quality HTC service provision which catalyzes HTC uptake by men, young people and KPs.

Gender Sensitive Indicators to Measure Performance and Desired Results	Data Source
General Population Desired Result and Target: By 2018: at least 38.7% of women (15-49) and 33.8% of men (15-49) report having been tested for HIV and received their result within the last 12 months (an increase from for women from 30.5% for men from 26.7%).	THMIS
80% of all women attending at least one ANC visit are tested for HIV and receive their results (55% TDHS).	TDHS
Service Provision Desired Result: 5,469,026 people tested annually. **Indicators:** Percentage of women and men (15-49) who received an HIV test in the past 12 months and know their results. Percentage of KPs who have tested for HIV in the last 12 months and who know their results. Proportion of health facilities providing quality HTC services according to national standards	HMIS

INVESTMENT AREA 3: ELIMINATION OF MOTHER TO CHILD TRANSMISSION (eMTCT)

Strategic Gender Issues

Strategic Gender Issues for Women and Girls

Due to fear of stigma and discrimination by community members, some women do not attend clinic and access eMTCT services so as not to disclose their HIV status.

Inadequate quality health services especially for women during child delivery in rural areas.

Inadequate numbers of professional and trained traditional midwives, limited accessibility of basic health supplies like gloves cotton, antiseptic and milk formula for infants born by Women Living with HIV (WLHIV).

Due to poverty many women are not able to buy milk formula for their infants and hence depend on exclusive breastfeeding

Strategic Gender Issues for Men and Boys

There is inadequate understanding and appreciation of the importance of participating in eMTCT among some men, coupled with their low involvement in Reproductive and Child Health (RCH) services.

Result

R6: Friendly RCH services to enhance women and men involvement in eMTCT strengthened.

Strategies

S7: Advocate and sensitize communities to reduce eMTCT related stigma and improve eMTCT friendly services.

S8: Strengthen the capacity of health service providers on new eMTCT and RCHC strategies

S9: Strengthen friendliness and quality of eMTCT services to catalyse increased uptake for women and men.

Gender Sensitive Indicators to Measure Performance and Desired Results	Data source
Pregnant Women: By 2018, 100% of all HIV positive, pregnant women receive ARVs to prevent transmission (up from 77% in 2012).	Cross reference ART indicator for pregnant women above
Infants and Children: Percentage of infants born to HIV –positive women receiving a virological test for HIV within 2 months of birth.	CTC Database (HEI card) HMIS THMIS
Infants and Children: 90% of all HIV exposed children are tested for HIV by the age of two months (4-8 weeks old) and receive their results within 4 weeks, by 2018.	

INVESTMENT AREA 4: COMPREHENSIVE SEXUALITY, GENDER & HEALTH EDUCATION, GENDER EQUALITY AND REDUCTION OF GBV

Strategic Gender Issues

Strategic Gender issues for Women and Girls.

1.1 Some women have suffered sexual abuse and rape which can expose them to HIV infection.

1.2 Early sexual debut or early marriage exposes young women to a particularly high risk of HIV infection since their biological features are not fully developed.

1.3 Young women at times remain ignorant about sexual matters as this is often viewed as a sign of purity and innocence appreciated culturally in certain parts of Tanzania.

1.4 Lack of life skills based HIV and sexuality education among primary and secondary schools girls contribute to early pregnancy and high risk of HIV infection.

1.5 Women may be aware of HIV risk reduction measures but often lack power and negotiation skills to protect themselves.

1.6 Patriarchy and male dominance cause unequal power-relations which makes women socially and economically dependent on males.

1.7 Young girls engaged in cross-generational sexual relationships motivated by money, gifts, prestige or fashion often involve lack of negotiation power to negotiate safe sex.

1.8 Some existing customary norms, morals and practices prevent women and young girls from discussing sexuality and hence shy away from open communication about sex and sexuality.

1.9 Traditional practices like female genital mutilation, early marriages, widow inheritance, widow cleansing, rape, dry sex, wife sharing and practices to manage infertility increase the risk and vulnerability of women to HIV infection.

Strategic Gender Issues for Men and Boys

1.10 Some men take advantage of their physical strength and sexual decision making authority to coerce women into sex. Violence and male domination tends to make women unable to negotiate safe sex or leave the dangerous relationships they have with these men.

1.11 Most men in rural areas often have lower HIV knowledge as compared to their urban counterparts.

1.12 Some men who pay for or provide favors in exchange for sex but do not practice safer sex place themselves and their sex partners at higher risk of HIV infections.

1.13 Men who migrate from home for extended periods of time for employment and business trips may be tempted to casual sex which predisposes them and their partners to high risk of HIV infection.

1.14 In some cultures men share wives or male relatives are compelled to marry the widows of deceased male relatives, which places them and their partners at higher risk of HIV infection.

1.15 Cases of rape and sexual abuse of boys are also increasingly coming to light. Some have suffered rape, sexual abuse and molestation.

1.16 Beliefs in masculinity and some normative values on raising of boys propagate widespread acceptance of multiple sexual partnering, casual sexual relationships, condoning of violence, substance abuse, risk-taking, aggression and disregard for or non-commitment to sexual safety to prove manhood.

1.17 For older men, society does not discourage trans-generation sex, which puts older men and their sexual partners at risk of HIV infection.

Results

R7: Schools that provide life skills based HIV and comprehensive sexuality education for girls and boys increased

R8: Number of KPs[1] identified and provided with comprehensive sexuality, gender and health education increased.

R9: GBV and harmful cultural practices decreased; gender sensitive attitudes and behavior increased.

Strategies

S10: Facilitate the promotion and development of life skills and CSE among girls and boys on Sexual and Reproductive Health Rights (SRHR).

S11: Enhance the capacity of traditional, religious and opinion leaders on gender, to advocate against the harmful cultural beliefs, and to encourage gender sensitive attitudes and behavior.

S12: Promote open discussions, increased knowledge and awareness on gender issues and GBV that increase vulnerability to HIV

S14: Integrate interventions to address and respond to violence against women including access to emergency contraception, PEP and other interventions.

Gender Sensitive Indicators to Measure Performance and Desired Results	Data sources
CSE (Comprehensive Sexuality Education) Desired Results **Indicators:** • Percentage of schools that provided life skills based HIV and sexuality education within the previous academic year. • Number of teachers trained in LSE for HIV • Number of learners exposed to life skills-based HIV education **General Adult Population (15-49) Desired Results and Target:** Comprehensive HIV knowledge increased to 64% from 42.2% for women and 72% from 50.3% for men by 2018. **Indicators:** • Percentage of adults (15-49) with comprehensive HIV knowledge	EMIS BEST TOMSHA THMIS
Gender Based Violence: Desired results: Reduction of physical or sexual violence from male intimate partners from 40.7% to 20% by 2018 **Indicators:** • Number of reported cases of GBV by most vulnerable groups (women, men, girls and boys). • Number of people completing an intervention pertaining to gender norms that meets minimum criteria. (Disaggregated by age and sex) **GBV:** Decrease in percentage of men and women (aged 15-49) who agree that a husband is justified hitting or beating his wife for specific reasons, from 38% and 54% respectively (TDHS, 2010) to 30% and 46% respectively by 2018.	TDHS TOMSHA/ GBV DATA COLLECTION TOOL TDHS

INVESTMENT AREA 5: CONDOM PROVISION PROGRAMMING

Strategic Gender Issues for Women and Girls

1.1 Women have inadequate capacity to negotiate condom use: therefore during sexual intercourse they are often unable to either control or insist on proper and consistent use of condom.

