United Republic of Tanzania

Prime Minister's Office

HIV Response Sustainability Roadmap Part A

December 2024

Table of Contents

List of Tables

List of Figures and Boxes

List of Boxes

Acronyms

ABC/M	Activity-based costing and modelling
ADDO	Accredited drug dispensing outlets
AGYW	Adolescent girls and young women
ART	Antiretroviral therapy
ARV	Antiretrovirals
CHMT	Community health management team
CHW	Community health worker
COP	Country operational plan
CSO	Civil society organization
CTC	Care and treatment center
DHIS	District Health Information Software
DREAMS	Determined, resilient, empowered, AIDS-free, mentored and safe
eLMIS	Electronic logistics management information system
FSW	Female sex workers
GDP	Gross domestic product
GNI	Gross national income
HIE	Health information exchange
HIS	Health information system
HIV	Human immunodeficiency virus
HMIS	Health Management of Information System
HRH	Human resources for health

HTS	HIV testing services
LGBTQ	Lesbian, gay, bisexual, transgender, and queer
MAT	Medication assisted therapy
MOH	Ministry of Health, Community Development, Gender, Elderly and Children
MSM	Men who have sex with men
NGO	Non-governmental organization
NPHL	National public health laboratory
NSMF	National Multisectoral Strategic Framework for HIV and AIDS
NSSF	National Social Security Fund
OOP	Out-of-pocket
PEPFAR	U.S President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
PO-RALG	President's Office of Regional Administration and Local Government
PrEP	Pre-exposure prophylaxis
PWUD	People who use injectable drugs
RHMT	Regional Health Management Team
SBC	Social behavioural change
SWG	Sustainability Working Group
TACAIDS	Tanzania Commission on AIDS
THIS	Tanzania HIV Impact Survey
TIIS	Training Institution Information System

TOMSHA	Tanzania Output Monitoring System
UHC	Universal Health Care
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VMMC	Voluntary medical male circumcision
WHO	World Health Organization

Foreword

As the HIV epidemic has evolved, the response has become increasingly complex. Despite collective efforts, new HIV infections and AIDS-related deaths persist, highlighting the ongoing struggle to achieve epidemic control and achieve response sustainability. Over the years, Tanzania has made significant progress in reducing HIV infections, AIDS-related deaths and increasing the number of People Living with HIV who know their HIV status and have achieved viral suppression, which is critical in controlling the epidemic. However, the data show considerable population, gender, and regional variations in the disease burden. It is evident that the epidemic is rapidly spreading along the fault-lines of social-economic and political development processes. HIV prevalence among key and vulnerable populations remains significantly higher than in the general population, and the epidemic has a marked gender bias, disproportionately affecting women, in particular adolescent girls and young women (AGYW). While the government has significantly increased domestic funding, the response remains dependent on external funding.

The Government, in collaboration with our development partners, and in particular, UNAIDS, and the United States Government, have embarked on developing the "HIV Response Sustainability Roadmap Part A" to address services and financial sustainability challenges. The Roadmap complements our existing National Multi-Sectoral Strategic Framework on HIV and AIDS 2021/22-2025/26 (NMSF V), the Health Sector Strategic Plans 2021-2026 (HSSP V), and the Health Sector HIV and AIDS Strategic Plan 2022-2026 (HSHSP V). The Roadmap focuses on three strategic issues. ***First***, the sustainability of the HIV response services, ensuring that high-impact services are available, accessible, and are being utilized by all people in need, and that no one is left behind. ***Secondly***, to ensure the HIV response is financially sustainable. The Government has a moral and legal obligation to ensure that as external funding declines, services continue uninterrupted. ***Thirdly,*** the roadmap is systematically focused on strengthening the resilience, functionality, and sustainability of the health and community systems that constitute our core platforms for service delivery.

To achieve these goals, we call for strategic and concerted efforts by all people. Our vision for 2030 and beyond is ***"Reduction of New HIV Infections and AIDS-related Deaths by 95%, and Stigma and Discrimination Reduced to <5%".*** It is ambitious and feasible. To achieve this vision, Tanzania, is committed to addressing the challenges we face, ranging from fragmentation of services, low coverage, and inadequate targeting, prioritization, and funding of high-impact interventions. The government is committed to improving HIV response leadership and governance, clarifying mandates, roles, and responsibilities of service providers, and enhancing accountability.

Our efforts will transform the HIV response from an emergency mode to a sustainably controlled response, focusing on people at higher risk or most vulnerable, and gradually increasing domestic funding to reduce donor dependence. Over time, communities will be

meaningfully engaged to take leadership and ownership of community-based and led responses. At the sector level, the HIV response will be adequately mainstreamed into other development sector projects. The Roadmap provides guidance on how we shall improve the social, policy, and legal enabling environment to ensure seamless access and utilisation of services. These paradigm shifts have significant strategic benefits ranging from cost-efficiency, improved intervention-efficacy, improved adherence and retention of clients, and improved scope and coverage of the response.

As we move forward, it is imperative that all stakeholders commit to transforming the current state of the response and move towards services and financial sustainability. The lessons of the past should inform our future strategies to achieve better health outcomes. It is our collective duty to deliver on that promise.

_____

Hon. William V. Lukuvi (MP),
Minister of State, Prime Minister's Office
(Policy, Parliament and Coordination),

Acknowledgments

The development of the HIV Response Sustainability Roadmap Part A, went through a three-phase consultative process i.e., Sustainability Dialogue, Sustainability Assessment, and the development of the Roadmap Part A. The entire process involved a wide range of stakeholders drawn from government institutions, civil society organisations (including faith-based organisations), PLHIV and KVP, private sector – including the media, academia, implementing partners, and development partners (i.e., UNAIDS, WHO, and US Government Agencies). The contributions from the stakeholders through the **Multisectoral Sustainability Working Group (SWG)** improved the quality of the Roadmap conceptualization, planning, and the quality of high-level outcomes, pathways for change, and the analysis and response strategies targeting social, policy, and legal barriers. The Government of Tanzania is sincerely grateful for the unwavering commitment and dedication of all members of the SWG. Their involvement ranged from participation and technical and policy contributions during the writing, review, and validation of the different reports. Their inputs have enhanced the quality and accuracy of the document.

The Government is grateful to all development partners who provided financial and technical support. In particular, special appreciation goes to UNAIDS and the USG (PEPFAR, CDC, USAID, and DOD). Without their support, the development of the Roadmap would not have been possible. Apart from supporting the process costs, they also provided funding for one international and three national consultants who provided technical support in the roadmap development process. The Government is equally grateful for the support provided by USAID-funded Analytics for Advancing Financial Sustainability of the HIV/AIDS Response (AFS), led by Avenir Health, for their initial work conducting the Sustainability Assessment that formed the basis of the work in phase 2. Their support accelerated the processes in phase two and equally enhanced the quality of the Assessment report.

Finally, we sincerely thank the staff of TACAIDS and members of the core team for their unwavering support and coordination of the entire process. Without their support and commitment, the process would not have been possible.

_____

Dr. Jerome Kamwela,

Acting Executive Director,

Tanzania Commission for AIDS.

Executive Summary

According to the data from the Tanzania HIV Impact Survey (THIS) 2022-2023, 82.7% of all adults aged 15+ years living with HIV were aware of their HIV status: 84.8% of women and 78.4% of men. Among all adults living with HIV in Tanzania, who were aware of their HIV positive status, 97.9% were on ART, with a higher proportion among women at 98.4%, than among men at 96.7%. Lastly, among all adults living with HIV, 94.3% had achieved viral load suppression (VLS) on treatment, with a higher proportion among women at 94.9.% than among men at 92.9%. It is evident that the greatest challenge is to ensure people know their HIV status to facilitate access and use of HIV prevention or treatment services.

THIS 2022-2023 shows a decline in new infections to 60,000 annually from an estimated 72,000 annually in THIS 2016-2017. Equally, AIDS-related deaths have also been reduced by 67% from the 2010 baseline. Despite these achievements, it is evident that new HIV infections are not declining fast enough, and there are persistent gaps in case finding, particularly among key and vulnerable populations, men, youth, and children. There are key challenges associated with interruptions and retention in both HIV prevention and treatment services.

Overall, the HIV response is continually challenged by declining domestic and global financial resources earmarked for the HIV response. The situation is compounded by changing development partner priorities such as due to emerging epidemics such as COVID-19 and Mpox, and unpredictable natural disasters and political conflicts that may contribute to HIV funding being re-directed to mitigate such incidents. Tanzania's HIV response is heavily dependent on external donor funding, mainly from the U.S. President's Emergency Programme for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM).

The above situation demands that Tanzania develop and implement efficient and effective sustainability strategies and galvanize political leadership and commitment to sustain the HIV response. The process of developing a sustainability framework with this Roadmap started in March 2023, led by the Prime Minister's Office through the Tanzania Commission for AIDS (TACAIDS), in collaboration with the Ministry of Health (MoH), President's Office Regional Administration and Local Governments (PO-RALG), and the Ministry of Finance and Planning (MoFP), civil society organisations (CSO), United Nations Joint Programme on HIV/AIDS (UNAIDS) and the United States Government agencies (PEPFAR, USAID, CDC, DOD) among others. The development of the **HIV Response Sustainability Roadmap** is part of the process and builds on initial efforts by the Government of Tanzania (GOT) to address the issue of sustainability.

The Roadmap is premised on five sustainability domains i.e., leadership and governance (including laws and policies), Sustainable Financing, Service delivery, Systems, and Community roles. Analysis around these domains revolved around establishing the current state – progress and achievements made, barriers and gaps encountered.

The assessment of the current state contributed to understanding the desired future state. The process of envisaging the future state led to the development of the sustainability vision and goal. The vision visualized the state beyond 2030, while the goal considered the most strategic actions required to achieve the vision. The vision and goal statements adopted by the Multisectoral Sustainability Working Group are presented below.

Vision

Reduction of new HIV infections and AIDS related Deaths by 95%, and Stigma and Discrimination Reduced to <5%

Goal

Provide sustainable financing of the HIV response and improved quality of HIV services to all populations.

It is against this premise that the analysis identified the following ten (10) critical areas of change/transformation to ensure the realisation of the future state of the response and, in particular, the sustainability vision. The ten critical areas inform the strategic thinking of the future, and shape strategic directions of the response. They further inform the desired (anticipated) high-level outcomes (HLO) of the HIV response performance. The transformation areas are presented in Box 1 below.

Box 1: Ten Critical Areas of Transformations/Changes.

1. From an emergency to a sustained response/dealing with chronic illness
2. From a donor-dependent to a nationally efficient and sustained response
3. From a vertical to an integrated service, systems, planning and delivery approach
4. From a national to a community-based and community-led people-centred response
5. From a gender inequitable to a gender-sensitive and responsive response
6. From a sector approach to a multisectoral, decentralized and mainstreamed response
7. From fragmented oversight to a robust governance system that ensures accountability across all levels of the HIV response
8. From evidence-limited programming to a seamless data and technology-supported response
9. From a sub-optimal to enabling policy and legal environment that supports inclusivity and effectiveness using a public health approach
10. From basic community involvement to strategically empowered, community-led leadership in the HIV response

Successfully designing, implementing, and monitoring performance in line with these ten transformation areas will require the following minimum strategic inputs:

1. **Strong and sustained political leadership and governance** of the response that ensures a strong supportive social, policy, legal, and political environment for the multisectoral and decentralized HIV response.
2. **Sustained and incremental funding** of the response, with the greater funding coming from domestic sources.
3. **Meaningful and purposeful engagement and participation** by all people, including KVP and PLHIV. It is anticipated that communities will take on a greater role in initiating and leading some of the key community-based interventions.

The table below provides a comprehensive summary (by domain) of the identified HLO and the barriers and gaps that the roadmap has prioritized to address, and suggestions of pathways to change. These are further elaborated in section 3 of the Roadmap.

