

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

NATIONAL AIDS CONTROL PROGRAMME



NATIONAL GUIDELINE FOR COMPREHENSIVE PACKAGE OF HIV INTERVENTIONS FOR KEY AND VULNERABLE POPULATIONS

April, 2017
Second Edition

Publication Details

Published in 2017

Ministry of Health, Community Development, Gender, Elderly, and Children

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ISBN 978-9987-835-04-1

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Foreword

Tanzania has made substantial headway in the scale up of HIV interventions which has led to a reduction of the prevalence in the general population over the past 20 years. Given the disproportionate burden of the HIV epidemic among the key and vulnerable populations in the country, focus is now also very much needed to address the HIV prevention, care, treatment, and support needs of key and vulnerable populations. These key and vulnerable populations include people who are both extremely vulnerable to, and at an increased risk of, HIV due to their specific behaviors.

The Government of the United Republic of Tanzania has endorsed several global commitments and their respective plans of action, including the Sustainable Development Goals (SDGs) and the 2016 UNGA Political Declaration on HIV and AIDS, among others. The commitments made by Tanzania aim to improve the quality of life and achieve elimination of new HIV infections by targeting where new infections are concentrated. In line with this, the Government of Tanzania has developed these National Guidelines to guide and standardize the implementation of a comprehensive package of HIV and health interventions for the Key and Vulnerable Populations (KVPs) who are at high risk for HIV, to ensure that all populations have access to quality health services without stigma or discrimination.

It is envisaged that these guidelines will be used as a reference for different KVPs HIV stakeholders, including those in research, learning institutions, health facilities, individuals, and organisations working with KVPs for HIV prevention.

The Ministry of Health, Community Development, Gender, the Elderly, and Children (MoHCDGEC) will support the implementation of these national guidelines by creating the systems and structures to support its implementation. These include provision of the training packages, human resources, provision of drugs, equipment, and supplies that are necessary for provision of quality prevention and treatment services for KVPs.

As information and knowledge about HIV and AIDS continues to evolve, the MoHCDGEC remains committed to staying abreast of scientific developments in the field and ensuring that prevention, care, and treatment of HIV and AIDS are informed by these developments.



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Acknowledgements

The scope of the 2014 National Guidelines for Comprehensive Package of HIV Interventions for Key Populations was extended in 2017 to also include vulnerable populations. The guidelines were reviewed to clarify the community interventions package, and to reflect the latest available HIV related guidelines in the country including the October 1, 2016 circular issued by NACP, based on the 2015 WHO "treat-all" recommendation, which expanded antiretroviral therapy eligibility to all people living with HIV, and the recommendation to use HIV viral load as the preferred approach for monitoring all patients on antiretroviral therapy. A taskforce of members from government, development and implementing partners, and NGOs provided guidance to the revision process, under the leadership of the National AIDS Control Programme (NACP). Members included NACP, TACAIDS, UNAIDS, WHO, ICAP, MDM, CDC, USAID, WRAIR-DOD, THPS, TAYOA, PSI, Jhpiego, HJF/MRI, Save the Children, NACONGO, NACOPHA and TIP. We would like to thank all who were engaged in the comprehensive guideline revision.

Specifically, I would like to recognise and congratulate all staff of the National AIDS Control Programme who took on this task with great courage, commitment and zeal. The strong leadership and guidance of NACP Program Manager, Dr. Angela Ramadhani, was critical. Also, I would like to appreciate the excellent coordination and support of Neema Makyao and other Prevention staff. Without your commitment and dedication, it would have been very difficult to complete the task on time.

Finally, I wish to recognize all technical experts who participated in reviewing this Guidelines. Your contribution is highly acknowledged.

We wish you well, and look forward to your commitment and dedication in supporting the Ministry.



Dr. Neema Rusibamayila

DIRECTOR OF PREVENTIVE SERVICES

Acronyms and abbreviations

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community-Based Organization
CBHS	Community-Based HIV Services
CDC	Centers for Disease Control and Prevention
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender-Based Violence
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HJF/MRI	Henry Jackson Foundation/Medical Research Institute
HTS	HIV Testing Services
IEC	Information, Education, Communication
IPC	Infection Prevention Control
LGA	Local Government Authority
KVP	Key and Vulnerable Populations
MAT	Medically Assisted Treatment
MDH	Management and Development for Health
MDM	Medicine du Monde
MoHCDGEC	Ministry of Health Community Development, Gender, Elderly and Children
MSM	Men who have Sex with Men
NACP	National AIDS Control Programme
NACONGO	National Council of NGOs
NGO	Non-Governmental Organization
NSP	Needle and Syringe Programme
NS	Needle and Syringe
PEP	Post Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counselling
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
PO-RALG	President's Office – Regional Administration and Local

PrEP	Government
RTIs	Pre-Exposure Prophylaxis
SSA	Reproductive Tract Infections
STI	Sub Saharan Africa
SW	Sexually Transmitted Infections
TACAIDS	Sex Workers
TAYOA	Tanzania Commission for AIDS
TB	Tanzania Youth Alliance
THPS	Tuberculosis
TG	Tanzania Health Promotion Services
UNAIDS	Transgender people
USAID	Joint United Nations Programme on HIV/AIDS
UNODC	United States Agency for International Development
WHO	United Nations Office on Drugs and Crime
	World Health Organization

Definitions of Terms (Glossary)

Adolescents: Individuals between the ages of 10 and 19 years old are generally considered adolescents. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions, and their ability to access services.