1.2 Female condoms are less promoted; as a result very few women use them for HIV infection protection.

1.3 Female condoms are rarely readily available, relatively expensive and cumbersome to use, which causes the uptake of female condom to be low.

Strategic Gender Issues for Men and Boys

1.4 Some men reject the condom arguing it reduces the pleasure of sex.

1.5 Other men and their sexual partners may view use of condom as a sign of promiscuity.

Result

R10: Access to and use of male and female condoms promoted and expanded to all age groups engaged in sex.

Strategies

S15: Expand among men, women and MSM access to quality condom as a dual HIV protection method.

S16: Promote acceptability of usage of men and women condoms as a dual HIV protection method.

Gender Sensitive Indicators to Measure Performance and Desired Results	Data sources
General Adult Population (15-49): Desired Results and Target By 2018, 55% of both men and women, rural and urban, who engage in multiple sexual partnerships, report condom use at last their sexual intercourse i.e. increased from (in 2012) 34% for women and men to 40.4% (NMSF III, 2013-2018). **Indicators:** • Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse. • The percentage of young people aged 15-49 who had higher-risk sex in the preceding year and who used a condom on the last occasion of higher-risk sex • Number of male and female condoms distributed to end users in the last 12 months.	THMIS/ TOMSHA

Gender Sensitive Indicators to Measure Performance and Desired Results	Data sources
KP: Desired Results and Target, • By 2018, 80% of high risk groups (SW, MSM, and PWID) report condom use at last sexual intercourse. **Indicators:** • Percentage of KPs who reported using a condom during their last high risk sexual encounter.	THMIS/ Programme M&E
KP: PWID and SW tracked with unique identifiers for services in prioritized areas/ regions. • Number of KPs by category tracked with unique identifiers as defined by national KPs guideline	
KP: Desired Results and Target, • By 2018, 80% of high risk groups (SW, MSM, and PWID) report condom use at last sexual intercourse. **Indicators:** • Percentage of members of KPs who reported using a condom during their last high risk sexual encounter.	

INVESTMENT AREA 6: VOLUNTARY MEDICAL MALE CIRCUMCISION

Strategic Gender Issues for Men and Boys

- Circumcision of men has a protective effect against the spread of HIV/STI, 70% of men in Tanzania have been circumcised. The level is higher in urban areas (94%) compared to 64.2% in the rural areas. In some areas with high HIV prevalence is as low as 28% (NMSF III, 2013-2018).
- Appropriate information on the prevention benefits of male circumcision has not yet reached most of the Tanzanian community
- Some traditional ways of male circumcision are done by shared equipment increasing the risk of HIV infection

Result

R11: Safe circumcision of men and boys promoted and HIV/ STI infection reduced.

Strategy

S17: Promote social-acceptability of male circumcision as an HIV protection method and increase the coverage and use of VMMC services in Tanzania.

S18: Promote medical male circumcision to reduce HIV and STI infections.

Gender Sensitive Indicators to Measure Performance and Desired Results	Data sources
Adult Men (15-49), Desired Results and Target: 80% of men (15-49) in 12 prioritized regions with high HIV prevalence and low VMMC rates have access to VMMC services. **Indicator;** • Number of male circumcision surgeries performed according to national standards during the last 12 months. • Percentage of men 15-49 that are circumcised	HMIS/THMIS

INVESTMENT AREA 7: PROVISION OF SAFE BLOOD	
Strategic Gender Issues for Men and Boys, Women and Girls • Only 35.7% of donated blood in the country is screened according to universally accepted level and standards of the WHO. • Blood that has not been screened for HIV puts the recipient at the risk of HIV infection **Result** **R12:** Risk of HIV transmission among men, boys, women and girls through blood contaminated with HIV reduced. **Strategies** **S19:** Increase the availability of effectively screened donated blood by supporting and orienting the community to create blood donor club that combine HIV prevention and blood donation promotion activities by district.	
Gender Sensitive Indicators to Measure Performance and Desired Results	**Data sources**
TNBTS and its National Blood Supply Networks: Desired Results and Target; 100% of all donated blood is effectively screened for HIV, hepatitis B, hepatitis C, and syphilis as per WHO quality assurance procedures. Indicators: • Number of blood donor club that combine HIV prevention and blood donation promotion activities by district. • Percentage of donated blood units screened for HIV in a quality-assured manner	**TNBTS**

INVESTMENT AREA 8: SEXUALLY TRANSMITTED INFECTIONS

Strategic Gender Issues for Men and Women, Girls and Boys

1.1 STI infection among women can be without symptoms, hence may not be detected early by individuals themselves and health workers; thereby exposing them to risk of STI infection.

1.2 Some women, girls and KPs do not get tested or seek STI treatment due to unawareness or fear of stigma and judgment.

1.3 Boys and Girls below 18 years may also not get tested and treated due to age of consent.

Result

R13: Quality, gender responsive and age-appropriate integrated SRHR and HIV services to women and girls, men and boys as well as KPs including counseling and testing promoted.

Strategies

S20: Strengthen gender sensitive and age appropriate integrated SRHR and HIV services in health facilities and implementation of testing without parental consent for mature individuals below 18 years.

S21: Coordinate with other health programmes for the national strategy on Life Skills Education (LSE) to ensure effective dissemination of HIV and STI information.

S22: Promote use of vaginal and oral interventions (microbicide) to control the epidemic, STIs and undesired pregnancies.

S23: Promote facility based STI and targeted outreach services that are user friendly for (women), youth and key population groups.

Gender Sensitive Indicators to Measure Performance and Desired Results	Data sources
Gender Adult Population (15-49) Desired Results: STI infection rate reduced by 50% (from 7% to 3.5% of men and women) by 2018 and at least 75% of men and women (15-49) are accessing STI services. **Indicator:** • Percent of men and women reporting symptoms of STIs in the last 12 months who sought care at a service provider with personnel trained in STI care, of all respondents in a population-based or targeted survey aged 15-49.	THMIS HMIS
Health Facilities Desired Results and Target: All Regional Referral Hospitals and District Hospitals providing friendly health services to women, girls and KPs by 2018. **Indicator:** % of Regional Referral Hospitals and District Hospital providing friendly health services. % of health staff capacitated to provide women, girls and KPs health friendly services.	HMIS

INVESTMENT AREA 9: BEHAVIOUR CHANGE COMMUNICATION

Strategic Gender Issues for Women and Girls

1.1 Violence tends to make women unable to negotiate safer sex or leave the dangerous relationships they have with men.

1.2 Some women, young house maids, girls with disabilities, as well as orphans live at risk of sexual abuse and rape which can expose them to HIV infection.

1.3 Sextortion has been frequently cited among females seeking employment

1.4 Stigma and discrimination facing WLHIV discourages them from accessing health services.

1.5 Some widowed WLHIV have been stigmatized and blamed for their husband's death leading to property dis-inheritance with loss of social security.

1.6 The rights of some WLHIV have been violated through forced inheritance and cleansing rituals.

Strategic Gender Issues for Men and Boys

1.7 Some men who pay for or provide favours for sex but do not practice safer sex place themselves and put their sex partners at higher risk of HIV.

1.8 Men who travel away from home for extended periods of time for employment and business trips may be tempted to casual sex which predisposes them and partners to a high risk of HIV.

1.9 Inadequate knowledge and skills on sex and sexuality behaviours predisposes them to HIV infection.

1.10 Some traditional practices such as dowry paying, gender based distribution of domestic works, may create among boys attitude to degrade the status of women hence prepare boys to become sexually violent against women.

1.11 For older men, the society does not discourage trans-generation sex, placing older men and their sexual partners at high risk of HIV infection.