Table 1: High-Level Outcomes, Strategic Barriers and Pathways for Change

Domain	High-Level Outcomes	Blockages/Barriers/Gaps	Pathways for Change
Leadership and Governance	• By 2030, Tanzania will have a well-coordinated, resourced, and resilient HIV multisectoral response, with quality and equitable services for all populations • By 2030, Tanzania will have a strong enabling social, policy, and legal environment that will support equitable access, and utilisation of services by all populations including PLHIV and KVP • Less than 5% of PLHIV, those affected and KVP experience stigma and discrimination	• Suboptimal functionality of coordination and governance structures • Inadequate political leadership oversight at subnational levels, including CSOs • Inadequate resources for the response to support the response coordination, governance and leadership functions • Some sub populations (KVPs) face legal and societal barriers in accessing and utilizing HIV services • Though declining, internal and external stigma is still high and disrupts service utilization • Disruptions at donor's level affect programs support, including	• Strengthening political leadership and commitment to ensure sustained enabling policy, social and legal environment • Strengthening the capacity of the multisectoral and decentralized HIV coordination and governance and accountability structures including TWGs • Strengthen stakeholder's meaningful involvement building on the current SWAP approaches; • Mainstream sustainability in the "three one" principle in the National Policy on HIV • Review and update policy, laws, and related instruments to address policy, barriers to access and utilization • Strengthen capacity of law enforcers and decision makers to use health-rights-based approaches in planning and implementation of activities in service delivery • Implement the 2016 legal environmental assessment report (LEA) recommendations

Domain	High-Level Outcomes	Blockages/Barriers/Gaps	Pathways for Change
		management coordination/QI support for HIV services • Some policies, laws and strategies are overtaken by epidemic dynamics and global strategies that govern HIV services • Inadequate awareness of policies, laws and related regulations by service providers, service beneficiaries and the public • HIV-related external and internal stigma and discrimination is still high across populations • Inadequate resources to fully implement policy and strategies	• Strengthen policy and legal support to address root causes for gender inequality and violence • Institutionalize social contracting to support and facilitate community efforts in service delivery • Strengthen strategies to monitor and enforce adherence and compliance with existing policies and laws • Strengthen joint planning and accountability mechanisms building on the current TWGs • Strengthen the human resources capacity, including systematic increasing resources earmarked for multisectoral and decentralized coordination • Strengthen the capacity of the multisectoral response approach to ensure a greater reach and mobilisation of strategic partnerships and alliances
Sustainable Financing	• More than 50% of the multisectoral HIV response funding is from domestic resources, including the private sector • Improved efficiency and effectiveness of the HIV response to enhance efficiency gains	• HIV response is heavily dependent (90%) on external donor funding • Majority of the HIV HRH, lab, and commodities are dependent on external donor funding • Insufficient and inconsistent domestic funding for health, including HIV	• Strengthen government capacity to increase and sustain domestic funding for the HIV response • Galvanize political leadership to ensure sustained funding of the HIV response, including development of alternative and innovative resource mobilisation mechanism such as universal health insurance and specific HIV-related levies • Expand the donor base beyond the traditional donors (PEPFAR and GF)

Domain	High-Level Outcomes	Blockages/Barriers/Gaps	Pathways for Change
	• Increased co-financing to strengthen resilient and sustainable systems for health	• Vertical implementation of the HIV response interventions compromise efficiency and effectiveness • There is no defined mechanism for social contracting to fund/support CSOs/NGOs. • Inadequate prioritization may lead to financing of low impact interventions • Private sector not adequately engaged in the HIV response • Inadequate alternatives to government funding for domestic resource mobilisation for HIV response	• Strengthen public-private partnerships with the private sector to support implementation and funding of the HIV response. • Integrate HIV-specific interventions into the UHI mandatory essential benefit package over time • Strengthen mechanisms for co-payment of HIV commodities, particularly in the private sector, based on a public private partnership (PPP) arrangement • Strengthen HIV services integration in the broader health system • Strengthen the capacity of non-health sectors to mainstream HIV in their development programmes • Ensure effective operationalization and inclusion of low-income sub populations in the Universal Health insurance • Develop a stakeholders/service providers performance-based accountability framework • Develop and operationalize an effective resource tracking • Improve budget, allocation and technical efficiency of health and HIV funding to improve efficient and effective use of funding • Institutionalise and operationalize social contracting mechanisms to support CSO/CBOs/ FBOs (including KVP and PLHIV led) implement community-based and community led initiatives.

Domain	High-Level Outcomes	Blockages/Barriers/Gaps	Pathways for Change
Service Delivery	• 90% of people living with HIV and most at risk are linked to people-centred and context-specific integrated services[1] • 90% of PLHIV receive preventive treatment for TB • The 95-95-95 targets are achieved and maintained across all sub-populations. • 95% of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding • 95% of people at risk of HIV infection have access and are using comprehensive HIV prevention people-centred services • 95% of pregnant and breastfeeding women living with HIV have suppressed viral loads	• Vertical implementation of programmes and service delivery • Prevalence of stigma and discrimination, and GBV • Inadequate comprehensive knowledge of HIV and AIDS – limits access to services • Lower uptake of services by men and children • Some regions and sub-populations (men, children and KVP) are underserved • Sub-optimal scale-up of newer interventions (PrEP & HIV self-testing) • Health and community systems are fragile and lack adequate capacity (prone to external disruptions) • HIV services are inadequately integrated in the broader healthcare systems • Quality is compromised due to lack of appropriate capacity, especially at	• Strengthen HIV services integration with health care services (including primary health care), and mainstream in non-health sector development programmes • Strengthen implementation of effective strategies to address social, policy, and legal barriers to access and utilisation of HIV services • Strengthen the efficiency and effectiveness of the multisectoral and decentralized approach to deliver differentiated and targeted service delivery models • Empower community-led and KVP-led organisations (HR, skills, finance, operational systems) to deliver community-based HIV testing, prevention, and treatment services • Strengthen the policy and operational environment to embrace, adopt, and use new technologies and policies • Intensify social and behaviour change interventions to improve individual risk perception, and increase demand for HIV and AIDS services • Strengthen strategic health systems (Lab, HMIS, PSM, HRH) to ensure effective and sustained service delivery • Strengthen the PPP model of service delivery and support with the private sector and CSO

[1] Including other communicable diseases, noncommunicable diseases, sexual reproductive health, gender-based violence, mental health, drug and substance use, and other health and social welfare services they need for their overall health and well-being

Domain	High-Level Outcomes	Blockages/Barriers/Gaps	Pathways for Change
	• 95% of women of reproductive age have their HIV and SRHR service needs met • HIV services are integrated with broader health care services • Less than 5% of PLHIV and KVP experience stigma and discrimination, gender inequalities, and all forms of GBV	community level. i.e., HR and technology, infrastructure • Management of services providers remain challenging – given the numbers and diversity • Inadequate data management and use to inform service delivery • Stigma and discrimination – compromising access and use of services	
Systems	• The health systems (including sub- systems will be resilient and operating at optimal levels • Health systems will be adequately financed and funding will be sustained • Over 80% of the human resource needs will be met and sustained across the health systems. • 80% of the health information systems needed for the HIV response will be interoperable, functional and efficiently sharing data and strategic information • The procurement and supply chain will be fully integrated and functional	• Health systems are fragmented and not adequately interoperable and function at sub-optimal • Health systems strengthening and management is largely donor dependent • Systems operate vertically • Inadequate HRH, compounded by gaps in skills and competencies • Operational challenges with the infrastructure including intermittent access to internet and electricity. Many operations remain paper-based systems • Slow adoption and application of new technologies for the HIV response • Parallel HMIS systems limit systems interoperability • Procurement is donor-driven	• Strengthen the health systems – sub-systems - human resources, laboratories, procurement and supply, and health information systems • Advocate for the recruitment of adequate, skilled, and competent human resources • Leverage integration of HIV services into private healthcare provider services to address the HRH gap in the public sector • Strengthen the integration and interoperability of health systems, including community-led monitoring (CLM) • Accelerate the process of digitalizing health systems and, particularly HMIS to enhance the quality and management of data • Digitalize the supply chain system and introduce track and trace systems • Capacitate MSD to procure, store, and distribute HIV commodities • Mainstream HIV in all sectors (sector-wide approach)

Domain	High-Level Outcomes	Blockages/Barriers/Gaps	Pathways for Change
	• HIV response will be mainstreamed into other sectors policies and programmes	• Inadequate capacity for pharmaceutical and commodities quantifications – often top-down rather than evidence-based approached • Inadequate integration/alignment of procurement and supply chain information systems to enhance real-time inventory tracking, demand forecasting, and distribution • Frequent interruptions of sub-systems such as laboratory supplies and sample transportation system	
Community Role	• 30% of HIV testing and treatment services are being provided by community-led organisations • 80% of HIV prevention service targeting KVP and women are being delivered by the community, KVP, and women-led organisations • 60% of the programmes addressing societal enablers and barriers are delivered by community-led organisations, including KVP and PLHIV organisations	• Ad hoc and inadequate funding of community-based and community-led HIV response interventions • Inadequate HR, especially CHW • Inadequate coordination and accountability mechanisms among CSOs due to lack of adequate leadership and governance skills • Lack of systematic implementation of the community-based service delivery strategy • Weak governance, leadership, and management structures among PLHIV	• Scale up and roll out the CHW programme • Accelerate the implementation of the community-based health delivery services strategy • Advocate for sustainable financing for community-led initiatives • Strengthen the technical capacity of community-led organisations to delivery community-based, and community-led HIV prevention and treatment services • Institutionalise social contracting to support CBOs • Strengthen strategic partnerships between the private sector and CBOs to enhance service delivery • Strengthen the capacity for communities to implement CLM

Domain	High-Level Outcomes	Blockages/Barriers/Gaps	Pathways for Change
	• 90% of PLHIV and people at risk are linked to other integrated health and social services, including GBV/VAC preventive related	and KVP – compromising service delivery • Inadequate funding and HR capacity among community-led organisations • Inadequate technical skills to operationalize CLM • Low community-led organisations engagement with community-based and government-led leadership and governance structures • Minimal private sector engagement and support the HIV response • Inadequate linkages between communities and community-based health centres (with exception from the external donor included NGOs) • Prevalence of stigma and discrimination, gender inequalities, and GBV targeted to PLHIV and KVP • Fragmentation of services • Inadequate policy guidelines and oversight supervision of CBOs • There is no formal framework for community engagement and sub-	• Strengthen the capacity of CBOs to support and delivery key services for KVP and PLHIV

Domain	High-Level Outcomes	Blockages/Barriers/Gaps	Pathways for Change
		contracting of CBOs to provide community-based services	

Part 1: Introduction and Background Information

1.1 Background Information

The HIV response in Tanzania is becoming increasingly complex due to evolving development challenges such as shifting funding priorities, droughts, floods, and food insecurity, emergency public health threats like COVID-19, and the need for sustained, integrated approaches to prevention, treatment, and care. The mix of generalized and concentrated epidemic patterns adds further complexity. HIV prevalence among key and vulnerable populations remains significantly higher than in the general population, and the epidemic has a marked gender bias, disproportionately affecting women, particularly adolescents and young women. Despite efforts, new HIV infections and AIDS-related deaths persist, highlighting the ongoing struggle for epidemic control. Data show considerable regional variation in the HIV burden.

In Tanzania, prioritized HIV prevention and treatment services are informed and guided by the National Policy on HIV/AIDS 2001, the HIV and AIDS (Prevention and Control Act) of 2008 – (the Act is currently under review and amendment), and the Public Health Act of 2009. These policies are operationalized through the National Multisectoral HIV and AIDS Strategic Plan 2021/22-2025/26 (NMSF V), the Health Sector HIV Strategic Plan 2021- 2026 (HSHSP V), and the Health Sector Strategic Plan 2021-2026 (HSSP V). Despite the efforts made to ensure that HIV prevention and treatment services are available country-wide, not all people who need services have access. To address the challenges facing the HIV response, particularly those related to sustainably financing HIV prevention and treatment services and ensuring that services are available, accessible, and being utilized by all people, including key and vulnerable populations, the Government of Tanzania, has embarked on developing a HIV Response Sustainability Roadmap Part A. The Part A of the Roadmap constitutes the "strategy", while Part B will elaborate the transformation plan, including strategies, activities, a monitoring and evaluation plan, indicators, timeline and responsibilities and risk mitigation plan that will operationalize Part A.