Adolescent Girls and Young Women: Young women aged 15-24 who are more than twice as susceptible than their male counterparts to contract HIV due to a variety of social drivers that contribute to their increased risk and vulnerability. This population overlaps with the national expanded definition of orphans and vulnerable children (OVC).

Combination Prevention: Combination prevention programmes can be defined as; “rights based, evidence-informed, and community owned programmes that use a mix of biomedical, behavioral, and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections.” Source: UNAIDS (2010).

Comprehensive Package of Services for KVPs: This is the process of rendering services for KVP in a full set of interventions recommended; for example, offering prevention, care and treatment services (counselling and testing, PMTCT, family planning, GBV prevention and response, community based interventions as well as Information Education Communication at one setting).

Evaluation: Evaluation is a systematic and periodic assessment of actions in order to improve planning or implementation of current and future activities. Evaluation involves follow up of inputs, outcomes and impacts to assess whether the set out objectives have been achieved. This can be done internally (by the implementers) or externally (by outsiders).

Gender-Based Violence Gender-based violence results in physical, sexual, and psychological harm to both men and women and includes any form of violence or abuse that targets men or women on the basis of their sex. Unequal power relations between men and women significantly contribute to gender violence.

Harm Reduction: refers to policies, programmes, and practices that aim to primarily reduce the adverse health, social, and economic consequences of the use of drugs without necessarily reducing drug consumption. The first priority is a decrease in the negative consequences of drug use.

Key Populations (KPs): KPs are defined groups who, due to specific higher-risk behaviors, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often face legal and social issues related to their behaviors that increase their vulnerability to HIV and which limit their access to services. WHO guidelines focus on five key populations: 1) men who have sex with men, 2) people who inject drugs, 3) people in prisons and other closed settings, 4) sex workers and 5) transgender people. The key populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic.

Men Who Have Sex with Men (MSM): refer to all men who engage in sexual relations with other men. The words “men” and “sex” are interpreted differently in diverse cultures and societies and by the individuals involved. Therefore, the term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular community or social group.

Monitoring: Monitoring is a systematic and continuous assessment of the progress of an activity over time. Monitoring is part of implementation. Monitoring can be done through the process of collecting, coordinating, processing, and communicating information to assist management to make decisions. Monitoring encompasses follow-up of inputs, processes, and output.

Outreach: In this guideline outreach is defined as an activity implemented with a health facility located at a catchment area by providing HIV and health services to any populations who might not otherwise have access to those services. A key component of outreach is that the groups providing it meet those in need of outreach services at the locations where those in need are located.

Orphans and Vulnerable Children (OVC): Children age 0-17 who are identified according to the set of criteria established by the MoHCDGEC within the ‘National Guidelines for the Identification and Registration of Most Vulnerable Children.’ The definition is expansive and includes children who are: the heads of their household; single or double orphans; affected by HIV/AIDs; married or pregnant before 18; or at risk of contracting HIV themselves. Within the context of KVP, there is definitional overlap, particularly with regards to vulnerable adolescent girls age 15-17, and young moms (15-24) who are also caretakers of children identified as OVC.

People Who Inject Drugs (PWID): refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be

through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes – referred to as “therapeutic injection” – are not included in this definition. The definition also does not include individuals who self-inject non-psychoactive substances, such as steroids or other hormones, for body shaping or improving athletic performance.

People in Prisons and Other Closed Settings: There are many different terms used to denote places of detention which hold people who are awaiting trial, who have been convicted, or who are subject to other conditions of security. Similarly, different terms are used for those who are detained. In this guidance document, the term “prisons and other closed settings” refers to all places of detention within a country, and the terms “prisoners” and “detainees” refer to all those detained in criminal justice and prison facilities, including adult and juvenile males and females during the investigation of a crime, while awaiting trial, after conviction, before sentencing, and after sentencing. This term does not formally include people detained for reasons relating to immigration or refugee status, those detained without charge, and those sentenced to compulsory treatment and to rehabilitation centres.

People Who Use Drugs (PWUD): includes people who use psychotropic substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal), or transdermal. Often this definition does not include the use of such widely used substances as alcoholic and caffeine-containing beverages and foods.