Strategic Gender Issues Among KPs

1.12 KPs particularly the younger ones, are especially vulnerable to HIV, multifaceted stigma and discrimination, and violence.

Results

R13: HIV prevention efforts for women and girls through the protection and promotion of human rights and gender equality strengthened.

R14: The risk of HIV infection among the most vulnerable women, men, girls and boys due GBV, gender inequality and harmful socio-cultural practices reduced.

R15: Human rights particularly of women, girls and key populations promoted.

R16: The social well-being of women, men, girls and boys living with or directly affected by HIV improved.

Gender Sensitive Indicators to Measure Performance and Desired Results	Data sources
General Adult Population (15-49): Adults (15-49) reporting non-stigmatizing responses increased from 24.7% (2012) of women to 50% (2018) and from 39.9% of men (2012) to 65% (2018). **Indicator:** Percentage of adults (15-49) reporting non-stigmatizing responses.	THMIS
Youth(15-24) Desired Results and Target: Comprehensive knowledge about HIV and source of condoms increased from 40.3% to 60% among women and from 47.3% to 67% among men by 2018 **Indicator:** Percentage of Youth (15-24) with comprehensive knowledge about HIV and Condom use.	THMIS, TDHS
KPs: Stigma against KPs reduced	PLWHIV Stigma Index

INVESTMENT AREA 10: COMMUNITY BASED CARE AND SUPPORT INTERVENTIONS	
Strategic Gender Issues for Women and Girls 1.1 Some women especially in the rural areas care for PLHIV patients without adequate knowledge, skills and supplies for protecting service providers from HIV infection. 1.2 In some places, elderly women care for PLHIV relatives but without appropriate knowledge on prevention, hence they stand at a higher risk of HIV infection. 1.3 Experience reveal that the burden to raise and care for the OMVCs fall under elderly women, yet due to social economic hardship the OMVCs are forced to work for their basic needs. 1.4 There is a limited recognition and underestimation of the heavy HBC work load borne by women and girls in communities and households. **Strategic Gender Issues for Men and Boys** 1.5 Low involvement of men in providing care for PLHIV patients, which leads to disproportionate burden of care placed upon women and girls. **Result** **R18:** HBC service provision and resource mobilization strengthened and women and girls burden of care reduced. **R19:** Increased number of men caring for PLHIV **Strategies** **S27:** Improve capacity of women and men including the elderly women and men who provide HBC services at community and household settings. **S28:** Promote greater involvement of men in planning and providing HBC services. *Orphans and Most Vulnerable Girls and Boys*	

Strategic Issues for Girls and Boys 1.6 Girls and boys from disadvantaged homes often drop out of school to look after sick relatives, to work and earn income or food, or due to lack of school fees or girls married to men who take care of them. 1.7 Some OMVC (girls and boys) are subjected to child abuse, child labour and or trafficking from rural to urban areas to work as maids or gardeners **Result** **R20:** Multisectoral, gender sensitive community based support and service delivery for OMVC girls and boys enhanced. **Strategy** **S29:** Strengthen capacity of families and communities to recognize and provide psycho-social support and child care for OMVC girls and boys. **S30:** Advocate for sustainable and direct support for the care givers and OMVCs from available social support mechanisms	
Gender Sensitive Indicators to measure Performance and desired results	**Data sources**
Home Based Care Desired Result and Target: By 2018, 80% of LGAs to be allocating funds from own source for HBC services **Indicator:** % of LGAs allocating funds from own source, % of initiated social support mechanisms	C C H P report

INVESTMENT AREA 11: MAINSTREAMING HIV INTERVENTIONS

Mainstreaming gender and human rights into national HIV related laws, policies, plans, planning tools, training packages and institutional structures

Strategic Gender Issues

1.1 There is inadequate inclusion of gender dimensions in HIV related laws, policies, plans, planning tools, training packages and institutional structures of Government MDAs, LGAs, CSOs and Private sector programs. There are also conflicts between different ages of consent resulting in difficulties for the AIDS response. E.g. marriage at 14 years, but age of consent to test on HIV 18 years

1.2 SRHR services and HIV services are not fully linked and integrated. Therefore clients get inadequate services for male and female condoms, referrals for PEP, treatment of HIV co-infections and contraceptives.

1.3 Existing laws, legislation and policies do not address adequately issues of GBV and HIV

Results

R21: An enabling environment (laws, policies, plans, etc.) that addresses the needs of women, men, boys and girls in the implementation of the National Response to HIV improved.

R22: Policy and decision makers' commitment, transparency, accountability and support for HIV interventions using human rights and gender sensitive approaches enhanced.

R23: Women and girls have universal access to integrated multisectoral services for HIV, Tuberculosis (TB), and SRHR and harm reduction, including services addressing GBV

R24: HIV and GBV related issues predominantly recognized as human right issues that are accommodated by National laws and policies

R25: Community understanding of HIV and GBV as human right issues scaled up.

Strategies

S31: Ensure that all HIV related laws and policies are gender sensitive, aligned to each other, and conform to human rights principles and approaches.

S32: Ensure all HIV related programs are gender sensitive during planning, implementation and M&E phases and adhere to human rights principles.

S33: Ensure all key institutional structures respond to gender and HIV mainstreaming.

Resources for Mainstreaming Gender and HIV

Strategic Gender Issues

1.4 Budgets and efforts to address gender equality are rarely tracked in ways that make accountability for interventions easy.

Result

R26: Adequate resources for gender equality and human rights mainstreaming into HIV interventions mobilized, and specific budget lines created or maintained for gender issues in the national HIV response in all relevant government budgets at different levels; related implementation and monitoring and evaluation.

Capacity Strengthening for Gender and HIV

Strategic Gender Issues

1.5 There is inadequate awareness and knowledge among policy makers, decision makers, authorities, service providers and communities on the linkages between gender and HIV and their varying effect on women, men, girls and boys, and KPs.

1.6 There is inadequate translation and implementation of national, regional and international commitments, policies, laws and strategies into scaled up action to address the rights and needs of women, men, girls and boys as well as KPs.

Strategies

S34: Advocate for resource mobilization by MDAs, LGAs, CSOs, FBOs, Private Sector and DPs for mainstreaming gender in HIV interventions

S35: Build the capacity of key authorities and service providers such as police and health workers to mainstream gender and HIV issues at their work.

Results

R27: Institutional and human capacity of key authorities and service providers to deliver gender sensitive HIV related services strengthened.

R28: The proportion of public and private sectors, formal and informal sector operators developing and implementing gender sensitive HIV workplace interventions targeting women, men, girls and boys in an equitable manner increased.

Gender Sensitive Indicators to Measure Performance and Desired Results	Data sources
MDAs, LGAs & Private Sector: Percentage of public and private enterprise with HIV work place policies and programmes - 80% public and 60% private	Workplace surveys

7.1 Gender Sensitive Activities of the GOP 2016-2018

The Gender Operational Plan gender sensitive HIV activities are aligned to the NMSF III Investment Framework, which is also the new global approach to combating HIV. The approach is evidence based, informed planning and focuses on selected priority investment areas and targeted locations/populations with high impact potential. It also focuses on community ownership, services availability and accountability among others. It is results based and integrates services in order to avoid duplications to ensure cost-effectiveness to ensure sustainability of interventions. Therefore, some activities of the Operational Plan have been merged or integrated for the same purpose with a view to make them cost effective and sustainable in terms of financial, material and human resources.