The process of developing the Roadmap Part A included a three-phase process starting with a Stakeholder Mapping and Country Dialogue during phase 1, Sustainability Assessment in phase 2, and the development of this Sustainability Roadmap Part A in phase 3. The Roadmap development process was guided by

the global guidelines on HIV response sustainability planning published by UNAIDS. The HIV Response Sustainability Roadmap aims to mobilize and galvanize political leadership and commitment and inspire and influence operational practices that will contribute to service delivery efficiency and effectiveness.

This Roadmap outlines country-led pathways for change and transformation beyond 2030. The pathways are linked to the sustainability domains that include I) Leadership and Governance ii) Sustainable Financing, iii) Service Delivery, iv) Systems, and v) Community Role. The Roadmap is holistic and transformative, encompassing biomedical, structural, and behavioural aspects of the response.

1.2 The Theory of Change – How will the Roadmap Change the HIV Response?

The Roadmap is intended to change and transform the HIV response in a variety of ways to ensure long-term sustainability. The multistakeholder sustainability dialogue and assessment processes served as opportunities to understand what works, what doesn't and what needs to be changed or transformed to advance towards achieving epidemic control goals by and beyond 2030. Understanding the current state and visualizing the future, based on the epidemiological assessment and conducting a situation analysis of the sustainability domains, helped to conceptualize and contextualize the change and transformation processes and pathways. This section provides of summary of the areas of the HIV response requiring change.

A review of governance reveals two key areas requiring change: First, supportive political pronouncements have not always translated into the expected tangible results. Second, there are few fragmented governance and coordination structures at national and sub-national levels with overlapping mandates, roles, and responsibilities – that compromise their effectiveness and accountability. In the case of policies and laws, there are two emerging dimensions of change.

As the HIV response has evolved, some legal and policy gaps have emerged that are not yet addressed. The assessment also noted that some stakeholders are not always compliant with the legal and policy provisions. Changes will demand intense and targeted advocacy and communication using evidence-based information and data to influence and shape changes. Advocacy should lead to policy and legal reforms. In the context of leadership and governance, advocacy and capacity development is also needed to improve operational and governance efficiency and effectiveness - including improved resource allocations and an enabling social, policy, and legal environment.

Gender norms remain a significant barrier to women's access to HIV services, impacting disclosure, complicating index testing, and limiting adequate care for children. Harmful perceptions of masculinity also discourage men from seeking healthcare, leading to poorer HIV outcomes and increased gender-based violence. Addressing these issues will require intensive social and behaviour change (SBC) focused on transforming norms that drive HIV infections and hinder service access and utilization.

The HIV response is still being considered as an emergency. However, with the progress made to address the associated challenges, the response has to move from an **emergency to a sustainably controlled response.** Planning and programming need to change from vertical to integrated population-based approaches. Integration should also embrace the concept that the needs of people living with or affected by HIV (e.g., orphans and vulnerable children) are not homogenous. Hence, they need differentiated services and service delivery approaches. The "one-size-fits-all" approach has not yielded the desired results. Equally, the decentralization of the response demands a meaningful shift from a national approach to a sub-national one (regions and districts), contextualized by the degree of disease burden and localized epidemic drivers.

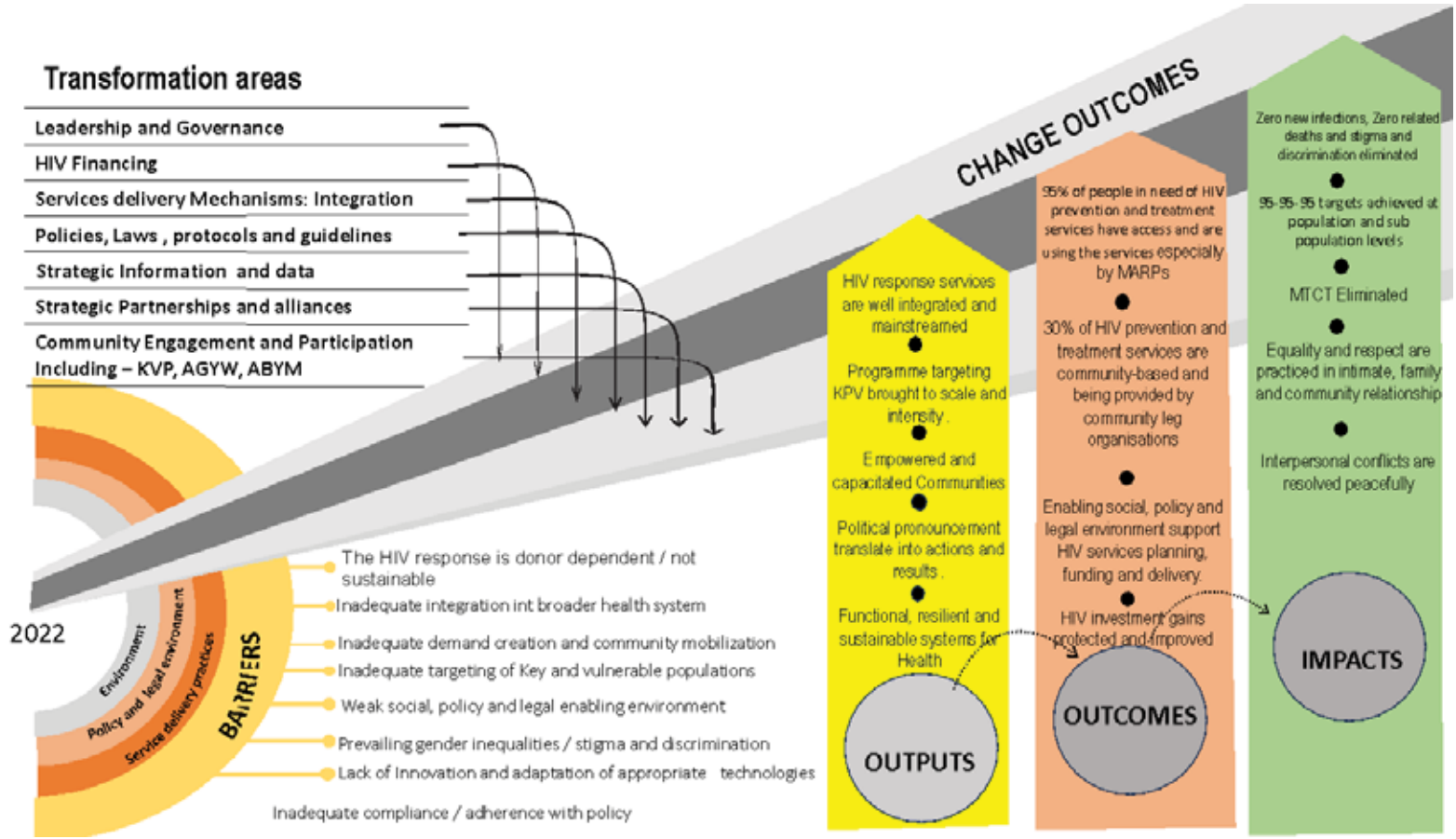
The most significant change has to occur in the way the HIV response is currently funded. Currently, the response is heavily dependent on external donors, especially PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). As a result, the HIV response has historically been implemented in a verticalized parallel system. While longstanding partnerships with these donors have resulted in improved outcomes, Tanzania urgently needs to reduce donor dependence through improved domestic funding mechanisms and effective integration of HIV-related services in the primary health care system and beyond. Programming also needs to maximally leverage private sector potential to meaningfully contribute to both financing and implementing HIV interventions.

The paradigm shift has significant strategic benefits as it is cost-efficient and effective, reduces beneficiary fatigue arising from vertical approaches, strengthens efficacy, improves programme synergy and effectiveness, and promotes adherence and retention. These changes are effective when supported by evidence-based strategies, applied best practices, and use of innovative

technologies. There is an urgent need to identify and strengthen areas of service delivery for efficiency gains. Tanzania will also need to explore and strengthen other innovative mechanisms, including health insurance and AIDS Trust Fund (ATF) mechanisms. The role of the community in the HIV response, both as service delivery partners and financiers, also needs to be harnessed.

The concept of transformation is based on the need to bring prioritized interventions to scale, expanding the scope and reach and significantly improving the availability, accessibility, acceptability, utilization, and quality of comprehensive HIV prevention and treatment services. The service providers are expected to provide the right services to the right target groups or individuals at the right place and time and at the desired scale and intensity.

Figure 1: The Roadmap Theory of Change



1.3 Country Context

Tanzania is classified as a lower-middle-income country whose economy has shown resiliency in recent years, with increased growth of 5.2% in 2023, moderate inflation, and reductions in the fiscal deficit. The total debt service to exports ratio of 19.6% indicates that Tanzania is reasonably managing its debt, and future

economic growth projections are positive, albeit recognizing the potential risks of a global recession and ongoing reforms not being sufficiently implemented. In 2020, Tanzania's government health expenditures amounted to $1,039 million, translating to $17 per capita and approximately 9% of all government expenditures and 4% of the Gross Domestic Product (GDP) per capita. In the 2019/20 fiscal year, Tanzania allocated 0.37% of its total government budget to HIV, which equates to 0.08% of the country's GDP.

The Office of the Prime Minister has the oversight responsibility for coordination, governance, and leadership of the national multisectoral HIV response in Tanzania mainland. The day-to-day activities are coordinated by the Tanzania Commission for AIDS (TACAIDS). These activities include formulating policy and guidelines and a strategic framework for planning all HIV/AIDS control activities. The HIV and AIDS (Prevention and Control) Act 2008[2] [amended in November 2019 [pg. 9-13])[3], specifies the requirements for the prevention, treatment, care, support, and control of HIV (2022).

Tanzania's epidemic is heterogeneous, disproportionately affecting some of the populations more than others. THIS 2022-2023 showed a higher HIV prevalence and incidence among females as compared to males, with incidence particularly higher among young females ages 15-24 years at 0.33% compared to <0.01% for young males, and also prevalence higher among women at 5.6% than men at 3.0%, all aged 15 years and above. The aggregate prevalence is estimated at 4.4%, which corresponds to approximately 1,548,000 adults living with HIV in Tanzania. Furthermore, the Integrated Biological and Behaviour Survey (IBBS) of 2022 showed a higher HIV prevalence among key populations than the general population, with a prevalence of 15.8%-34.0% for sex workers, 8.4% for men who have sex with men, and 5.1%-18.3% for people who inject drugs. The HIV prevalence among prisoners is estimated at 6.7%. Overall, the multisectoral response has contributed to a decrease in new HIV infections from 72,000 annually in 2016-2017 to 60,000 new infections in 2022-2023. Also, AIDS-related deaths have decreased by 67% since 2010 (THIS 2022/23). The country has registered significant progress towards the

[2] HIV and AIDS (Prevention and Control) Act, 2008 HIV and AIDS (Prevention and Control) Act, 2008 HIV and AIDS (Prevention and Control) Act, 2008

[3] HIV Prevention and Control Act (Amended in November 2019) HIV Prevention and Control Act (Amended in November 2019)

global 95,95,95 targets set by the UNAIDS. According to the THIS 2022-2023, 82.7% of adults living with HIV were aware of their HIV-positive status, 97.9% of adults living with HIV were on ART, and 94.3% of adults who were on ART had viral load suppression. These findings show marked progress since THIS 2016-2017, and meeting the second UNAIDS 95-95-95 target in Tanzania demonstrates access to robust HIV treatment provided through public health facilities and community-based service delivery points.

A review of the current multisectoral and health sector strategies indicates the priorities for Tanzania as three-fold:

- **Prevention of new HIV infections:** To prevent the occurrence of new HIV infections across all sub-populations and further prevent AIDS-related deaths by providing comprehensive, targeted, and differentiated HIV prevention and treatment services that resonate with individuals and specific sub-populations. This premise also demands the prioritisation of sub-populations at higher risk and the prioritisation of high-impact interventions.
- **Strengthen integration:** To strengthen integrated service delivery, including community-based and community-led services and integrated digital systems. The Sustainability Assessment, indicates that integrating HIV into broader health service delivery at the facility and community level is a prerequisite to HIV response sustainability. This will also require HIV-related data to be collected, recorded, and reported in integrated, interoperable, and efficient digital systems.
- **Sustainable HIV financing:** To ensure the HIV response is sustainably financed by developing innovative and sustainable domestic financing mechanisms, including increasing public and private sector funding and integrating HIV services into the implementation of the UHI Act.