Reproductive Tract Infections (RTIs): are infections of the genital tract. They refer to the site where the infection develops. They may or not be transmitted through sexual contact.

Sexually Transmitted Infections (STIs): are groups of infections that are predominantly transmitted through unprotected sexual contact with an infected person.

Sex Workers: include female, male, and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less “formal”, or organized. As defined in the Convention on the Rights of the Child (CRC), children and adolescents under the age of 18 who exchange sex for money, goods, or favours are “sexually exploited” and not defined as sex workers.

Surveillance: is the routine tracking of disease (disease surveillance) or risk behavior (behavioral surveillance) using the same data collection system over time. Surveillance helps

describe the epidemic and its spread, and can contribute to predicting future trends and targeting needed prevention programmes. In the case of HIV, surveillance typically tracks impact in terms of HIV and sometimes STI prevalence, and outcomes in terms of risk behavior.

Transgender: is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. It includes people who are transsexual, transgender, or otherwise gender non-conforming.

Vulnerable Populations (VPs): are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities, and migrant and mobile workers. In Tanzanian context mobile population include long distance truck drivers, fisher men, miners specifically small scale miners, construction workers, displaced people few to mention. These populations are not affected by HIV uniformly across all countries and epidemics (WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations 2016).

Young people: This term refers to those between the ages of 10 and 24 years.

Youth: This term refers to individuals between the ages of 15 and 24 years.

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Executive Summary

In mainland Tanzania the modified Delphi method was used to estimate population sizes and HIV prevalence among female sex workers (FSW), men who have sex with men (MSM) and people who inject drugs (PWID). The median size estimate for the FSW population is estimated at 155,450 (ranging from 128,610 to 198,050). The HIV prevalence among this group is estimated at 26%. The MSM population is estimated at 49,000 (ranging between 41,000 and 71,000 in urban areas) with HIV prevalence estimated at 25%. The PWID population is estimated at 30,000 (ranging from 20,000 to 42,500) with an HIV prevalence estimated at 36%. People who use drugs (PWUD) is estimated at 300,000 (Consensus 2014). According to UNAIDS Spectrum (2015), there is an increased number of new infections among younger populations. Out of all new infections, 43% occur among youth aged 24 years and younger. Adolescent girls and young women (AGYW) face higher risk of HIV infection. Out of adolescents newly infected, 70% are girls. The HIV prevalence increases 2.2 fold among girls during their transition to adulthood (0.8% for 15-19 year olds to 2% for 20-24 year olds).

To ensure an effective and sustainable response to HIV there is a need to reach key and vulnerable populations (KVPs) with a comprehensive package of prevention, treatment, care, and support interventions, along with other public health services and structural interventions. The interventions in the National Guidelines emerge and expand basing on current HIV guidelines available in the country and recommendations by the World Health Organization (WHO) and other United Nations agencies.

The goal of the National Guidelines is to promote increased access to a comprehensive package of quality HIV and AIDS health and social services to KVPs in order to significantly minimize the transmission of HIV and to reduce HIV-related morbidity, mortality, stigma, and discrimination. Implementation of the comprehensive package of interventions shall thereby contribute to the attainment of the Three Zeros: zero new HIV infections, zero discrimination, and zero AIDS-related deaths; as well as the Sustainable Development Goals (SDG) Agenda, which includes the target of ending AIDS by 2030.

The National Guidelines were developed through consultations involving the National AIDS Control Programme (NACP), Tanzanian Commission for AIDS (TACAIDS), Drug Control Commission (DCC), development partners, HIV implementing partners, civil society organizations, and other relevant government departments.

The following is a summary of good practice recommendations:

- Health centers and dispensaries are health care structures within communities that provide basic health services to the populations of their catchment areas. They shall continue to fulfil their role by providing services for KVPs at the facilities as well as

through mobile outreach HIV services. Health care workers from facilities, together with community-based HIV service providers located around hotspot areas, shall be key implementers. Facilities and community-based HIV services providers will be empowered to provide comprehensive KVP friendly HIV services.