Key: *HH = Household levels, W = Ward. V = Village level, HF = Health Facility level, W k= Workplace, D = District level, R = Regional level, N = National level, I = International level, N = New, O = Ongoing*

ACTIVITY	LEVEL	FAST TRACK AREAS	RESPONSIBLE	TIME FRAME	STATUS
INVESTMENT AREA 1: ANTI RETROVIRAL THERAPY (ART)					
R1: Equitable Access for Women and Men, Girls and Boys as well as KPs Living with HIV to Continuum Care, Treatment and Support Increased. **R2: Morbidity and Mortality Among Women and Men, Girls and Boys as Well as KPs due to Gender HIV Related Factors Reduced**					
S1: Enhance Gender Sensitivity and Friendliness of HIV Care and Treatment Services to Increase Uptake Particularly by Males, Young People and KPs					
1. Facilitate open dialogue sessions with PLHIV representatives/networks and health facility staff on client feedback on the human rights, gender sensitivity and friendliness of care and treatment services	HF, N	National	NACP, HF, HCWs, PLHIV Networks, TACAIDS	2016-2018	N
2. Develop SOPs to guide provision of socially acceptable male friendly quality care and treatment services	N	National	NACP, HFs, TACAIDS	2016-2018	N
3. Conduct workshop to orient HCPs on SOPs for socially acceptable male, KPs and adolescent/ youth friendly HIV care and treatment services	R, N	National	NACP, TACAIDS, HFs	2016-2018	N
S2: Promote Greater Enrolment of HIV Positive Men and Women, Boys and Girls as Well as KPs for HIV Care and Treatment Services					
4. Establish networks of male, youth and KPs champions to advocate for increased enrolment of men, young people and KPs in care and treatment	D	Selected districts	TACAIDS, LGAs, CSOs	2016-2018	O
5. Orient male, youth and KPs champion TOTs to advocate for increased number of men, young people and KPs enrolment in HIV care and treatment services	D	Selected districts	CMACs, CSOs, WMACs, VMACs	2016-2018	N

R3: HBC Service Provision and Resource Mobilization Strengthened and Women and Girl Burden of Care for PLHIV Reduced. **R4: Number of Men Caring for PLHIV Increased.**					
S3: Improve Capacity of Women and Men Including the Elderly Women and Men to Provide HBC Services at Community and Household Settings					
6. Carry out capacity and training needs assessment of men and women involved in HBC provision	R	Selected areas	NACP, CSOs	2016-2018	O
7. Review and update national training manuals for HBC to address capacity gaps and training needs of male and female HBC service providers	N	National	NACP, TACAIDS, CSOs	2016-2018	N
8. Conduct sensitization meetings for communities and LGAs to solicit funding mechanisms for remunerating HBC providers	V	Selected districts	PLHIV Networks, HF, LGAs, TACAIDS	2016-2018	N
9. Conduct policy dialogue sessions with private sector institutions, CSOs and communities to provide and advocate for budget allocations for adequate gloves, detergents, swabs and other supplies for use by HBC providers	N	National	NACP, TACAIDS, DSW, MOFEA	2016-2018	O
S4: Increase Awareness on the Importance of Couple/Partners to Disclose their HIV Status to Each Other, Consistent Use of ARVs and Regular HIV Testing					
10. Organise community dialogue sessions to increase understanding and awareness on the importance of couples/partners to disclose their HIV status to each other, consistent use of ARVs and regular HIV testing	V, N	National	TACAIDS, MOHSW, WMACs, VMACs ,	2016-2018	O
11. Train community health care providers to follow-up on PLHIV on adherence and compliance to ARVs through quarterly meetings at ward level	V, W, D	National	WEOs, VEOs, HCPs, CDOs	2016-2018	O
S5: Promote Greater Involvement of Men and Young People in Planning and Provision of HBC Services					
12. Organize FGDs to strengthen knowledge and skills of national HBC TOTs and District HBC Coordinators on HBC workload and the need for male and female – adults and young people - participation within households and communities.	N	National	NACP, CSOs	2016-2018	N

INVESTMENT AREA 2: HIV TESTING AND COUNSELLING					
R5: Available HTC Services Improved and the Number of Men, Adolescent-, Youth- and KP-friendly HTC Centers in Urban and Rural Areas Increased					
S6: Strengthen and Build Capacity for Quality HTC Services Provision which Catalyzes HTC Uptake by Men, Young People and KPs.					
13. Conduct research to determine factors that lower enrolment of men, young people and KPs in HTC and propose actions to address them.	R	Selected districts	NACP, TACAIDS, MoHCDGEC, NBS	2016-2018	N
14. Work with men and boys, women and girls as well as KPs to develop and operationalize strategies that address negative social norms around gender and sexual relationships affecting HTC update	N	National	TACAIDS, NACP, CSOs	2016-2018	N
15. Update the National VCT training curriculum and Policy using the developed SOPs to provide socially acceptable, gender sensitive and age-appropriate HTC services	N	National	TACAIDS, NACP, NBS	2016-2018	O
16. Conduct workshop to orient staff on the developed SOPs on socially acceptable, gender sensitive and age-appropriate HTC services	N	Selected districts	TACAIDS, NACP, NBS	2016-2018	O
17. Develop and air radio and TV spots to campaign for increased enrolment of men and young people in HTC	N	National	TACAIDS, NACP, Media Companies	2016-2018	O
INVESTMENT AREA 3: ELIMINATION OF MOTHER TO CHILD TRANSMISSION					
R6: Friendly RCH Services to Enhance Women and Men Involvement in eMTCT Strengthened					
S7: Advocate and Sensitize Communities to Reduce eMTCT Stigma and Improve Friendliness of eMTCT Services					
18. Conduct community dialogue sessions to address stigma and advocate for eMTCT	N	National	VMAC, CHAC	2016-2018	O
19. Develop and air radio and TV spots to campaign for increased participation of women and men in eMTCT services and address negative beliefs and attitudes	V	Selected districts	TACAIDS, NACP, Mass Media Companies	2016-2018	O
20. Develop and distribute fliers and posters for increased participation of women and men in eMTCT services and address negative beliefs and attitudes	N		TACAIDS, MoHCDGEC, NACP,	2016-2018	N

S8: Strengthen the Capacity of Health Service Providers on New eMTCT and RCHC Strategies					
21. Develop SOPs to guide provision of socially acceptable women and men friendly RCH services	R	Selected districts	NACP, TACAIDS, MoHCDGEC	2016-2018	N
22. Orient health service providers on new SOPs guideline	R	Selected districts	NACP, TACAIDS, MoHCDGEC	2016-2018	N
S9: Strengthen Friendliness and Quality of eMTCT Services to Catalyse Increased Uptake for Women and Men					
23. Organise open dialogue sessions between WLHIV and health facility workers on human rights and friendliness of eMTCT services	HF	Selected districts	HF in charge, Health care workers, P/WLHIV, CSOs	2016-2018	N