1.4 HIV Sustainability Journey in Tanzania

As the epidemic unfolds and the global political and policy landscape changes, it has increasingly become evident that Tanzania has to develop efficient and effective strategies to sustain its multisectoral response on three fronts – i.e., a) sustainable financing of the response, b) sustaining service delivery systems especially along the continuum of Resilient and Sustainable Systems for Health

(RSSH), and finally c) maintaining and strengthening the social, policy, legal and political environment necessary to support un-interrupted accessible and utilization of HIV prevention and treatment services. Currently, most of the funding for the response comes from three sources: the Government of Tanzania (domestic), PEPFAR (external) and the Global Fund (external).

In its efforts to reduce donor dependence and ensure long-term sustainability, the government has focused on increasing domestic resources, inspiring meaningful contributions from the private sector, mainstreaming HIV responses in other development sectors and capital projects, and, more significantly, putting in place strategies to support efficiency in service delivery including HIV integration in mainstream health services. While these strategies have yielded some worthwhile results, the outcomes remain sub-optimal. All the recent multisectoral and health sector strategic plans reflect these efforts.

Previous sustainability assessment reports reveal that inadequate financial resources, human and technological capacity, and lack of meaningful community and private sector engagement and participation compromise not only the efficiency and effectiveness of the response, but further contribute to short- and medium-term lack of sustainability and of national and local ownership of the response.

To redress the situation, from 2015 - 2021, PEPFAR pioneered the development of the HIV/AIDS Sustainability Index and Dashboard (SID) tool in collaboration with other partners, including the Government of Tanzania,[4] CSOs, private sector, WHO, UNAIDS, Global Fund (GFATM) and PLHIV networks. Using the Dashboard, the country was able to track progress and identify areas that require further strengthening from a "sustainability" perspective and enable informed HIV/AIDS investment decisions[5]. This process was complemented by the development of the HIV Investment case, that has significantly contributed to SMART Decision making for SMART investment in HIV response.

---

[4] Government of Tanzania agencies: Ministry of Health, MoH, PORALG, Ministry of Finance and Planning (MoFP), and Tanzania Commission on TACAIDS),

[5] https://www.state.gov/wp-content/uploads/2022/06/Tanzania.pdf

Currently, the Government of Tanzania is collaborating with UNAIDS, PEPFAR, and other stakeholders in developing the HIV response Sustainability Roadmap. The Roadmap is the culmination of previous efforts and an infusion of new and innovative thinking around sustainability policies and strategies. The current process is anchored in key national strategies and plans that align with the country's National Five-Year Development Plan 2020/25 (FYDP III). These strategies, coupled with Tanzania's Universal Health Insurance Act, support a sustainable approach by reinforcing domestic resource mobilization, improving service delivery, and ensuring long-term resilience in the fight against HIV/AIDS.

Building on lessons learned from the geographical exits (i.e., withdrawing support in the saturated/ non-priority councils) as well as the transition of blood safety, infection prevention and control (IPC), injection safety, and healthcare waste management to the Government of Tanzania —where disruptions in implementation partner (IP) support adversely affected the management, coordination, and quality improvement (QI) of the respective services—it is crucial that the sustainability roadmap incorporates clear mitigation strategies. Specifically, a robust, phased transition of service delivery and governance is essential to ensure continuity of quality services and sustained health outcomes as the government assumes full ownership.

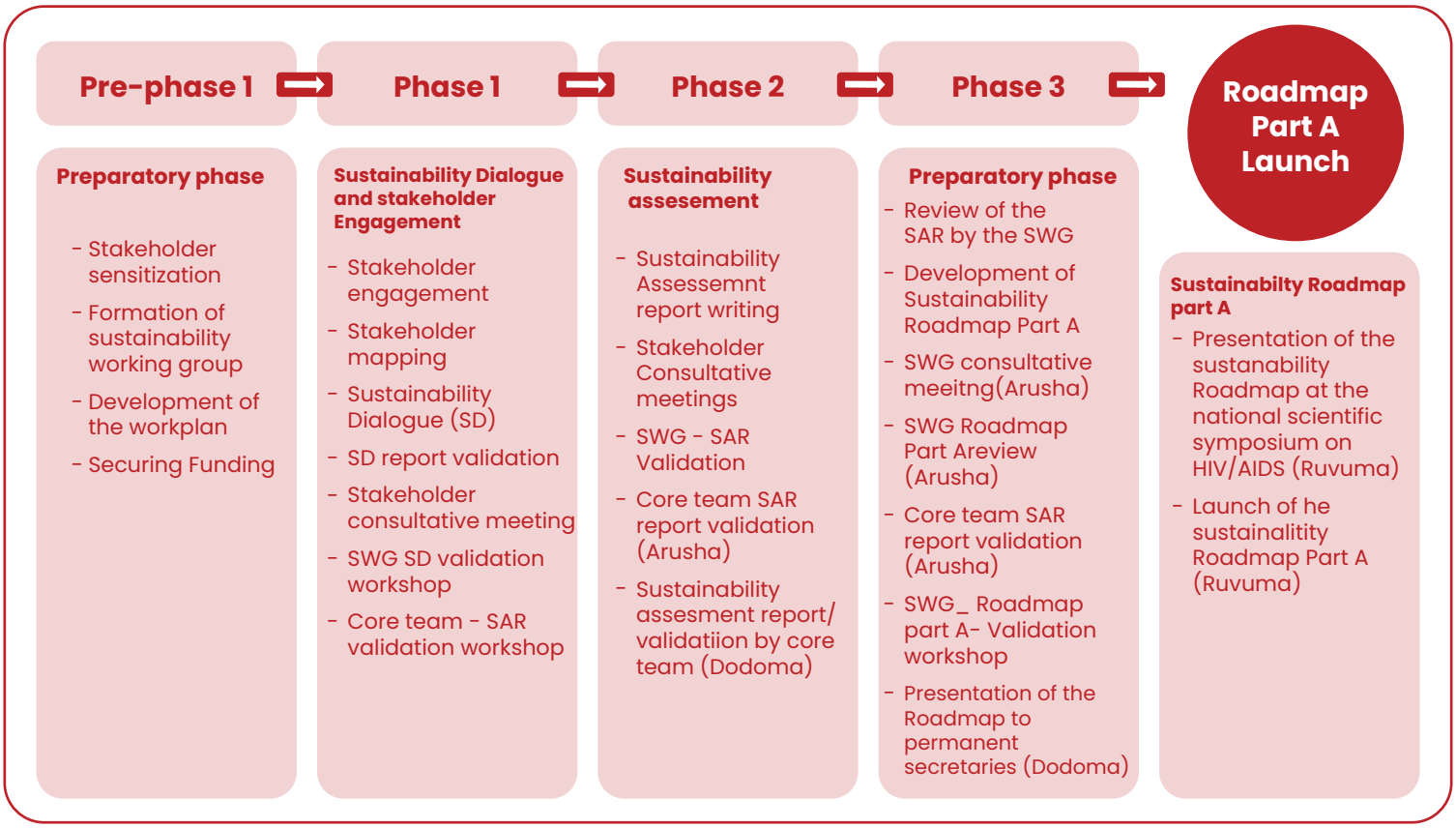
Part 2: The HIV Sustainability Roadmap Development and Approach

2.1 The HIV Sustainability Roadmap Timeline, Process, and Workflow

The process of developing the HIV Response Sustainability Roadmap Part A involved three phases i.e., Phase 1: Sustainability Dialogue and Stakeholder mapping, Phase 2: Sustainability Assessment of the current state of the HIV response, and Phase 3: the Development of the Roadmap Part A.

In Tanzania this process was initiated in October 2023 by TACAIDS. The objective was to sensitize, mobilize and galvanise political leadership to support the sustainability of the HIV response. Meetings were held with high-ranking government officials including the Prime Minister, Minister of President's Office Regional Administration and Local Government, Minister of Health, Minister of Finance, and their respective Permanent Secretaries. Others who participated in the meetings included representatives from PEPFAR, USAID, DOD, CDC, UNAIDS, representatives of CSOs, PLHIV, and key and vulnerable population-led organisations. The specific activities carried out during each phase are shown in the table below.

Figure 2: Roadmap Development process



The key outcomes of the pre-phase 1 activities were the formation of the Multisectoral Sustainability Working Group, resources were mobilized and the process of recruiting consultants to support the process was initiated.

2.2 The Sustainability Working Group – Tanzania.

The Sustainability Working Group (SWG) was formed to oversee the development process of the Roadmap Part A and provide technical and policy guidance on key issues. The terms of reference for the SWG followed the principle of inclusivity, diversity, and gender representation, ensuring that no one was left behind. The SWG membership is multisectoral, with diverse representation from government agencies, bilateral and multilateral development partners, civil society organisations (CSOs), including faith-based organisations (FBOs), PLHIV, and representatives of key and vulnerable organisations. Additional members were co-opted based on technical needs and expertise, especially during the analysis of the sustainability dialogue and sustainability assessment of the response.

The SWG further organized itself into four sub-working groups (governance, finance, service delivery and systems and community) around the five prioritized sustainability domains. Each sub-SWG was charged with the responsibility of facilitating data collection, conducting preliminary analysis, primary quality assurance, and presenting their findings to the main SWG in a plenary setup where the issues were discussed by all members. The sub-committees were also charged with the responsibility of visualizing the future state of the HIV response from the domain context, including having discussions on the long-term vision and goal of the response.

The following SWG roles in the terms of reference (TOR) were adapted from the global guidance and reviewed and contextualized to the situation in Tanzania:

a) Oversee the development of the HIV Response Sustainability Roadmap
b) Convene a sustainability dialogue and ongoing country consultations
c) Ensure that stakeholders are engaged
d) Ensure the sustainability Roadmap is regularly reviewed and updated
e) Monitor progress towards the country's vision of sustainability

TACAIDS was identified as the secretariat of the SWG.

Figure 3: Responsibilities of the technical working group

2.3 Stakeholder Mapping.

A stakeholder mapping was conducted to identify the key stakeholders (institutions) involved in the planning, funding, and implementation/service delivery of the HIV response. The respective institutions were requested to nominate a representative to the SWG. For purposes of continuity, it was anticipated that the nominated members would participate as much as possible in the entire process covering the three phases. Their participation in the development of the Sustainability Roadmap was based on their mandate, comparative advantage, and capacity. The list of the institutions selected to be members of the Sustainability Working Group (SWG) for Tanzania Mainland is attached as Appendix 1.

2.4 Tanzania Sustainability Goals and Vision

Understanding the current state of the HIV response was the foundation for visualizing the future state of the HIV epidemic and the sustainability domains. The process of identifying the future state was also informed by several strategy documents, the key ones being: the National Multisectoral HIV and AIDS Strategic Framework, the Health Sector Strategic Plan, the Global AIDS Strategy, and the Tanzania HIV Investment Case 2.0. Tanzania aims to have achieved HIV epidemic control by 2030 and to have eliminated mother-to-child transmission of HIV.

Tanzania will make significant progress in reducing donor funding dependence by progressively increasing domestic funding. By 2030, Tanzania hopes that the HIV response will be financially sustainable. The social, policy, legal, and political enabling environment will be conducive enabling equitable distribution, access, and utilisation of HIV response services by all people, especially key and vulnerable populations. Health and community systems will be functional, resilient, and sustainable. Community engagement and participation will be better organized, meaningful, and participatory. Communities will take a lead role in implementing community-based and community-led HIV prevention and treatment interventions. Governance and leadership will have significantly improved, translating into measurable outcomes, including increased domestic funding, greater involvement and participation by key and vulnerable populations, and meaningful institutionalisation of the multisectoral approach to the response implementation. Sufficient institutional and human resources capacity will be strengthened to systematically address critical barriers to HIV services.