- Community-based outreach should be provided by a health facility located within the hotspot to improve KVP engagement and connectivity to health and other social services. All biomedical outreach HIV services should be implemented by trained health workers from a catchment area in a manner consistent with the Community-Based HIV and AIDS Guidelines and HIV Care and Treatment Guidelines. Service reports shall be sent back to the same health facility.
- HIV Combination Prevention using a mix of biomedical, behavioral, and structural approaches to meet the HIV prevention needs of particular communities shall be implemented. These will include a range of services along the care and treatment cascade including: HIV testing, prevention of mother-to-child transmission (PMTCT), family planning, comprehensive condom programming, targeted social and behavior change communication (SBCC) and information, education, and communication (IEC), antiretroviral therapy (ART), tuberculosis (TB) and sexually transmitted infection (STI) screening and treatment, and voluntary medical male circumcision (VMMC). Harm reduction intervention should be provided as an intervention delivered in combination.
- Opioid substitution therapy such as Medically Assisted Treatment (MAT) shall be provided to all opioid dependent users. This, along with other harm reduction services, will be expanded and scaled up to reach more PWIDs and PWUDs.
- Linkage and referral mechanisms from/to community support programmes for KVP shall be established to ensure that KVPs newly identified as living with HIV are referred to health facilities to initiate ART. Additionally, persons on ART who are lost-to-follow-up (LTFU) will be traced and returned to care and treatment services.
- Gender-based violence (GBV) prevention shall be mainstreamed in all KVP activities.
- Integration of HIV services with reproductive health and rights (RHR), including family planning, infertility treatment, and cervical cancer management shall be available to AGYW, FSW, and other KVPs.
- Sensitization and awareness of hepatitis B and C prevention shall be made available to all KVP and health workers.

- TB screening, diagnosis, prevention, and treatment shall be a high priority for all prisoners, as well as all KVPs living with HIV.
- KVPs who have harmful alcohol and substance use shall have access to psychosocial interventions, including assessment, counselling, and linkage to rehabilitation services.
- Age appropriate school and out-of-school-based prevention programmes in the context of comprehensive sexuality education for children and young people shall be rolled out.
- Cash transfers/incentives for preventing HIV among VPs shall be implemented to keep vulnerable girls in schools and prevent adolescent girls from engaging in transactional and age-disparate relationships.

CHAPTER 1

1.1 Background

The HIV epidemic in Tanzania has existed for three decades and has claimed many lives. By the end of 2015, it was estimated that 1.34 million Tanzanians (750,000 women and 500,000 men aged 15+ years and 90,000 children less than 15 years) were living with HIV, while approximately 38,000 HIV-related deaths were reported annually. HIV prevalence has continued to decline progressively among adults aged 15-49 from 7% in 2003 to 5.1% in 2012. In Tanzania Mainland, the HIV epidemic is generalized and affects both urban (7.2%) and rural (4.3%) settings. Approximately 80% of all HIV infections among adults aged 15-49 years are through heterosexual transmission/contacts. According to a modes of transmission analysis conducted in 2014, 38.8% of new HIV infections were among partners in stable heterosexual relationships. Sex workers, their clients, and clients' partners accounted for 13.3% of new HIV infections; MSM and their partners for 7.7%; PWID and their partners for 2.2%; and casual heterosexual sex couples and their partners for 36.5%.

Tanzania accounts for 4.5% of the global HIV burden, ranking seventh (7th) in the world in terms of the total number of reported deaths (GFATM, OIG report - 2016). Despite the small number of studies done in Tanzania Mainland, the estimated number of VPs include: AGYW (80,142); fisher community (5,400); people in uniform (61,600); people in mining industry (225,000); prisoners (8,700); and truckers (3,400). Further evidence indicates HIV prevalence of 36% among PWID; 26% among FSW; 25% among MSM; and 6.7% among prisoners.¹ HIV prevalence among transgender people is not known.

Research identified an estimated 16 million PWID in 151 countries. Of these, approximately 3 million PWID are HIV infected.^{2,3} Globally, an estimated 10% of all new HIV infections are attributed to the injecting of drugs, rising to 30 per cent when sub-Saharan Africa is excluded.⁴ With available data, PWID have 22 times the rate of HIV infection as the general population in 49 countries, and in 11 countries it is at least 50 times higher.⁵ PWID are also over burdened with hepatitis C viral infection (HCV). On average, the prevalence of HCV infection among PWID is often greater than 50% in most countries⁶, compared to the global anti-HCV (exposure to HCV) prevalence among the general population at less than 3%.⁷

Studies among MSM show consistently higher HIV prevalence rates among MSM than non-MSM practicing men.⁸ Globally HIV prevalence among MSM in various capital cities is 13 times higher when compared to the general population.⁹ Among transgender people (specifically transgender women) studies show high risk behaviors, high prevalence of sexually transmitted infections (STIs), and that they are 49 times more likely to be living with HIV when compared to the general population.¹⁰

Despite disproportionately being affected by HIV, both MSM and transgender people are commonly underserved and under-resourced, particularly in low- and middle-income countries. Limited coverage and access to HIV prevention, treatment, and care services was common, whereby fewer than one in ten MSM worldwide have access to the most basic package of HIV prevention interventions.¹¹ A combination of stigma, discrimination, and criminalization limits MSM and transgender people from accessing available services.^{12,13,14} There has been a global failure to understand and respond adequately to their public health and human rights needs.¹⁵