INVESTMENT AREA 4: COMPREHENSIVE SEXUALITY, GENDER & HEALTH EDUCATION, GENDER EQUALITY AND REDUCTION OF GBV					
R7: Schools that Provide Life Skills Based HIV and Comprehensive Sexuality Education for Girls and Boys Increased **R8: Number of KPs[2] Identified and Provided with Comprehensive Sexuality, Gender and Health Education Increased.** **R9: GBV and Harmful Cultural Practices Decreased; Gender Sensitive Attitudes and Behaviour Increased.**					
S10: Facilitate the Promotion and Development of Life Skills and CSE Among Girls and Boys on Sexual and Reproductive Health Rights (SRHR)					
24. Conduct youth friendly Focus Group Discussion (FGDs) in and out of schools to identify gender related SRHR issues that facilitate HIV infection among girls and boys in and out of schools	R	Selected districts	MOEST, Institute of Curriculum Development, TACAIDS, MOHCDGEC, NBS	2016-2018	N
25. Review and include identified gender related SRHR issues in the Life Skills Training Package for in and out of schools youth	N	National	MOEST, Institute of Curriculum Development, TACAIDS, MOHCDGEC, NBS	2016-2018	O
26. Design and launch mass media national campaigns to reach parents, in and out of school youth and the general public with messages about comprehensive sexuality education and gender equality	N	National	MOEST, TACAIDS, MOHCDGEC	2016-2018	0
27. Identify and training KPs to provide education on life skills and SRHR	N	National	MOEST, TACAIDS, MOHCDGEC/ MUHAS, AMREF, CSOs	2016-2018	N
28. Adopt available needs assessment based findings to strategize and plan for GBV, HTPs and gender issues related to HIV advocacy and capacity building activities among community, traditional and religious leaders	N	National	TACAIDS, MOHCDGEC, CHACs	2016-2018	N
29. Develop advocacy training package for training community, traditional and religious leaders as change agents on advocating against GBV, HTP and for gender issues related to HIV	N	National	TACAIDS, MOHCDGEC, CHACs, CSOs Training Institutions,	2016-2018	N

S11: Enhance the capacity of traditional, religious and opinion leaders on gender, to advocate against the harmful cultural beliefs, and to encourage gender sensitive attitudes and behavior.					
30. Train community, traditional and religious leaders as change agents to advocate against GBV, HTPs and for HIV gender related issues	D	Selected districts	CHACs, Peer Educators, Mass Media Companies	2016-2018	N
31. Conduct community awareness sessions to identify socially acceptable alternatives to negative aspects of traditional initiations e.g. '*unyago*', '*jando*' as well as rituals of widow inheritance or and cleansing, wife sharing and FGM 'kitchen parties'	D	National	TACAIDS, MOHCDGEC, religious, community & traditional leaders, CHACs, Peer Educators	2016-2018	N
32. Train community groups on how to design advocacy messages about comprehensive sexuality education and gender	N	National	TACAIDS, MOHCDGEC, CSOs, religious, community & traditional leaders, CHACs, Peer Educators	2016-2018	N
33. Support community groups to carry out community led advocacy activities on comprehensive sexuality education and gender	D	National	TACAIDS, MOHCDGEC, CSOs, CHACs, Peer Educators	2016-2018	N
S12: Promote open discussions, increased knowledge and awareness on gender issues and GBV that increase vulnerability to HIV					
34. Develop gender, GBV and HIV information kit to facilitate community discussions on gender issues, GBV and HIV	N	National	TACAIDS	2016-2018	N
35. Identify and training community ambassador on gender issues and GBV that increase vulnerability to HIV	N	Selected District	TACAIDS, MoHCDGEC, CSOs	2016-2018	N
36. Organise community dialogue to address social cultural norms which influence the increase of GBV hence vulnerability to HIV	N	Selected District	TACAIDS, MoHCDGEC, CSOs	2016-2018	N

S13: Integrate interventions to address and respond to violence against men and women, boys and girls including access to emergency contraception, PEP and other interventions.					
37. Establish mechanism to link GBV survivors with facilities for emergency and continuous access to services.	R		TACAIDS, MoHCDGEC, CSOs	2016-2018	O
38. Promote establishment of one stop centre for GBV survivors at health centres.	R		TACAIDS, MoHCDGEC, CSOs	2016-2018	O
INVESTMENT AREA 5: CONDOM PROVISION PROGRAMMING					
R10: Access to, and Usage of Male and Female Condoms Promoted and Expanded for All Age Groups Engaged in Sex,					
S14: Expand among men and women access to quality condom as a dual HIV protection method.					
39. Undertake a study on quality and usage of male and female condoms	N	National	NBS, MOHCDGEC, TACAIDS, SMG, TBS	2016-2018	O
40. Establish Multisectoral National Condom Technical Working Group (TWG) and link it to the Prevention Technical Working Committee to advocate for condom programming, access and usage	N	National	TACAIDS, MOHCDGEC, NBS, SMG	2016-2018	N
41. Identify and deploy community condom distributors in homes, workplaces, recreational joints including bars, hotels, lodges/guest houses, sports grounds, beaches, long distance trucks transit areas, fishing and mining communities, border crossing areas	HF, N	National	MOHCDGEC, HF	2016-2018	O
S15: Promote acceptability of usage of men and women condoms as a dual HIV protection method.					
42. Organise community dialogue sessions to address socio-cultural barriers to women and men, girls and boys using condoms as a dual protection method	N	National	VMAC, CSOs	2016-2018	O

INVESTMENT AREA 6: VOLUNTARY MEDICAL MALE CIRCUMCISION					
R11: Safe Circumcision of Men and Boys Promoted and HIV and STI Infections Reduced					
S16: Promote Social-acceptability of Male Circumcision as an HIV and STI Protection Method and Increase the Coverage and Use of VMMC Services in Tanzania					
43. Organise community dialogue to address socio-cultural barriers to male circumcision	V	Selected districts	VMACs, HFs, CSOs	2016-2018	O
44. Organise awareness raising and social mobilization campaign to promote acceptability of medical male circumcision as a means for HIV and STI prevention	N	Selected Region	TACAIDS, NACP, CSOs	2016-2018	O
INVESTMENT AREA 7: PROVISION OF SAFE BLOOD					
R12: Risk of HIV Transmission Among Men and Boys, Women and Girls Through Contaminated Instruments Reduced					
S17: Increase the Availability of Effectively Screened Donate Blood by Supporting and Orienting the Community to Create Blood Donor Club that Combine HIV Prevention and Blood Donation Promotion Activities by District.					
45. Establish community based blood donor club that promote education on HIV prevention and blood donation	N	National	MOHCDGEC, TACAIDS MOEST,	2016-2018	O
INVESTMENT AREA 8: SEXUALLY TRANSMITTED INFECTIONS					
R13: Quality, Gender Responsive and Age-Appropriate Integrated SRHR and HIV Services to Women and Girls, and Some KPs Including HCT and Promotion of Female and Male Condoms at Health Facilities and Work Places Expanded.					
S18: Strengthen Gender Sensitive and Age Appropriate Integrated SRHR and HIV Services at Health Facilities and Implementation of Testing Without Parental Consent for Mature Individuals Below 18 Years.					
46. Train health workers to provide gender sensitive and age appropriate SRH services, including testing without parental consent for mature individuals below 18 years.	HF	Selected districts	NACP, PLHIV networks, MOHCDGEC, TACAIDS, MCDGC	2016-2018	N
S19: Coordinate with Other Health Programmes for the National Strategy on Life Skills Education (LSE) to Ensure effective Dissemination of HIV and STI Information.					
47. Organise awareness session for women and girls on prevention and treatment of HIV and STI as well as provision of Life Skills Education	V, N	Selected areas	NACP, PLHIV networks, MOHCDGEC, TACAIDS,	2016-2018	N