The sustainability assessment outcomes indicate that to achieve epidemic control and eventually end AIDS as a public health threat, the response must endeavour to prevent new infections, end AIDS-related deaths and equally eliminate stigma and discrimination. The national strategies further envision that effective realization that people know their HIV status, enrol and are retained on treatment (or prevention services), and those on treatment are virally suppressed.

The overarching vision of the future state as agreed during the Roadmap development process is:

Vision

Reduction of new HIV infections and AIDS related Deaths by 95%, and Stigma and Discrimination Reduced to <5%

The goal focused on achieving long-term financial sustainability of the HIV response through domestic resource mobilization and similarly ensuring sustained availability, access, and utilization of prioritized prevention and treatment services to all in need.

Goal

Provide sustainable financing of the HIV response and improved quality of HIV services to all populations.

Both the vision and goal are aligned and resonate with the national vision and goals of the HIV response as articulated in the fifth National Multisectoral HIV and AIDS Strategic Framework and the Health Sector Strategic Plan. Both the vision and goal also align with the Global statements as documented in the Global AIDS Strategy 2021-2026 by UNAIDS.

The realisation of both the vision and the goal will be complemented by ensuring that the country achieves the suggested High-Level Outcomes (HLO). Specific indicators will be established during Roadmap Part B development process.

Part 3: High-Level Outcomes, Barriers, and Pathways of Change

The process of development of the Roadmap Part A, has involved reviewing the current state which looks at changes in epidemiological data. In the context of sustainability domains, the situational analysis examined the progress made in the improvements in service delivery mechanisms, and in strengthening the enabling environment for the HIV and AIDS response using a **"**sustainability lens**"**.

In charting the future state of the response, the process has considered how the situation will improve to enable timely achievement of the desired health outcomes and improvements in service delivery in the context of specific sustainability domains. Changes will also be defined by the extent the implementation process will have successfully identified and addressed strategic social, policy and legal barriers that compromise access and utilisation of services, especially by people at higher risk of HIV infections and those already living with HIV.

Service delivery will need to be scaled up, accelerated, and sustained to have the desired impact. Ensuring that services are people-centred and resonate with their specific needs is a primary prerequisite. Equally improving the efficiency and effectiveness of services delivery using differentiated services delivery (DSD) models will be key. It also calls for the application of best practices and strategic focus on critical barriers and bottlenecks hindering efficient planning, funding, implementation, and delivery of HIV prevention and treatment services.

The following section presents the HLOs, strategic barriers, and critical pathways of change by sustainability domains. i.e., a) Leadership and Governance (including policies and law), b) Services Delivery, c) Systems that support HIV service delivery, d) Financial Sustainability, and e) Community Role in the HIV Response.

3.1 Leadership and Governance

Tanzania has demonstrated strong political leadership and commitment at different levels of the HIV response. Collectively the leadership has led to the establishment of a cohesive system of laws, policies, strategies and programs that guide the national multisectoral and decentralized response. It has also helped to align the HIV response with other national development policies, laws, and development commitments, including Tanzania's regional and global obligations.

As a result, several non-health sectors are mainstreaming the HIV response in their development work or capital projects.

The leadership and political commitment have led to the development of the National Multisectoral Strategic Framework (NMSF V) 2022/23-2025/26, and the Health Sector Strategic Plan V, which provides the technical and policy guidance on the HIV response planning, financing, and service development. These core documents are aligned with the 3rd National Five-Year Development Plan (FYDP III), the Global AIDS Strategy 2021-2026, the UN Political Declaration 2021 on HIV and AIDS, and WHO's Global Health Sector Strategy 2022-2030.

Tanzania has endeavoured to ensure adherence to international standards and protocols periodically set by World Health Organisation (WHO) and UNAIDS. Tanzania is a signatory to the Alma Ata Declaration of 1978, the Abuja Declaration of 2001, the Declaration of Astana in 2018, and the Dar es Salaam Declaration for Action to End AIDS in Children of 2023, and the UNGA Declaration of Commitments on HIV and AIDS 2021. These efforts demonstrate the government's intent to ensure that services are comprehensive, equitably distributed, and accessible to all people.

The coordination and management of the national, multisectoral, and decentralized HIV response will be strengthened for greater efficiency and impact. Strong leadership will enhance stakeholder accountability and ensure sound financial governance. Robust policy and legal frameworks will drive equitable HIV outcomes across all populations. Institutionalizing multisectoral collaboration will broaden the response scope and foster strategic partnerships, enhancing coordination and governance. The TWG structure will reflect the expanded and stronger domestic financing and leadership of the response. With focused and strategic advocacy, domestic funding will increase, reducing reliance on external donors. Political and community leaders will benefit from a more structured and effective oversight mechanism, improving overall accountability.

3.1.1. Governance and Coordination Structures

The governance structures of the response are well established. Tanzania has adopted the multisectoral and decentralisation approach in setting up the structures to bring the services closer to the people. The structures are established by law, policy, or as an administrative function by the government. All structures have clearly defined roles and responsibilities. The Sustainability Assessment identified the following structures - The Prime Minister's Office (PMO) provides oversight, leads the coordination and

management of Tanzania's National Multisectoral HIV and AIDS response. The Permanent Secretary for Policy and Parliamentary Coordination at the PMO oversees inter-ministerial initiatives and chairs the National HIV and AIDS Joint Thematic Working Group (JTWG). The JTWG serves as a platform for coordinating efforts among the government, development partners, and program implementers. The coordination of the multisectoral response falls under the responsibility of the Tanzania Commission for AIDS (TACAIDS). The Ministry of Health (MoH) manages and coordinates the health sector response premised at the National AIDS, STI, and Hepatitis Control Programme (NASHCoP), and The President's Office - Regional Administration and Local Government (PO-RALG) oversees the response at regional and council levels.

The Sustainability Assessment noted that these structures, their roles, and responsibilities are adequately defined and, to a large extent, are functional. The challenge is that they operate at sub-optimal levels mainly due to a lack of resources, i.e., funding and human resources. In some instances, the roles and responsibilities were found to be overlapping – a situation that tends to compromise the degree of accountability. While significant progress has been made, the leadership has yet to achieve the desired results. Domestic funding remains low, perpetuating the HIV response dependence on external funding. Communities are inadequately prepared to take on leadership roles in community-based and community-led responses. HIV response integration and mainstreaming in development work and projects are still at sub-optimal levels. Stakeholders' accountability remains weak and ad hoc.

In the desired future state, governance structures for the HIV response will be fully optimized, supported by adequate funding and skilled human resources. Clearly defined roles and responsibilities will eliminate overlaps, enhancing accountability across all levels. Strengthened leadership will drive measurable progress and achieve the intended outcomes of the response. With increased domestic funding, the dependency on external sources will be significantly reduced, ensuring greater financial sustainability. Communities will be empowered and well-prepared to assume leadership roles in community-based and community-led responses, resulting in more inclusive and localized decision-making. Integration and mainstreaming of the HIV response in development projects will reach optimal levels, embedding HIV considerations across sectors. Stakeholder accountability mechanisms will be robust, systematic, and data-driven, ensuring sustained and transparent engagement throughout the response. The following table presents the domains HLO, barriers and bottlenecks, and pathways for change.

Table 2: Leadership and Governance - High-Level Outcomes, Strategic Barriers and Pathways for Change

Domain	High-Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
Leadership and Governance	By 2030, Tanzania will have a well-coordinated, resourced, and resilient HIV multisectoral response, with quality and equitable services for all populations	• Suboptimal functionality of coordination and governance structures. • Inadequate political leadership oversight at subnational levels, including CSOs • Inadequate resources for the response to support the response coordination, governance and leadership functions • Though declining, internal and external stigma is still high and disrupts service utilization • Disruptions at donor's level affect programs support, including management coordination/QI support for HIV services	• Strengthening political leadership and commitment to ensure sustained enabling policy, social and legal environment • Strengthening the capacity of the multisectoral and decentralized HIV coordination and governance and accountability structures including TWGs • Strengthen stakeholder's meaningful involvement building on the current SWAP approaches • Mainstream sustainability in the "three one" principle in the National Policy on HIV • Strengthen joint planning and accountability mechanisms building on the current TWGs • Strengthen the human resources capacity, including systematic increasing resources earmarked for multisectoral and decentralized coordination • Strengthen the capacity of the multisectoral response approach to ensure a greater reach and mobilisation of strategic partnerships and alliances

3.1.2. Policy and Legal Context

Tanzania has made progress in developing policies and laws intended to guide the leadership, management, and governance of the HIV multisectoral and decentralized response. While some of these instruments are progressive, others have been found to be inadequate. Such instruments have been identified as among the policy or legal barriers to access and utilisation of HIV and AIDS services, especially with key and vulnerable populations. The roadmap advocates for policy and legal reforms to remove such barriers. If not removed, such barriers will only serve to increase risks and vulnerabilities, especially among the KVP. The following policies and legal instruments govern the HIV response:

- **The Constitution** of the United Republic of Tanzania (1977, Revised Edition 2002). The constitution protects the "Right to Health" for all people, including those directly related to HIV, including discrimination (Sections 8 and 13). While certain aspects of sex work, such as procuring sex, living on earnings of "prostitution", same-sex relationships, and injectable drug use remain illegal, the constitutional provisions enable the provision of HIV services to all;

- **National Policy on HIV/AIDS** (2001) – The policy provides guidance on HIV services planning, delivery, and monitoring. It further outlines provisions that protect the rights of PLHIV and those affected by the epidemic, including on issues related to stigma and discrimination; **TACAIDS Act (2001**) – This Act sets out legal provisions of TACAIDS legislation and sets out the operational framework, including its TACAIDS mandate, roles and responsibilities; **The Drugs and Prevention of Illicit Traffic in Drugs Act**: The Act provides legal protections for individuals struggling with addiction; and

- **The HIV and AIDS (Prevention and Control) Act of 2008**, amended in 2019 - The Act constitutes provisions that guide the provision and conditions of HIV prevention and treatment services, including protection of PLHIV, and access to services.

One of the key challenges associated with policies and laws in the context of HIV response is the inadequate knowledge and understanding of the legal or policy provisions, inadequate capacity to enforce adherence and compliance, or simply conflicting ethical principles. Many people don't understand the boundaries

between violations of human rights against claims of their own rights. As a result, discriminatory practices and rights violations persist. Some instruments are not fully aligned with the globally accepted best practices, and some seem outdated.

It is envisaged that the future policy and legal environment will be enabling and supportive of the HIV response. A public health approach will be the key strategy to reach out to KVP with HIV and AIDS services. Policy and legal instruments will address social, policy, and legal barriers, including stigma and discrimination, gender inequalities, GBV, and other health rights violations. Several plans, policies, guidelines, and strategies will be updated to strengthen prioritization of specific metrics for monitoring progress.

Table 3: Enabling Policies and Laws - High Level Outcomes, Strategic Barriers and Pathways for Change

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
Enabling Policies and Laws	• By 2030, Tanzania will have a strong enabling social, policy, and legal environment that will support equitable access, and utilisation of services by all populations including PLHIV and KVP • Less than 5% of PLHIV, those affected and KVP experience stigma and discrimination	• Some policies, laws and strategies are overtaken by epidemic dynamics and global strategies that govern HIV services • Inadequate awareness of policies, laws and related regulations by service providers service beneficiaries and the public • Some sub populations (KVPs) face legal and societal barriers in accessing and utilizing HIV services • Inadequate resources to fully implement policy and strategies • HIV-related external and internal stigma and discrimination is still high across populations	• Review and update policy, laws, and related instruments to address policy, barriers to access and utilization • Strengthen strategies to monitor and enforce adherence and compliance with existing policies and laws • Strengthen capacity of law enforcers and decision makers to use health-rights-based approaches in planning and implementation of activities in service delivery • Implement the 2016 legal environmental assessment report (LEA) recommendations • Strengthen policy and legal support to address root causes for gender inequality and violence • Institutionalize social contracting to support and facilitate community efforts in service delivery

3.2. Sustainable Financing

The HIV response in Tanzania is largely dependent on external donor funding, especially from PEPFAR and the Global Fund. Domestically, health spending is financed by government, private health insurance, and other out-of-pocket (OOP) expenses. In fiscal year 2022, the total health expenditure (THE) was $2.9 billion, translating to $50 per capita and approximately 8% of all government expenditures and 5% of the Gross Domestic Product (GDP). The share of the government's health expenditure amounted to 34% of the total health expenditures; Tanzania allocated 0.37% of its total government budget to HIV, which equates to 0.08% of the country's GDP. Domestic resource mobilisation remains the bottleneck in the national HIV response, according to the PEPFAR-led Sustainability Index Dashboard (SID), which was conducted in collaboration with the government and other key stakeholders in 2021. Domestic resource mobilization scored 1.94 out of 10.