Global data on FSW indicates that, on average, they are 14 times more likely to be living with HIV than their counterparts in the general population.¹⁶ The potential for clients of FSW to serve as a “bridging population” for spreading HIV to the general population cannot be underestimated.¹⁷ For example, in Asia there are an estimated 10 million women selling sex to an estimated 75 million men, who in turn have intimate relations with a further 50 million people.¹⁸ A combination of multiple sexual partnerships, barriers to negotiate safer sexual practices (consistent and correct condom use), with many clients refusing to use condoms,^{19,20} are factors that significantly contribute toward sex workers becoming HIV infected.^{21,22}

A systematic data review of global prevalence on HIV infection among FSW found it at 11.8%. The highest prevalence of HIV was in Sub-Saharan Africa (36.9%), followed by Eastern Europe (10.9%), Latin America and the Caribbean (6.1%), Asia (5.2%), and lowest prevalence found in Middle East and North Africa (1.7%).²³ Globally, most sex workers are women, yet a substantial number of male and transgender (TG) sex workers exist. The biological risks of anal intercourse and high prevalence of HIV identified among MSM and TG people have raised the profile of these issues.^{24,25,26}

Over 30 million men and women spend time in prison each year and nearly all return to their community within a few months to a year.²⁷ Prisoners have higher prevalence of HIV, hepatitis B and C, STIs, and TB compared to the general population: HIV prevalence among prisoners was 6-50 times higher than in the general population.²⁸ Poor health among prisoners was closely associated with various behaviors prior to and during incarceration, including unsafe injecting of drugs and unsafe sex. Scarcity and illegality of needles inside prisons leads to the sharing of contaminated injecting equipment among PWID and this accelerates the spread of blood borne infections.²⁹ Drug use inside prisons is common, with a substantial number of prisoners entering with established drug dependency and habits. Other prisoners can be initiated into drug use to cope with stress in prisons.^{30,31,32} Despite this, most prisoners have poor or no access to HIV and STI prevention, commodities, treatment, care, and support services.^{33,34}

AIDS is now the leading cause of death among adolescents (aged 10–19) in Africa and the second most common cause of death among adolescents globally.¹ According to UNAIDS

estimates, adolescents are the only age group in which deaths due to AIDS are not decreasing, while all other age groups combined experienced a decline of 38% in AIDS-related deaths between 2005 and 2013. Compared to adolescent boys and young men, AGYW can easily get “off track” to achieving their life goals due to gender inequitable norms, lack of education opportunities, lack of livelihood options, and stigma and discrimination, which can lead to dangerous risk factors such as early, coerced, and intergenerational sex; transactional sex; child marriage; gender-based violence, and exploitation.

In Tanzania, the 2014 consensus estimates using a modified Delphi method found the number of PWID to be in the range of 20,000 to 42,500 in mainland Tanzania, and HIV prevalence was estimated at 36%; MSM ranging between 41,000 and 71,000 in urban mainland Tanzania, while HIV prevalence was estimated at 25%; and FSW at 155,450 with HIV prevalence estimated at 26%.

An Integrated Behavioral and Biological Survey (IBBS) that was conducted among PWID in Dar es Salaam in 2014 estimated the size of population of PWID to be around 10,000. It indicated that use of both injecting and non-injecting drugs among PWID started during adolescence. Although behaviors which make PWID susceptible to HIV and other infections were fairly common, 38.7% of the study participants believed they were at no or low risk of HIV infection.

An IBBS undertaken in 2013 among FSW in seven regions estimated HIV prevalence among FSW in Tanzania at 26.6%. Syphilis prevalence was 7.0% and herpes simplex virus type 2 (HSV-2) infection nationally in this population was 54.1%. Population size of FSW in the seven regions was estimated at 31,434. Only a third of FSW reported consistent use of condom during sex with a client in the month preceding the survey.

A qualitative and quantitative study among MSM in Dar es Salaam in 2013 reported a median age at first anal sex was 18 years and majority (83.0%) were single, while 10% reported being married/cohabiting with a woman. Condom use was fairly low in this population (48% and 32% had used condoms during the last sexual encounter). Only about a quarter had used condoms in their last sexual encounter with a woman. The prevalence of HIV, HSV-2, syphilis, and hepatitis B infections were 22.2%, 40.3%, 1.0%, and 4.9%, respectively.

The prevalence of HIV in prisons at 6.7% is relatively higher than the general population HIV prevalence estimated at 5.3% in the 2011-2012 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS). HIV prevalence among female inmates is significantly higher than the HIV prevalence among male inmates (14.7% versus 5.2%). Moreover, HIV prevalence among female inmates is

more than twice as high when compared to the female prevalence in the general population (14.7% versus 6.2%).