S20: Promote Use of Vaginal and Oral Interventions (microbicide) to Control the Epidemic, STIs and Undesired Pregnancies					
48. Organise community dialogue sessions to create awareness and promote the use of vaginal and oral interventions (microbicides) to control HIV, other STIs and undesired pregnancies.	V, N	Selected areas	NACP, PLHIV networks, MOHCDGEC, TACAIDS,	2016-2018	N
S21: Promote facility based STI and targeted Outreach Services that are User Friendly for Men, Women, Youth and KPs Groups					
49. Facilitate provision of mobile microbicide services to reach out to the difficult to reach women, youth and KPs groups.	V, N	Selected districts	NACP, PLHIV networks, MOHCDGEC, TACAIDS, AMREF	2016-2018	
INVESTMENT AREA 9: BEHAVIOUR CHANGE COMMUNICATION					
R14: HIV Prevention Efforts for Women and Girls Through the Protection and Promotion of Human Rights and Gender Equality Strengthened. **R15: The Risk of HIV Infection Among the Most Vulnerable Women, Wen, Girls and Boys due GBV, Gender Inequality and Harmful Socio-Cultural Practices Reduced.** **R16: Human Rights Particularly of Women, Girls and Key Populations Promoted** **R17: The Social Well-Being of Women, Men, Girls and Boys Living with or Directly Affected by HIV Improved.**					
S22: Increase Discussions on Behavioural Change Communication on Gender Issues and to Reduce GBV, Stigma and Discrimination, and Harmful Traditional Practices that Increase Vulnerability to HIV.					
50. Conduct Training of Trainers (TOT) workshop for Council Multisectoral AIDS Committee (CMACs) and District GBV Focal persons on GBV, stigma, discrimination and HTPs that increase vulnerability to HIV	N	National	TACAIDS, CSOs	2016-2018	O
51. Conduct orientation workshop on gender issues, GBV, stigma and discrimination and HTPs that increase vulnerability to HIV among Ward Multisectoral AIDS Committee (WMACs), Village Multisectoral AIDS Committee (VMACs) and GBV representatives in zones, wards and village	D	Selected districts	Trained TOTs (CMACs, DGBV-FP)	2016-2018	O
52. Conduct awareness dialogue sessions to opinion leaders, religious, government and traditional leaders from selected villages on the linkage between gender issues, GBV, stigma and discrimination, HTPs and increased risk of HIV.	V	Selected districts	CMACs, Village Neighbourhood Watch clubs	2016-2018	N
53. Undertake a scoping study to identify gender related factors that facilitate HIV in the formal and informal workplaces within the country at border crossing areas	N	National	POPSM, ABCT, TACAIDS, MOHCDGEC, SADC, EAC	2016-2018	N

S23: Collect, Analyse and Disseminate Data on GBV.					
54. Include in THMIS national assessment data on GBV and related practices that increase vulnerability to HIV (establish GBV national data collection, analysis and reporting systems)	N	National	TACAIDS, MOHCDGEC, WHO, CSOs, NBS	2016-2018	O
S24: Integrate Behaviour Change into Interventions which Seek to Address GBV in National HIV Response.					
55. Develop Standard Operational Procedure to integrate SRHR and HIV programs to address and respond to GBV within HIV services including access to emergency contraception and PEP	N	National	MOHCDGEC, TACAIDS, PMO-RALG	2016-2018	
56. Establish Districts Networks, and build the capacity of gender based Service Providers (such as police gender desk, lawyers and paralegals, medical practitioners, CSOs, community and religious) on various gender issues including handling of GBV cases.	D	Selected districts	TOTs, District GBV&HIV Focal Persons	2016-2018	O
57. Open up a free telephone hotline service to monitor and document and to link GBV survivors with their District DNVSPs to receive free services of emergency contraception and PEP	N	National	TACAIDS, MOHCDGEC, MOHA/Police Dept,	2016-2018	N

INVESTMENT AREA 10: COMMUNITY BASED CARE AND SUPPORT					
R18: HBC Service Provision and Resource Mobilization Strengthened and Women and Girls Burden of Care Reduced. **R19: Increased Number of Men Caring for PLHIV** **R20: Multisectoral, Gender Sensitive Community Based Support and Service Delivery for OMVC Girls and Boys Enhanced.**					
S25: Improve Capacity of Women and Men Including the Elderly Women and Men who Provide HBC Services at Community and Household Settings.					
58. Undertake capacity and training needs assessment of men and women HBC providers	R	Selected districts	NACP, CSOs, LGAs	2016-2018	O
59. Review and update national training manuals for HBC to address capacity gaps and training needs of HBC service providers	N	National	NACP, TACAIDS, CSOs	2016-2018	N
60. Orient national TOTs using updated HBC training manuals	N	National	NACP	2016-2018	N
61. Mentor HBC service providers using updated training manuals	N	Selected districts	DMO, HBC Coordinator, ToTs	2016-2018	N

62. Organise sensitization and community dialogue meetings with communities and LGAs to solicit funds and to advocate for budget allocations for gloves, detergents and supplies required by HBC providers	N	National & Selected districts	NACP, TACAIDS, DSW, MOFEA	2016-2018	O
S26: Promote Greater Involvement of Men in Planning and Providing HBC Services					
63. Organise FGDs to sensitize HBC TOTs and national District HBC Coordinators on the workload of women and men caring for PLHIV to promote increased male participation in HBC within households and communities		National & Selected districts	National HBC, CSOs, MOHCDGEC	2016-2018	N
S27: Strengthen Capacity of Families and Communities to Recognize and Provide Psycho-social Support and Child care for OMVC Girls and Boys.					
64. Review existing community structures to support families of affected PLHIV and/ or OMVC and adopt a reorganized gender sensitive support structure	N	National	DSW, MOEST, MOHCDGEC, TACAIDS	2016-2018	N
65. Advocate for districts councils to allocate budget to support poor families taking care of home bound PLHIV and OMVC,	N	National	CSOs, PLHIV networks, MOFEA, DSW, MOHCDGEC	2016-2018	N
66. Advocate for cash transfers to motivate '*mama mkubwa*' and families caring for OMVC	V	Selected districts	DSW, VMAC,	2016-2018	N
S28: Advocate for Sustainable and Direct Support for the Care Givers and OMVCs from Available Social Support Mechanisms					
67. Organize meetings with financing groups like village community banks, commercial banks, TASAF, SACCOS, SATF, RFE, Cooperatives to give priority and ring fence quotas for self-initiated IGA groups of PLHIV, OMVC or their families.	V	Selected districts	Selected areas	2016-2018	N
68. Advocate for grants availability to implement social protection framework and avail micro-finance services to mitigate the impact of HIV on caregivers and women, men, girls and boys living with HIV.	N	National	TACAIDS, MOHCDGEC	2016-2018	O
69. Organize meetings with LGAs, FBOs, CBOs, NGOs and social support groups to support families of PLHIV and/or OMVC who are directly affected by HIV.	V	Selected districts	DSW, VMAC	2016-2018	N

INVESTMENT AREA 11: MAINSTREAMING HIV INTERVENTIONS

R21: An enabling environment (laws, policies, plans, etc.) that addresses the needs of women, men, boys and girls in the implementation of the National Response to HIV improved.
R22: Policy and decision makers' commitment, transparency, accountability and support for HIV interventions using human rights and gender sensitive approaches enhanced.
R23: Women and girls have universal access to integrated multisectoral services for HIV, Tuberculosis (TB), and SRHR and harm reduction, including services addressing GBV
R24: HIV and GBV related issues predominantly recognized as human right issues that are accommodated by National lows and policies
R25: Community understanding of HIV and GBV as human right issues scaled up.
R26: Adequate resources for gender equality and human rights mainstreaming into HIV interventions mobilized, and specific budget lines created or maintained for gender issues in the national HIV response in all relevant government budgets at different levels; related implementation and monitoring and evaluation.
R27: Institutional and human capacity of key authorities and service providers to deliver gender sensitive HIV services strengthened.
R28: The proportion of public and private sectors, formal and informal sector operators developing and implementing gender sensitive HIV workplace interventions targeting women, men, girls and boys in an equitable manner increased.