Increases in domestic funding have been relatively low and unable to offset the external dependency. Other innovative sustainability financing mechanisms are still evolving and have yet to make a significant impact towards financial sustainability. The government's contribution remains insufficient to close the significant HIV resource gap of TZS 828 billion, which represents 31.4% of the total health budget. This gap is widening as foreign aid declines faster than the slow growth in government allocations.

While Tanzania offers user fee exemptions at public facilities for low-income and priority groups and most HIV services, OOP expenses continue to be high and accounted for 27% of total health expenditures in 2022. Health insurance plans in Tanzania, including the National Health Insurance Fund, the Community Health Fund, and the social insurance benefit for National Social Security Fund members, are limited in reach, with 15% of Tanzanians reporting having some form of health insurance in 2022.

In 2021, Tanzania conducted an activity-based costing and management (ABC/M) study that found the cost to test one person for HIV was $8.30, and the average annual cost per patient on treatment was estimated at $237, with the annual ART costs for stable clients approximately half of the unstable clients. The use of these

unit costs will improve technical and allocative efficiencies, that scored 3.17 out of 10 in the 2021 Sustainability Index Dashboard.

To move towards a sustained sustainability strategy, Tanzania will need to explore more efficient, effective, and innovative means to mobilize domestic resources. This approach will also include the involvement of the private sector institutions. A review of service delivery systems will be key in improving and enhancing efficiency gains. The Sustainability Roadmap strategy encompasses a three-pronged pathway towards financial sustainability that will include - a) increased domestic funding, - including private sector contribution, b) instituting other innovative mechanisms such as health insurance, HIV Trust Fund and cost-sharing, and finally c) expansion of the donor base beyond the current donors.

Table 4: Sustainable Financing - High Level Outcomes, Strategic Barriers and Pathways for Change

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
Sustainable Financing	• More than 50% of the multisectoral HIV response funding is from domestic resources, including the private sector • Improved efficiency and effectiveness of the HIV response to enhance efficiency gains • Increased co-financing to strengthen resilient and sustainable systems for health	• HIV response is heavily dependent (90%) on external donor funding • Majority of the HIV HRH, lab, and commodities are dependent on external donor funding • Insufficient and inconsistent domestic funding for health, including HIV • Vertical implementation of the HIV response interventions compromise efficiency and effectiveness • There is no defined mechanism for social contracting to fund/support CSOs/NGOs.	• Strengthen government capacity to increase and sustain domestic funding for the HIV response • Galvanize political leadership to ensure sustained funding of the HIV response, including development of alternative and innovative resource mobilisation mechanism such as universal health insurance and specific HIV-related levies • Expand the donor base beyond the traditional donors (PEPFAR and GF) • Strengthen public-private partnerships with the private sector to support implementation and funding of the HIV response. • Integrate HIV-specific interventions into the UHI mandatory essential benefit package over time

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
		• Inadequate prioritization may lead to financing of low impact interventions • Private sector not adequately engaged in the HIV response • Inadequate alternatives to government funding for domestic resource mobilisation for HIV response	• Strengthen mechanisms for co-payment of HIV commodities, particularly in the private sector, based on a public private partnership (PPP) arrangement • Strengthen HIV services integration in the broader health system • Strengthen the capacity of non-health sectors to mainstream HIV in their development programmes • Ensure effective operationalization and inclusion of low-income sub populations in the Universal Health insurance • Develop a stakeholders/service providers performance-based accountability framework • Develop and operationalize an effective resource tracking • Improve budget, allocation and technical efficiency of health and HIV funding to improve efficient and effective use of funding

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
			• Institutionalise and operationalize social contracting mechanisms to support CSO/CBOs/ FBOs (including KVP and PLHIV led) implement community-based and community led initiatives.

3.3. Service Delivery

The HIV response service delivery framework is founded on two pillars i.e., prevention and treatment. While services are distinct, they are complementary and cannot be considered in isolation. Tanzania has prioritized HIV prevention and has put in place several strategies intended to stop the acquisition and transmission of new HIV infections, including pediatric infections. Tanzania has adopted the "combination prevention" approach in the provision of HIV prevention services.

Several strategies are used to prevent the spread of HIV, including Voluntary Medical Male Circumcision (VMMC), Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), Prevention of Mother to Child Transmission (PMTCT), condom programming, and social and behaviour change interventions. The services have been rolled out across the country, and performance varies from one region to another and by subpopulation, indicating the urgent need to review and adapt the current service delivery model to more efficient ones, including service integration, mainstreaming of HIV prevention interventions into all sectors, using differentiated service delivery models, and even strengthening community-based and community-led services. The need to strengthen the capacity of community health workers also emerges as a critical priority.

The variations in performance also call for evidence-based prioritization and scale-up of high-impact interventions such as PrEP, targeting key and vulnerable populations, including vulnerable adolescent girls and young women (AGYW), with precision prevention interventions. HIV testing services (HTS) is critical in identifying people living with HIV who don't know their status for purposes of linking them with care and support. It is equally important as an entry point to link people with negative HIV status to effective HIV prevention services such as PrEP, PEP, VMMC, and behaviour change interventions.

In the case of treatment care and support, Tanzania already has an effective continuum of care and support model. This framework has supported Tanzania in the implementation of the strategies leading to the achievement of the 95-95-95

targets. Although Tanzania has achieved the second and the third 95 targets, it is yet to achieve the first 95 target. This is an area of critical concern as the first 95 target is a primary determinant of the impact of the second and third targets. Efforts have been made to strengthen community mobilisation and identification of people at higher risk of infection and linking them with HIV testing services, including provider-initiated counselling and testing (PITC), client-initiated counselling and testing (CITC), or even HIV self-testing. Integration of HTS in other services such as PMTCT, VMMC, STI, and reproductive health care services has expanded the scope of HIV testing and the identification of PLHIV who don't know their HIV status.

The vision for service delivery is to reach the 95-95-95 targets and beyond and transform the response into an integrated, multisectoral effort. Special attention will be paid to underperforming regions and targeted efforts made to ensure equitable access for all subpopulations.

Table 5: Service Delivery - High Level Outcomes, Strategic Barriers and Pathways for Chang

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways fo
Services Delivery	● 90% of people living with HIV and most at risk are linked to people-centred and context-specific integrated services[6] ● 90% of PLHIV receive preventive treatment for TB ● The 95-95-95 targets are achieved and maintained across all sub-populations. ● 95% of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding	● Vertical implementation of programmes and service delivery ● Prevalence of stigma and discrimination, and GBV ● Inadequate comprehensive knowledge of HIV and AIDS – limits access to services ● Lower uptake of services by men and children ● Some regions and sub-populations (men, children and KVP) are underserved	● Strengther services (i mainstrea programm ● Strengther address so and utilisa ● Strengther multisecto differentia ● Empower (HR, skills, f

[6] Including other communicable diseases, noncommunicable diseases, sexual reproductive health, gender-based violence, mental health, drug and substan they need for their overall health and well-being

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
	• 95% of people at risk of HIV infection have access and are using comprehensive HIV prevention people-centred services • 95% of pregnant and breastfeeding women living with HIV have suppressed viral loads • 95% of women of reproductive age have their HIV and SRHR service needs met • HIV services are integrated with broader health care services • Less than 5% of PLHIV and KVP experience stigma and discrimination, gender inequalities, and all forms of GBV	• Sub-optimal scale-up of newer interventions (PrEP & HIV self-testing) • Health and community systems are fragile and lack adequate capacity (prone to external disruptions) • HIV services are inadequately integrated in the broader healthcare systems • Quality is compromised due to lack of appropriate capacity, especially at community level. i.e., HR and technology, infrastructure • Management of services providers remain challenging – given the numbers and diversity • Inadequate data management and use to inform service delivery • Stigma and discrimination – compromising access and use of services	community-based HIV testing, prevention, and treatment services • Strengthen the policy and operational environment to embrace, adopt, and use new technologies and policies • Intensify social and behaviour change interventions to improve individual risk perception, and increase demand for HIV and AIDS services • Strengthen strategic health systems (Lab, HMIS, PSM, HRH) to ensure effective and sustained service delivery • Strengthen the PPP model of service delivery and support with the private sector and CSO

3.4. Systems

In Tanzania, HIV services are supported by the broader health system, necessitating a better understanding of the key features of the systems that are essential for the prevention, diagnosis, care, and treatment of HIV, including 1) human resources, 2) commodities/supply chain, 3) laboratories, 4) health information systems, 5) financing and 6) leadership and governance. Human Resources form the foundation of the health system's capacity to support service delivery. While evidence shows an increased HR capacity, the most recent (2018) estimates for Tanzania indicate a continued HRH shortage, with only 0.6 medical staff per 1,000 people, far below the 2.5 per 1,000 people recommended by WHO. An additional 210,000 healthcare workers will be needed to meet the needs of a population estimated at 60 million. Several factors contribute to HRH shortages, including a fragile economy for adequate budgetary allocation of resources for the recruitment of health workers. For example, in the fiscal year 2024/25, the government allocated TZS 400 billion for HRH, marking a 14.3% rise from the previous fiscal year. This budget supported the employment of 15,000 new healthcare workers, a substantial 50% increase in HRH employment compared to 2023/24 but significantly falling short of the required HRH estimated at 229,245. The addition of 15,000 new healthcare workers, while significant, represents only a small fraction (6.5%) of the overall deficit. The government has launched a new integrated and coordinated CHW program that will strengthen the delivery of basic health services at the community level.

A functional and efficient commodity procurement and supply chain is critical in sustaining service delivery. The Medical Stores Department (MSD) is mandated to procure, store, distribute, and produce the needed and approved medicines and medical supplies. It also serves as a centralized warehouse for the other zones. Donors have supported several initiatives to strengthen the procurement and supply chain in order to address issues of stock-outs of essential medicines and supplies and the establishment of the establishment Strategic Management Office (SMO) to oversee improvements in the supply chain and the Integrated Logistics System (ILS). This support also aimed at incorporating vertical program commodities, such as HIV, into the national system.

The process also involved the development of the EPICOR software programme intended to optimize resource planning for health commodities. Efforts are needed to improve the integration and interoperability of existing systems. The Strategies

for Enhancing Access to Medicines (SEAM) program established the accredited drug dispensing outlets (ADDOs) to improve access to non-prescription health commodities in places with limited access. Other projects have aimed to strengthen the supply chain through improved logistics, job training, quantification, procurement, quality assurance, warehousing and distribution, and waste management programme. The above initiatives have capacitated the government to make objective estimates, quantifications, storage, and distribution of essential commodities and pharmaceuticals, including ARVs. Moving to bottom-up quantification from the current top-bottom for vertical programs is in the pipeline and is expected to start by 2025. However, Tanzania is still dependent on external support and in particular PEPFAR and Global Fund, for the procurement of commodities for HIV. This dependence poses long-term sustainability challenges. In addition to securing domestic funds for the provision of HIV commodities, there are further opportunities to explore efficiencies in the provision of HIV commodities, such as distributing private sector self-test kits, utilizing less expensive ARV regimens, improving the efficiency of housing and distributing commodities, and increasing the use of local manufacturers and suppliers.