1.2 Rationale for the National Guidelines for KVP

KVPs are important to the dynamics of HIV transmission in a given setting and are essential partners in the national response to the epidemic.³⁵ There is evidence of overlapping sexual networks between KVP and the general population, indicating that HIV among KVPs is not isolated and if not addressed accordingly it poses risk to the national response. To ensure an overall effective and sustainable response to HIV there is a need for special interventions to reach out to KVPs with a comprehensive package of prevention, treatment, care, and support services. These National Guidelines for KVPs are intended to assist in this process. Importantly, these National Guidelines for KVPs emerge and expand upon, as well as compliment, key government policy documents. Consequently, this guideline document is intended to:

1.3 Goal and Objectives

Goal

The goal for these Guidelines is to inform and provide guidance to stakeholders in the delivery of a cost-effective, comprehensive, and friendly package of quality health and social services to all KVPs in order to significantly minimize the transmission of HIV and to reduce HIV-related mortality, morbidity, stigma, and discrimination. Implementation of the comprehensive package of interventions shall thereby contribute to the attainment of the goal of ending AIDS by 2030.

Objectives

1. To develop, strengthen, and scale up an evidence-based comprehensive package of interventions and services for prevention, treatment, and care of HIV and AIDS.
2. To create and maintain an enabling environment for HIV and AIDS related interventions through targeted advocacy and community.
3. To define the package of services to be offered for community-based interventions for KVP groups in order to ensure that these services are tailored to relevant social, cultural and other contexts in Tanzania.
4. To define the package of services to be offered for health facility-based interventions for KVP groups in order to ensure that these services are tailored to relevant social, cultural and other contexts in Tanzania.

1.4 General Guiding Principles of National Guidelines

Successful responses to the public health crises of HIV infections among KVP should be guided by the following principles that will help develop and implement effective programmes and interventions.

Universal Access, Equity, and the Right to Health

- Ensure services and programmes implemented are non-stigmatizing, non-discriminatory, accessible, acceptable, affordable, and equitable for all. Universal health access aspires to provide a package of health benefits to all that will lead to improved health outcomes.
- All services and programmes are gender and age sensitive and address the special needs of men, women, and transgender people from KVP
- Improve the legal, policy, and social environment to allow access by KVPs to available health services
- Ensure safety, privacy, informed consent, confidentiality, and the principle of 'do no harm' are respected for KVPs engaged in all aspects of HIV programmes – from programme design to delivery.

Meaningful Engagement of Key & Vulnerable Populations in Designing, Planning, Implementation, and Monitoring of Programmes

- Foster active, meaningful and collaborative engagement of community members, KVPs, and other affected populations, including those that are HIV-infected, in programmes and interventions to ensure recommendations outlined in these National Guidelines have a greater opportunity of implementation and contribute to the national HIV response.

Multi-Sectoral Partnerships Combined with Political and Institutional Commitment and Accountability

- Develop, build upon, and sustain collaborative partnerships to support coordinated, comprehensive, transparent, accountable, and cost-effective public health responses to address the multiple health needs of KVP
- Strong political leadership and commitment at all levels are integral to an effective and sustained response to HIV and AIDS
- The direct participation of communities in service delivery, including demand creation, needs to be integrated into the national response, from the planning phase and budgeting, to implementation, and monitoring and evaluation

Advocacy

- Advocate for an enabling environment that allows for the protection and promotion of the health of all KVP and supports effective and efficient programming
- Plan, monitor, and evaluate advocacy efforts for effectiveness and in response to the needs of KVPs

Gender Sensitivity

- There is a growing recognition that gender norms and gender-based violence are some of the most influential factors driving HIV transmission worldwide. Widespread ignorance around issues of sexuality and gender commonly leads to stigma, discrimination, and violence. All programme activities need to address the disparities that result from gender discrimination and gender-based violence.

Research and Evidence-Based Planning

- Undertake adequate and appropriate research on KVP to ensure responses to HIV and AIDS are informed by evidence and the HIV clinical cascade services are accessible, high quality, and have the anticipated outcomes and impact. Research activities need to improve the amount and quality of strategic information for decision-making at all levels to ensure effective planning and allocation of resources where they are most needed.

Scaling Up Sustainable, Culturally Relevant Services and Balancing the Need for Prevention, Treatment, and Care

- Scaling up of services will need to ensure that resources (both human and financial) are available and that cost effectiveness of delivering services is an important consideration. Implementation of services must prioritize the sustainability of the intervention, results, and the outcomes. Various factors need to be considered such as financial, material and human resources, and community ownership to ensure the efficiency, efficacy, and effectiveness of the interventions.
- Scale-up of appropriate, culturally relevant and sensitive, low-threshold services (ensuring that implementation facilitates easier access to KVP HIV friendly services, such as through appropriate opening hours suited to KVP services and programmes) while maintaining quality and sustainability. Develop and maintain community ownership and organizational capacity to support scaling up and sustainability of services and programmes.