S29: Ensure that all HIV related laws and policies are gender sensitive, aligned to each other and conform to human rights principles and approaches.

70. Convene national stakeholder's meeting to discuss HIV related laws, policies and strategies in the context of gender and human rights	N	National	TACAIDS, MOHCDGEC, MOJCA, Networks of PLHIV and KPs	2016-2018	
71. Review and update key legal, policy and strategic documents on HIV[3] for gender sensitivity and human rights, stigma and discrimination for PLHIV.	N	National	Legal Reform Commission, TACAIDS, NACP. MOHCDGEC, PMOs	2016-2018	O
72. Organize policy dialogue to present results of the reviewed legal, policy and strategic documents and develop recommendations to make them gender sensitive	N	National	TACAIDS, NACP, MOHCDGEC, PMOs, MOJCA, Law Reform Commission	2016-2018	O
73. Organize social mobilisation to raise awareness and engage communities to demand on gender mainstreaming in national response to HIV through mass events such as World AIDS day and Women's International Day	N	National	TACAIDS, NACOPHA, PLHIV networks, TAWLA, Human Rights Organisations , Women Groups, MOHCDGEC	2016-2018	O

S30: Ensure all HIV related programs are gender sensitive during planning, implementation and M&E phases and adhere to human rights principles.					
74. Review gaps and recommend specific actions to make MKUKUTA / NSGRP, and plans of MDAs for planning and budgeting for Councils and Sectors gender sensitive.	N	National & Selected districts	TACAIDS, MOHCDGEC, PMORALG, POPSM	2016-2018	O
75. Update MDAs plans and tools to make them gender sensitive based on the recommended actions	N	National & Selected districts	MOEVT, TACAIDS, MOHCDGEC	2016-2018	N
76. Orient service providers from selected MDAs on updated plans and planning Tools	N	National & Selected districts	TACAIDS, NACP, MOHCDGEC, Regions, Sectors, Councils	2016-2018	O
S31: Ensure all key institutional structures respond to gender and HIV mainstreaming.					
77. Review gaps and recommend specific actions to make the HIV related training packages for HIV health service providers, health workers, judiciary, police, teachers MDA staff, universities and parliamentarians gender sensitive and human rights centred	N	National	TACAIDS, MOHCDGEC, MoEST, PMORALG, POPSM	2016-2018	N
78. Update national in-service and pre-service training packages to make them gender sensitive based on the recommended actions	N	National	TACAIDS, MOHCDGEC, MoEST, PMORALG, POPSM	2016-2018	N
79. Review, monitor and evaluate gender-sensitive adolescent and youth friendly curricula, with the participation of adolescents and young people	N	National	MOEST, TACAIDS, MOHCDGEC	2016-2018	N
80. Orient service providers on updated training modules	N	Selected districts	TACAIDS, MOHCDGEC, MoEST, PMORALG, POPSM	2016-2018	N
81. Convene bi annual gender and HIV national stakeholder's meeting to discuss gender related issues in HIV response	N	National	TACAIDS, MoHCDGEC, MoEST, PMORALG, CSOs, FBOs	2016-2018	N

S32: Advocate for resource mobilization by MDAs, LGAs, CSOs, FBOs, Private Sector and DPs for mainstreaming gender in HIV interventions					
82. Develop TORs and establish a National Technical Committee to coordinate implementation, monitoring and evaluation of the activities of the Gender Operational Plan for HIV Response in Tanzania Mainland (2016-2018)	N	National	TACAIDS, NACP, MOHCDGEC, PMO, PMORALG, NBS, Gender Macro Group	2016-2018	N
S33: Build the capacity of key authorities and service providers such as police and health workers to mainstream gender and HIV issues at their work.					
83. Organize a national stakeholders' conference to mobilize budgets for mainstreaming gender in HIV related interventions in compliance with national regional and international commitments and to ensure gender specific budgeting.	N	National & selected districts	TACAIDS, MOHCDGEC, NACP, MOFEA, PMORALG	2016-2018	N
84. Disseminate the Gender Operational Plan to key stakeholders including the Regional Coordinators (RCT), MDAs, Councils, CSOs and FBOs Umbrella organizations, Development Partners and Private Sector	N	National	TACAIDS, NACP, MOHCDGEC	2016-2018	N
85. Conduct training on adaptation of GOP 2016-2018 in mainstreaming gender and HIV into the programs and interventions of key stakeholders including HCPs, police, judiciary, traditional practitioners/healers, CSOs and FBOs, HIV Focal Points, Parliamentary Committees, policy makers, planners	N	National, Districts	TACAIDS, MOHCDGEC	2016-2018	N

8.0 The Management and Institution Framework for Implementing the GOP 2016-2018

The management and institutional framework for implementing this Operational Plan is aligned to the existing structures of the national HIV response. The Operational Plan provides a well-coordinated, effective, transparent, accountable, sustainable leadership and management structure based on 'Three Ones' principles at central, regional and LGA levels to deliver a national HIV response which involves public, private and CSO stakeholders. The implementation of activities contained within this Operational Plan is coordinated by TACAIDS in collaboration with different structures at various levels from development partners, national, regional, council, community and health facility levels.

8.1 The National Level

At the national level the President Office is the main oversight structure for HIV response coordinated by TACAIDS. In line with its mandate, TACAIDS works hand in hand with MoHCDGEC and President Office, Regional Administration and Local Government (PMO-RALG) and other stakeholders to undertake the following roles during implementation of this Operational Plan:

A. Coordination, planning, mobilizing resources, M&E, reporting and sharing information on implementation of activities contained in this Operational Plan.
B. Strengthening linkages and harmonizing roles of gender focal persons and HIV focal persons by ensuring that functions are implemented in a synergistic manner.
C. Deploying and managing technical support at regional and other sub-national levels.
D. Commissioning and disseminating research findings related to Gender and HIV response.
E. Monitoring and overseeing implementation of gender sensitive HIV interventions.

Gender Responsive and sensitive HIV strategies and activities of this Operational Plan are coordinated by the respective TACAIDS Directorates include: National Response, Advocacy and Information, Finance and Resource Mobilization, Policy and Planning, and Monitoring and Evaluation. Since gender is a cross cutting issue, the Gender Technical Working Group, which is the sub-committee of Enabling Environment Thematic Technical Working Group oversee and report on the management, implementation and progress of implementing of this Operational Plan for the HIV Response in Tanzania Mainland.

8. 2 The Development Partners at National Level

The development partners and related Development Partners Group (DPG) on AIDS, and the Joint United Nations Programme on HIV including its 11 Cosponsors[31] act as partners providing additional human, financial, material and technical contributions towards the implementation of the activities contained in this Operational Plan as part of the national HIV response.

8.3 MDAs at Central Level

MDAs at their central levels will be responsible for strengthening implementation of gendered HIV activities within their sectors through: -

A. Ensuring that gender responsive and sensitive HIV activities contained within this plan are included and implemented through their sector plans and budgets as part of internal and external mainstreaming of both gender and HIV.

31 http://www.unaids.org/en/aboutunaids/unaidscosponsors.

B. Reviewing, strengthening and harmonizing roles and functions of gender and of HIV technical committees and teams within the sectors to avoid duplication of efforts and enhance synergy.
C. Mobilizing financial, technical and material support for gender sensitive HIV intervention.
D. The MoHCDGEC and its programs and structures provide specialized skills and technical oversight, capacity strengthening, research, surveys and surveillance on medical aspects of gender sensitive HIV issues.
E. The MoHCDGEC and its programs and structures provide specialized skills and technical oversight and capacity strengthening on gender issues.
F. Institutions of higher learning, provide technical assistance to stakeholders in implementing activities contained in this GOP for the HIV Response in Tanzania Mainland.