Numerous other systems have been developed and implemented to improve the collection and organization of health data. Many of these systems are donor-supported, including Tanzania Output Monitoring System for HIV and AIDS (TOMSHA), DHIS2, and CTC Database, among others. Operations seem vertical with minimal integration. The Health Information Exchange (HIE) provides interoperability mechanisms to streamline data collection, improve data quality, and enable comprehensive data analysis. There is a further need to review and improve the interoperability of the systems. Equally strengthening the related human and technological capacity and the infrastructure will enhance the efficiency and effectiveness of the HIS. Addressing the issue of HIS fragmentation will enable integration of data from TOMSHA and Community Led Monitoring (CLM) with the national health management information systems. It is important to address the issue of systems donor dependence to ensure sustainability and national ownership.

The assessment noted that the laboratory system was equally functioning at a sub-optimal level. Strengthening the system will enable timely diagnosis of HIV, treatment initiation, and ongoing monitoring. A strengthened laboratory system will efficiently support a comprehensive range of tests from HIV tests to detect the

HIV virus, opportunistic infections (e.g. tuberculosis, hepatitis B), tests to determine the stage of HIV (e.g., CD4 count, viral load), liver and kidney function tests, other blood and urine tests to measure response to treatment, and HIV drug resistance testing. At present, the Tanzania laboratory system uses a hub-and-spoke model, where facilities within a catchment area ("spokes") send samples to a centralized collection point ("hub"), which then aggregates samples for transportation to a testing laboratory. This system links over 7,000 spokes and 300 hubs to the 17 regional and zonal testing labs able to conduct viral load tests. The government of Tanzania has undertaken several initiatives to strengthen the laboratory system in partnership with development partners, ranging from quality management to training laboratory technicians and providing technical assistance to improve supply chain management.

To optimise services uptake and retention, intensifying demand creation, improving the levels and quality of comprehensive awareness and knowledge of HIV and AIDS will be critical. Similarly addressing structural barriers such as i.e. poverty, food insecurity, stigma and discrimination, GBV, negative social-cultural norms will be required. These efforts will be complemented by ensuring the functionality and efficiency of supportive health systems such as laboratory, supply and procurement, human resources, and health information systems. The process will also ensure systems integration, interoperability, and have the capacity to support service delivery without disruption.

The following table presents the HLO associated with the service delivery, the critical barriers likely to compromise service delivery, access, and utilisation, and further suggests strategic pathways to ensure services availability, equitable distribution, and sustainability. Services will be delivered using differentiated service delivery models.

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
Systems	• The health systems (including sub-systems will be resilient and operating at optimal levels • Health systems will be adequately financed and funding will be sustained • Over 80% of the human resource needs will be met and sustained across the health systems. • 80% of the health information systems needed for the HIV response will be interoperable, functional and	• Health systems are fragmented and not adequately interoperable and function at sub-optimal • Health systems strengthening and management is largely donor dependent • Systems operate vertically • Inadequate HRH, compounded by gaps in skills and competencies • Operational challenges with the infrastructure including intermittent access to internet and electricity. Many operations remain paper-based systems • Slow adoption and application of new technologies for the HIV response • Parallel HMIS systems limit systems interoperability • Procurement is donor-driven • Inadequate capacity for pharmaceutical and commodities quantifications – often top-down rather than evidence-based approached	• Strengthen the health systems – sub-systems - human resources, laboratories, procurement and supply, and health information systems • Advocate for the recruitment of adequate, skilled, and competent human resources • Leverage integration of HIV services into private healthcare provider services to address the HRH gap in the public sector • Strengthen the integration and interoperability of health systems, including community-led monitoring (CLM) • Accelerate the process of digitalizing health systems and, particularly HMIS to enhance the quality and management of data • Digitalize the supply chain system and introduce track and trace systems • Capacitate MSD to procure, store, and distribute HIV commodities • Mainstream HIV in all sectors (sector-wide approach)

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
	efficiently sharing data and strategic information • The procurement and supply chain will be fully integrated and functional • HIV response will be mainstreamed into other sectors policies and programmes	• Inadequate integration/alignment of procurement and supply chain information systems to enhance real-time inventory tracking, demand forecasting, and distribution • Frequent interruptions of sub-systems such as laboratory supplies and sample transportation system	

3.5. Community Role in HIV Response

Community in the context of the HIV Sustainability Roadmap refers to individuals, networks, organizations, and local structures working collaboratively in HIV response efforts. These include constituencies such as PLHIV, key and vulnerable populations, civil society organizations (faith-based organizations, community-based organizations, and local NGOs), local government structures (e.g., Multisectoral AIDS Committees, Health Facility Governance Committees, and Health Service Boards), community health workers (CHWs), social welfare officers (SWOs), community development officers (CDOs), opinion leaders (e.g., chiefs and religious leaders), and private sector actors. When empowered and meaningfully engaged, communities are the cornerstones of a comprehensive multisectoral and decentralized HIV response.

Globally, since the onset of the HIV epidemic, communities have played a critical role in advancing human rights and supporting interventions to reduce gender inequalities and gender-based violence. Their informal roles tend to support and promote an enabling social, policy, and legal environment necessary for HIV services delivery. Specifically, community-led organizations play a pivotal role in community mobilisation, facilitating social and behaviour change, addressing social/cultural norms and practices that impact the HIV response (especially with regard to key and vulnerable populations), primary HIV prevention interventions, ART adherence, and retention in care.

The sustainability assessment found that in Tanzania, four aspects of the community role in the HIV response are particularly important in ensuring the sustainability of HIV response: 1) The network of community health workers (CHWs), 2) the use of community-based HIV services, 3) coordination of civil society organizations (CSOs), and leveraging the private sector in supporting community-centred HIV response efforts.

Tanzania's Community Health Worker (CHW) initiative was first established in 1978. In 2015, in response to the global call to strengthen community-based health and HIV responses, it evolved into a more robust **Community-Based Health Care Programme (CBHP)**. Since then, the government has developed and launched national guidelines for CHW integration. Currently, the initiative has recruited approximately 20,000 CHWs, with plans to expand this number to over 135,000.

CHWs are assigned to HIV Care and Treatment Centres (CTCs), where they provide education, support, and client follow-up. While CHWs are considered volunteers, they receive financial incentives in the form of stipends. However, funding challenges persist, as the government has not fully budgeted for the training and supervision of CHWs, leading to reliance on inconsistent donor support. The introduction of the Unified Community System (UCS), a data-sharing platform, aims to improve coordination between CHWs and health facilities by consolidating patient information and enhancing the delivery of community-based HIV testing, prevention, treatment, care and support, and other health services.

Community-based HIV services involve a mobile team traveling to communities, offering services at home, mobile location, workplace, and campaign-based testing. This approach has been shown to be effective in identifying HIV positive individuals early and linking them with care and support services. The approach has been most effective in outreach-related activities targeting difficult-to-reach sub-populations with interventions such as HTS (including venue-based testing) and condom distribution. Venue-based testing, such as at festivals, has been effective in reaching men and youth, who are often less likely to be tested. Expanded community-based testing has the potential for improvements in the percentage of PLHIV who know their HIV-positive status.

Strengthened communities can equally support and accelerate other community-based interventions, including community ART initiation for KVP, community ART refills for stable clients, community-based PrEP services, demand creation and advocacy, and enhanced outreach services. Studies have shown that community-based testing campaigns significantly increase HIV status awareness, particularly among KVP, youth, and men. Initiatives like the FIKIA project have demonstrated the effectiveness of this model, diagnosing new HIV cases and rapidly linking individuals to treatment.[7,8]

---

[7] Maruyama H, Franks J, Laki D, Msumi O, Makyao N, Rwabiyago OE, Rabkin M, Kagashe MJ, El-Sadr WM. Bringing HIV services to key populations and their communities in Tanzania: from pilot to scale. J Int AIDS Soc. 2021 Jul;24 Suppl 3(Suppl 3):e25718. doi: 10.1002/jia2.25718. PMID: 34189856; PMCID: PMC8242965.

[8] Geldsetzer P, Francis JM, Ulenga N, Sando D, Lema IA, Mboggo E, Vaikath M, Koda H, Lwezaula S, Hu J, Noor RA, Olofin I, Larson E, Fawzi W, Bärnighausen T. The impact of community health worker-led home delivery of antiretroviral therapy on virological suppression: a non-inferiority cluster-randomized health systems trial in Dar es Salaam, Tanzania. BMC Health Serv Res. 2017 Feb 22;17(1):160. doi: 10.1186/s12913-017-2032-7. PMID: 28228134; PMCID: PMC5322683.

The potential for community-based CSOs, CBOs, and faith-based organisations, which account for approximately 12000 organisations, has not been fully explored and leveraged. However, WHO is currently developing a digital platform to map and organize CSOs and, in particular, document their capacity, areas of focus, and comparative advantage in HIV prevention and treatment service delivery.

Considering the capacity, mandate, and comparative advantage of CSOs will enable the government to establish strategic partnerships with them to implement the commitments outlined in the 2021 Political Declaration on HIV and AIDS and the Global AIDS Strategy 2021-2026) on community / CSO engagement and participation in the HIV response delivery including specific targets such as the 30–60–80 goals by 2030 and beyond (i.e., 30% of testing and treatment services to be delivered by community-led organizations; 60% of the programmes to support the achievement of societal enablers to be delivered by community-led organizations; 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by the community, key population and women-led organizations) as outlined below.

Baseline data related to these indicators is not currently available and needs to be generated as soon as possible during the implementation of the Sustainability Roadmap Part B. It is also critical that communities will be empowered with relevant skills to undertake community-led monitoring of these indicators.

All stakeholders acknowledge the strategic role of the private sector not only in expanding the scope of service delivery but, more importantly, in funding the response. The role has been minimal and unstructured. Currently, Tanzania has approximately over 200 registered private hospitals, 700 private health centres, and 1,800 private dispensaries that provide HIV care. Some of these facilities include those run and managed by faith-based and not-for-profit organizations (NGOs). The potential for public-private partnerships with the objective of expanding HIV service delivery, especially in districts without public hospitals, should be a critical consideration. Some of the innovative approaches for the PPP collaboration include institutionalising the concept of social contracting, where the government could specifically contract qualified and competent non-government and private sector institutions to provide specific services for a fee.

Equally, a review and strengthening of some non-profit organisations that are almost defunct but played a critical role in the response in the past could be a game changer. Such organisations include The AIDS Business Coalition of Tanzania

(ABCT), The Association of Private Health Facilities of Tanzania (APHTA), The Association of Tanzania Employer, and Tanzania Private Sector Foundation. On the other hand, strengthening the Christian Social Services Commission could equally have a multiplier effect with the FBO network which is currently receiving USAID support.

For resilient and sustainable community systems, communities will need to be strategically empowered to initiate and successfully implement community-based and community-led HIV prevention and treatment services in line with the 2021 United Nations Declaration of Commitment and the Global AIDS strategy.

The Table below provides illustrative details of the high-level outcomes for the envisioned future state, current and anticipated barriers and bottlenecks in achieving sustainability goals, and the pathways of change for enabling the community to play a critical role in the HIV response by 2030 and beyond.