Decentralization, Integration and Public-Private Partnerships

- These National Guidelines for KVP need to be integrated as much as possible into general health care services either directly or through the process of referrals and linkages in order to leverage increasingly scarce resources and to deliver value for money.
- These National Guidelines for KVP require support from all stakeholders and for complimentary synergies of each stakeholder to be utilized to support Public Private Partnerships (PPP). The current health sector HIV and AIDS strategy promotes PPP in all aspects including financing, implementation, and progress monitoring.

Friendly Services for KVP

- Peer involvement: Peers are the ones who most understand the needs of their fellows. Interaction between them facilitates a sense of belonging to the group and breaks the barriers of misunderstanding, mistrust, and intimidation. In addition, peers can be models for each other, as well as navigators, to track and refer their fellow peers.
- Self help and support groups: Belonging to a group where members share similar life conditions and problems provides the assurance that one is not alone. Collective thinking and problem solving in the group empowers individuals through having an insight to how others managed their situations. In addition, it helps the group find solutions suitable for their collective situation.
- Outreach: individuals may not seek certain services for various reasons. These reasons can be personal (e.g. level of awareness, perceptions, trust, etc.), socio-cultural (taboo, stigma), legal, financial, geographical, etc. Outreaching to KVPs can help transcend those barriers.

International and Regional HIV-Related Commitments

- The 2016 Political Declaration on HIV and AIDS was adopted by the UN General Assembly in June 2016, hence by all UN member states. World leaders have committed, among other things, to doubling the number of people on HIV treatment and reaching all people with prevention services. The 2016 Political Declaration includes the following targets:
 - Doubling the number of people on treatment
 - Accelerating prevention outreach
 - Stopping new HIV infections among children
 - A new focus on women, adolescent girls, young people and gender equality
 - The right to health belongs to everyone, everywhere

- AIDS out of isolation
 - Financing the end of AIDS
 - Accountability and sustainability
- Political commitment to address health, with particular focus on AIDS, TB and malaria. In 2015, the African Union renewed the “AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB, and Malaria Response in Africa (AU Roadmap) until 2021” in order to accelerate progress to end the epidemics of AIDS, TB, and malaria by 2030, in line with the African common position for post-2015.

1.5 Target Audience for the National Guidelines for KVPs

MoHCDGEC will closely collaborate with President’s Office of Regional Administration and Local Government Authority and TACAIDS to facilitate smooth implementation of these National Guidelines by *all* stakeholders in Tanzania Mainland that are involved in the implementation of HIV and AIDS programmes. As HIV and AIDS is a cross cutting issue, it is important that other sectors are engaged to better understand the high vulnerability and marginalization of KVPs. This will be a reference and advocacy document to be utilized by the following: relevant government ministries, development partners, non-government organizations, community-based organizations, faith-based organizations, private sector, service providers, and KVP community members, as well as those from the general population.

1.6 Technical Development Process of the National Guidelines for KVPs

This document was developed through a consultative process involving the NACP, TACAIDS, relevant key ministries and departments, as well as development partners and civil society organizations.

The scope of the 2014 guidelines for KPs was extended in 2016 to also include VPs. The guidelines were reviewed to clarify the community interventions package, and to reflect the latest available HIV-related guidelines in the country, such as the WHO "treat-all" recommendation on eligibility for ART among people living with HIV, and the recommendation to use HIV viral load monitoring as the preferred approach compared with immunological and clinical monitoring. A taskforce of members from government, development and implementing partners, and NGOs provided guidance to the revision process, under the leadership of NACP.

CHAPTER 2: COMBINATION PREVENTION OF HIV INTERVENTIONS TARGETTING KVPs

2.0 Introduction

Combination Prevention Package for Key and Vulnerable Populations

This section gives detailed explanation on effective prevention strategies that are distinguished by using a combination of behavioral, structural, and biomedical interventions in coordination. Combination prevention programmes operate on individual, family, community, and societal levels to address the specific needs of the populations at risk of HIV infection. Combination prevention takes a bottom-up approach that encourages ownership of the response by local communities. The HIV-prevention programme for KVPs is based on a combination prevention approach that addresses behavioral, biomedical, and structural components.

To ensure that key and vulnerable populations across the country receive the essential services to minimize risk of and vulnerability to HIV and STI infections, an essential service package has been developed for programmes in Tanzania. The essential package contains the vital services, activities, and information that all HIV programmes with KVPs should be provided. The efficacy of the components of the essential package is strongly supported by evidence. However, new research and new international guidelines show that there are other interventions that are showing promising results for KVPs. These interventions are recommended as desirable elements, though they are not considered necessary for preventing the spread of HIV. In the Tanzanian context some of these interventions remain to be implemented in small-scale learning sites and are not recommended in these National Guidelines.