8.4 Regional Administrative Secretariats

Regional Administrative Secretariats (RASs) are critical in coordinating implementation of activities in this Operational Plan at regional and LGA levels. The RASs responsibilities in implementing this Operational Plan include:

A. Coordination of gender sensitive HIV interventions.
B. Advising district stakeholders on gender and HIV issues.
C. Sharing information on sound gender sensitive HIV practices across districts.
D. Ensuring that relevant gender sensitive HIV activities are included in Council Comprehensive Health Plans (CCHPs).
E. Disseminate guidelines and policies to use in planning and implementing gender sensitive HIV interventions.
F. To oversee M&E on implementation of gender sensitive HIV interventions by districts.

8.5 Local Government Authorities

District Executive Directors work with the respective gender and HIV coordination structures at their levels to coordinate and oversee planning and implementation of gender sensitive HIV interventions within their jurisdiction. HIV coordinating structures under LGAs like Village Multisectoral AIDS Committees (VMACs), Ward Multisectoral AIDS Committees (WMACs), and Council Multisectoral AIDS Committees (CMACs) coordinate and lead gender sensitive HIV interventions within their respective areas.

8.6 Civil Society Organisations

In implementing gender sensitive HIV interventions contained in this plan, the CSOs are coordinated and provided with technical support by their respective umbrella organizations as well as the Government coordinating units at all levels. PLHIV support groups and networks among the CSOs play a particular role in monitoring and advocating for gender related HIV human rights and policy issues.

8.7 The Private Sector

In support of implementing activities in this plan, the private sector under coordination of the Association of Tanzania Employers (ATE) continues to:

- Avail resources for treatment and care activities,
- Provide gender and HIV related information and technical experts and Open up communication channels to support monitoring,
- Information sharing for gender related HIV issues.

The informal sector also works closely with the Ministry of labour to implement activities contained in this Operational Plan.

9.0 Monitoring and Evaluation of the Implementation of the Operational Plan

The activities contained in this Operational Plan are monitored, evaluated and reported within the framework of the Tanzania National Multisectoral HIV M&E System (HIV-MES). M&E aligns with HIV-MES goal which is to use relevant and comprehensive evidence provided in a timely manner in HIV-related planning and decision-making.' M&E activities for the gender and HIV interventions are organized around the twelve components of the effective national M&E system as follows: -

9.1. The monitoring and evaluation of activities are coordinated by TACAIDS Directorate for M&E. M&E activities at sectors, sub-national and service delivery levels are undertaken by stakeholders at all levels as agreed upon by TACAIDS and the M&E TWG.

9.2. Knowledge and skills in monitoring and evaluating gender sensitive HIV activities are strengthened at national, sub-national and service delivery level. This human capacity strengthening is done based on HIV-MES capacity assessment and a capacity strengthening plan

9.3. The M&E TWG incorporates gender and HIV M&E among its main areas of focus and includes representation of MoHCDGEC in its membership. The M&E TWG coordinates and manages the gender related HIV M&E activities at national, sub-national and service delivery level.

9.4. The national HIV M&E framework already indicates how gender and HIV issues are measured for relevant indicators with their data sources, information products and stakeholders. In addition the TWG identifies strategic gender and HIV M&E activities and includes them in the implementation work plans for stakeholders' and TACAIDS.

9.5. The M&E TWG continuously advocates for gender responsive M&E plans and activities. In line with this the M&E TWG ensures that surveys and surveillance which are undertaken apply tools and protocols which capture gender and HIV issues. Likewise the routine program monitoring tools are also aligned to capture pertinent gender and HIV information. All the information generated is captured in the national HIV database.

9.6. Annually, the M&E TWG and TACAIDS list gender and HIV related research and learning needs as well as priorities. Likewise the M&E TWG and TACAIDS include gender and HIV information in the HIV reports and information products. These reports and information products are disseminated and stakeholders encouraged in using gender related information for decision making during planning and implementation of gender transformative and sensitive HIV interventions.

10.0 Foreseen Risks and Mitigation Strategies for Implementing the GOP

This Operation Plan may carry some inherent risks and assumptions such as the possibility of inadequate leadership support for implementation, limited implementation capacity, insufficient cooperation of stakeholders and delays or inadequate funding for interventions. TACAIDS and other stakeholders have planned actions to mitigate these risks as follows:

10.1. The probability of inadequate leadership support for implementation is low as the Government MDAs, CSOs, private sector and all stakeholders are committed to combating HIV in a gender sensitive manner. However the impact, if it occurs, would be significant. TACAIDS and stakeholders will continue to maintain and encourage regular discussions among partners at all levels to sustain leadership support for implementing activities in this Operational Plan.

10.2. The probability of limited implementation capacity is medium as various implementers have received significant capacity strengthening in aspects of gender and HIV interventions. If the capacity is not sustained or retained then the quality of interventions could be compromised. HIV Development Partners, TACAIDS and other stakeholders will continue to provide sustained technical assistance and capacity strengthening to implementers of activities contained in this Operational Plan.

10.3. The probability of insufficient cooperation of stakeholders is low since initial discussions and previous working arrangements have proved that stakeholders are willing to continue to collaborate closely across sectors to plan and implement gender sensitive HIV interventions. TACAIDS will continue to work closely with stakeholders to step up joint coordination structures and mechanisms for implementing activities contained in this Operational Plan.

10.4. The possibility of delays or inadequate funding for interventions contained in this Operational Plan is medium. There is funding at national levels for coordinating and managing gender sensitive HIV interventions. However, Tanzania is a vast country and it may be difficult to raise sufficient funds to implement activities contained in this plan in all districts and villages. Delays or inadequate funding could lead to some activities not being implemented as planned. TACAIDS will continue to work with stakeholders to advocate for adequate commitment and timely disbursements of funding for implementing activities contained in this Operational Plan.

11.0 Conclusions

This Operational Plan is to be implemented from the year 2016 to 2018 as a tool to enhance coordination and supervision of gender sensitive HIV activities being undertaken by various stakeholders at national levels down to community service delivery points. The Operational Plan will be reviewed and a third edition developed by 2019, by then the fourth generation NMSF which will have been developed.

TACAIDS ensures that adequate resources are mobilized and the organizations responsible for implementing activities contained in this Operational Plan undertake activities to an optimum level. TACAIDS provides supportive supervision where need be to solve issues and challenges encountered in the implementation of activities contained in this plan.

Annually TACAIDS organizes stakeholders meeting to review implementation of activities in this Operational Plan. This annual meeting provides solutions to challenges and proposed activities to enhance the implementation of gender sensitive HIV activities.
The implementation of activities contained in this Operational Plan for the HIV Response in Tanzania Mainland leads to stakeholders addressing gender related HIV differences, inequalities, issues and needs of communities within Tanzania Mainland.

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(Footnotes)

1 FSWs and their clients, MSM, PWIDs, OMVCs, long distance truck drivers, miners and fishermen

2 FSWs and their clients, MSM, PWIDs, OMVCs, long distance truck drivers, miners and fishermen

3 Example: The National AIDS Prevention and Control Act of 2008, National AIDS Policy of 2013, Occupational Safety and Health Act (OSHA), Labour Laws, Security of Employment Act, Property and Inheritance Act, National HIV Policies for HBC/VCT/OMVC and Sector policies (e.g. education, agriculture, etc.)

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