Table 6: Community Role in the HIV Response - High Level Outcomes, Strategic Barriers and Pathways for Change

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
Community Role	• 30% of HIV testing and treatment services are being provided by community-led organisations • 80% of HIV prevention service targeting KVP and women are being delivered by the community, KVP, and women-led organisations • 60% of the programmes addressing societal enablers and barriers are delivered by community-led organisations, including KVP and PLHIV organisations • 90% of PLHIV and people at risk are linked to other integrated health and social services, including GBV/VAC preventive related	• Ad hoc and inadequate funding of community-based and community-led HIV response interventions • Inadequate HR, especially CHW • Inadequate coordination and accountability mechanisms among CSOs due to lack of adequate leadership and governance skills • Lack of systematic implementation of the community-based service delivery strategy • Weak governance, leadership, and management structures among PLHIV and KVP – compromising service delivery • Inadequate funding and HR capacity among community-led organisations • Inadequate technical skills to operationalize CLM • Low community-led organisations engagement with community-based	• Scale up and roll out the CHW programme • Accelerate the implementation of the community-based health delivery services strategy • Advocate for sustainable financing for community-led initiatives • Strengthen the technical capacity of community-led organisations to delivery community-based, and community-led HIV prevention and treatment services • Institutionalise social contracting to support CBOs • Strengthen strategic partnerships between the private sector and CBOs to enhance service delivery • Strengthen the capacity for communities to implement CLM • Strengthen the capacity of CBOs to support and delivery key services for KVP and PLHIV

Domain	High Level Outcome	Blockages / Barriers / Gaps	Pathways for Change
		and government-led leadership and governance structures • Minimal private sector engagement and support the HIV response • Inadequate linkages between communities and community-based health centres (with exception from the external donor included NGOs) • Prevalence of stigma and discrimination, gender inequalities, and GBV targeted to PLHIV and KVP • Fragmentation of services • Inadequate policy guidelines and oversight supervision of CBOs. There is no formal framework for community engagement and sub-contracting of CBOs to provide community-based services	

Part 4: Limitations

The process of developing this Roadmap Part A, including the assessment, did not involve discussing interventions that the government may not be able to take on in the short term due to fiscal space constraints, policy or legal barriers, or other socio-economic factors. Part B of the Roadmap will identify specific interventions that can be taken on in the short and long term by the government in partnership with the private sector, civil society, community-led organizations, and development partners. That document will consider the comparative strengths of each partner to contribute to the vision of a sustainable HIV response.

Part 5: Key Inputs for the Transformation Plan (Roadmap Part B)

In developing Part B of the Roadmap, the process will draw strategic information from the outcomes of Part A. In particular Part B will be informed and guided by the sustainability vision and goal articulated in Part A. It will also be guided by the analysis of the current state of the HIV response, the high-level outcomes, and the suggested pathways for change for each sustainability domain. The pathways for change are premised on responding to the strategic and prioritized barriers, and gaps that not only prevent sustainability being achieved, but equally possess potential threat to the overall sustainability of HIV prevention and treatment response.

Part B will also reflect on the following ten (10) critical transformation areas, to ensure its robustness strategic focus and impact.

1 From an emergency to a sustained response/ dealing with a chronic illness

With the advancement in medical science, HIV and AIDS are no longer life-threatening. Treatment has turned the epidemic into a chronic illness.

2 From a national to community-based and community-led people centred response

Development of new and innovative fiscal policies and financing mechanisms, the government has great potential to turn the epidemic to fully depend on domestic funding despite the competing needs for government funding.

3 From a vertical to an integrated services planning and delivery approach

Vertical programs have failed to deliver the desired impact and efficacy. Neither have they contributed to efficiencies in service delivery. Integration has the potential to be cost-effective and reduce client fatigue, leading to better chances for adherence and retention, especially for KVP (Key and Vulnerable Populations).

4 From a national to community-based and community-led people centred response

It is evident that communities have increasingly become the pillar for the HIV response's sustainability. Their meaningful engagement and participation will enhance the objective.

5 From a gender inequality to a gender-sensitive and responsive response

The HIV epidemic has significant gender bias coupled with other social and economic inequalities. HIV has had a great impact on women and, in turn, on society. Addressing these inequalities will pave the way for a meaningful and impactful response.

6 From a sector approach to a multisectoral, decentralized, and mainstreamed approach

Mainstreaming the concept of multisectoralism will enable the country to expand the scope and reach of the response, widening the opportunity to reach more people, including captive populations such as people working in specific sectors such as fisheries, mining, tourism, agriculture, and education, etc. A multisectoral approach also increases the possibilities for tapping into sector resources to fund HIV response.

7 From fragmented oversight to a robust governance system that ensures accountability across all levels of the HIV response

Strengthening governance structures and implementing an accountability framework will be essential to drive ownership, coordination, and results-oriented actions. This involves empowering local leaders and stakeholders, ensuring clear roles and responsibilities, and enhancing transparency in resource allocation and service delivery. A strong governance framework will align with national and global standards, fostering trust and commitment within the HIV response ecosystem.

8 From evidence-limited programming to a seamless, data and technology-supported HIV response

Enhancing the use of technology and strategic information systems is crucial for real-time data collection, analysis, and application in decision-making processes. This shift supports targeted interventions, performance tracking, and program adjustments based on evidence. Leveraging digital health tools and interoperable systems will improve the quality and reach of services, optimizing outcomes and sustainability.

9 Policy environment that supports inclusivity and effectiveness using public health approach

The HIV response must be supported by policies that remove barriers to service access, especially for key and vulnerable populations. Reviewing and revising policies to reflect international best practices ensures that rights are protected, stigma is reduced, and laws facilitate comprehensive, stigma-free healthcare. This will create a conducive environment for implementing impactful and equitable interventions.

10 From basic community involvement to empowered, community-led leadership in the HIV response

Empowering communities to lead and implement HIV initiatives enhances sustainability and ownership of the response. By shifting to a people-centered approach where community members drive programs, there is an increase in cultural relevance, trust, and participation. Strengthening community structures and providing training and resources for leadership will reinforce local capacities and ensure long-lasting, impactful results.

Appendixes

Appendix 1: Institutional Membership in the Sustainability Working Group (SWG)

1. Association of Private Facilities in Tanzania
2. Association of Tanzania Employers
3. CEO Roundtable of Tanzania
4. Christian and Social Services Commission
5. Christian Council of Tanzania
6. Christian Pentecostal Churches of Tanzania
7. Geita Gold Mine
8. Ministry of Community Development, Gender, Women and Special Groups
9. Ministry of Health
10. Ministry of Education, Science and Technology
11. Ministry of Finance
12. Ministry of Foreign Affairs and East African Cooperation
13. Ministry of Minerals
14. Ministry of Transport
15. Ministry of Works
16. National Council of NGOs
17. National Council of People Living with HIV in Tanzania
18. UNAIDS
19. World Health Organisation
20. National Muslim Council of Tanzania (BAKWATA)
21. President's Office, Planning Commission
22. President's Office of Public Service Management and Good Governance
23. President's Office of Regional Administration and Local Government (PO-RALG)
24. Prime Minister's Office of Labor Youth, Employment and Disability
25. Prime Minister's Office of Policy, Parliament, and Coordination
26. Seventh Day Adventist Church of Tanzania
27. Tanzania Commission for AIDS
28. Tanzania Episcopal Conference
29. Tanzania Private Sector Foundation
30. National Council of Muslims
31. United States Government Agencies (PEFPAR, USAID, DOD and CDC)

Appendix 2: Definition of Terms used in Roadmap Part A

Accountability	The social or legal obligation of a service provider to demonstrate efficient use of resources (finance, HR, materials etc) earmarked for HIV response, and secondly to ensure that services are delivered in a timely manner, desired quality and in compliance with agreed standards.
Community-based HIV services	These are services that are often community-based delivered by the community or an external service provider. In the case of Tanzania the services are either provided by MOH, or other NGOs funded to work with communities. Communities are in most cases beneficiary.
Community-led HIV services	These are services that community take the lead in planning, delivery and monitoring. The often community initiated, or in collaboration with the nearest community-based health facility. They include CLM.
Domain	Domain is a particular field of thought, activity, or interest. It sets out common ideas with similar characteristics or intended programmatic goals
Empowerment	The process of strengthening the capacity of individuals or organisations to make informed decisions and choices, and subsequently take the most appropriate actions.
Enabling Environment	An enabling social, policy, and legal environment is one in which laws and policies are supportive of HIV services planning, delivery, access and utilisation by diverse clients including KVP. To the right to health – including HIV prevention and treatment are not only respected, protected but also fulfilled.
Equity	The absence of unnecessary, avoidable, and unfair differences between individuals, groups or communities with respect to economic and social potential, and in particular, equitable access to HIV and AIDS services
Goal	A goal is a statement of what needs to be accomplished to achieve a vision or specific strategy. Goals are specific, measurable, and achievable "intentions" that a person or an organization aims to accomplish within a defined timeframe for a specific purpose.
Governance	Governance is a system that enables oversight, monitoring, and accountability of the processes and people within a system or organisation. Governance is associated with accountability, engagement, and participation by the people.
High-Level Outcomes	High-level outcomes (HLOs) articulate the state or condition that must exist in order to sustain the HIV response beyond 2030, and they reflect the higher-level transformative changes that are needed to achieve the long-term goals of the country's HIV response. HLOs are the building blocks for the change framework and the transformational plan, which will be developed in Phase 4.
Health Systems Strengthening	The term refers to a process that empowers the health system to deliver effective, safe and high- quality interventions to those who need them. Health systems strengthening focus on issues around services delivery,

	finance, leadership and governance, pharmaceuticals and commodities, and strategic information. A health system encompasses all organizations, people, and actions whose primary purpose is to promote, restore, or maintain health. It includes health service delivery, laboratory services, a robust health workforce, health information systems, access to essential medicines, financing, and leadership/governance (stewardship). In the context of HIV, a strong health system is crucial for the delivery of comprehensive HIV services, including prevention, testing, treatment, care, and support, ensuring that these services reach all individuals, especially key populations and those most vulnerable to HIV.
Integration	Integration has been used to mean putting different services together to maximise efficiency, efficacy, and outcomes. In the context of HIV, integration refers to the coordinated delivery of HIV prevention, testing, treatment, and care services alongside other health services within the broader health system. Integration aims to enhance efficiency, improve patient experience, and expand access to comprehensive healthcare by reducing stigma, minimizing barriers to care, and addressing the multiple health needs of individuals within a single, unified system.
Leadership	Leadership is defined as a social process that involves inspiring and shaping policies, influencing efficient and effective service delivery, use strategic information to inform decision making, resource allocation and service delivery. Leadership is characterised by strong interpersonal skills, values, and a commitment to collective risk taking and accountability.
Mainstreaming	Mainstreaming refers to the process of integrating services in other non-health sector's development projects and workplace health and wellness programmes.
Pathways of change	A pathway of change refers to how the changes for reaching a specific high-level outcome are achieved. For the HIV Response Sustainability Roadmaps, these changes will describe the major shifts that are necessary to transform the response from its current state to a desired, future state. This may require more than a simple one-to-one change in a set of existing components over time. Thus, these transformative shifts refer to necessary changes throughout the HIV programme that are required to achieve the high-level outcomes.
Right to Health	The right to health has been defined as the right to "the highest attainable standard of health" – including HIV
Risk	HIV related risk is defined as the likelihood of a person to be exposed to HIV or the likelihood that an infection may occur. It is also associated with external risk factors (structural factors) that exacerbate the risk process such as poverty, GBV, food insecurity, etc.
Sustainability	**Financial sustainability** refers to a situation where most of the financial resources needed for the HIV response are assured from domestic sources.

	Sustainability is characterised by reduced donor dependence, efficiency and effectiveness of service delivery. **HIV services sustainability** refers to a situation where services are not at risk of being withdrawn or withheld due to lack of resources (human, finance, systems etc.) to pay for their procurement and delivery.
Transformation plan	The sustainability transformational plan will be developed during Phase 4. It should outline what is needed to implement the sustainability strategies and actions that can achieve the desired changes and sustain their impact. This plan is referred to as Roadmap Part B
Viral Suppression	Viral suppression- an HIV RNA<1000 copies/ml on viral load testing. Viral suppression is the reduction of HIV in a person's blood to very low, often undetectable, levels as a result of effective antiretroviral therapy (ART). Achieving viral suppression is a key indicator of successful HIV treatment, as it not only improves the health and quality of life of the individual but also significantly reduces the risk of transmitting the virus to others. Sustained viral suppression is essential for reaching the global HIV targets and ending AIDS as a public health threat by 2030.
Vision	A vision is a long-term, broad futuristic idea or concept that describes the desired future state or outcome / What you wish to accomplish in a 5-, 30- or 50-years timeframe with the HIV response. A vision informs strategic directions (pathway) into the future and shape your goals
Vulnerability	Vulnerability refers to unequal opportunities, social exclusion, unemployment, and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. The factors underlying vulnerability may reduce people's ability to protect themselves, access, or remain on services. Vulnerability is often exacerbated by social and structural issues (external) that the affected person has no control of. Vulnerability factors range from personal and societal to development factors.

United Republic of Tanzania

Prime Minister's Office

HIV Response Sustainability Roadmap

Part A

December 2024