Comprehensive packages of HIV and health interventions targeting all KVPs include: HIV diagnosis, treatment, care, and support (HIV testing services [HTS], ART, PMTCT, nutrition, TB, HIV post-exposure prophylaxis [PEP]); prevention of STIs, including consistent and correct use of condom; and interventions aimed at reducing harm due to substance abuse (opioid overdose management and medically assisted treatment [MAT] such as opioid substitution therapy [OST] and other drug dependence treatment). Other interventions for harm reduction to be addressed are BCC interventions; sexual and reproductive health services (SRHS) such as STI management, contraception, conception and pregnancy, cervical cancer screening, and VMMC; and prevention and management of co-infections and co-morbidities such as TB, viral hepatitis, mental health, other non-communicable diseases (NCDs), etc.

Essential Package of Combination Prevention for KVPs

- HIV Care, Treatment, and Support Services

- HTS
- STI Prevention, Screening, and Treatment
- VMMC
- TB Screening and Referral to Treatment
- Family Planning and SRHS
- Peer Education
- Emergency Contraception
- Targeted IEC
- Comprehensive Condom Programming
- Risk Assessment, Risk-Reduction Counseling, and Skills-Building
- Evidence-Informed Behavioral Interventions
- Harm Reduction for PWID, including Needle and Syringe Programs, Opioid Overdose Management and MAT, such as OST and other Drug Dependence Treatment
- Reducing Stigma and Discrimination and Addressing Barriers to HIV and Health Services
- Empowering the Community, Including Ownership and Leadership
- Gender-Based Violence Prevention and Response
- Enforce Supportive Policies
- Addressing Gender Inequality and Violence
- Interventions to Reduce Stigma and Discrimination
- Health Service Integration
- Income Generating Activities

Desirable Elements

- Viral Hepatitis Screening, Vaccination, Treatment and Care
- Mental Health
- PEP
- Post-Abortion Care
- Cervical Cancer Screening and Treatment
- Screening for Anal and other Cancers

The delivery of biomedical interventions, such as STI management and HIV testing, treatment, care, and support services should be provided at primary health care facilities located near hotspots or areas where KVPs congregate. Given the varied geographic and cultural settings in which KVPs live and work, implementing partners need to work closely with the council health management teams to define priorities for structural interventions to reduce vulnerability.

The following are the main components of combination prevention for KVP HIV interventions.

2.1 HIV Testing Services (HTS)

HTS allows persons to know their HIV status and make informed decisions about their health based on their HIV status. The current national “Test and Start” (on ART) guidelines are as relevant to KVPs as they are to the general population. It includes a confidential dialogue between an HTS provider and an individual, couple, or family. Furthermore, it serves as an entry point for clients into HIV care, treatment, and support services and reinforces HIV prevention efforts by providing clients with risk-reduction counselling and behavior change. The key components of all HTS services are: pre-test session, HIV test, post-test session, and linkage to other services (including HIV care and treatment, post-test clubs, VMMC, family planning, etc.) and ongoing supports. HTS is important to KVPs as this group is at increased risk of HIV infection, therefore early HIV diagnosis is significant for prevention of HIV transmission.

HTS Modalities include:

- Stand-Alone Client Initiated HIV Testing and Counselling Services
- Provider-Initiated Testing and Counselling (PITC) at Public and Private Health Facilities
- Mobile or Outreach Services at Hotspots
- Home-Based HTS at Hotspots (e.g.: index-client based models)
- Work place settings
- Campaigns
- Prisons settings
- Refugee camps

2.1.1 Community-Based HTS

Community-based HTS includes an array of important venues that offer HTS to individuals, couples, families, and KVPs outside of health facilities. Community-based HTS programmes play a critical role in providing outreach services to clients in communities. Examples of community-based settings applicable to KVPs in offering HTS are listed below and additional information on this topic can be found in the National Comprehensive Guidelines for HTS of MoHCDGEC.

Community-based HTS settings include:

- Stand-Alone Client Initiated Testing Service
- PITC in Outreach Services
- Mobile or Outreach Settings
- Home-Based HTS Settings either through Door-to-Door or Index Clients
- Workplace Settings
- Campaigns

The HIV testing procedure (including blood sample collection, placing on test device and interpreting results) MUST be done by trained and accredited HTS providers only as per National Comprehensive Guidelines for HTS of the MoHCDGEC.

2.1.2 HTS Delivery Approaches to KVPs

Thoughtful delivery points and approaches shall aim for co-location of services for key and vulnerable populations at higher risk of HIV exposure to reduce access barriers. HTC shall also prioritize reaching KVPs at higher risk of HIV exposure together with their sexual partners, where appropriate which include sexual and injecting drug use partners of PWID, clients and partners of SWs, and MSM.

Suggested HTS delivery points for reaching KVPs include:

- Medically Assisted Therapy (MAT) sites;
- Home-based HTS (Door to door),
- Mobile or outreach HTS at KVP hotspots;
- Other settings such as prisons and other closed settings, refugees' camps, etc
- Health facilities, which include hospitals, health centres, dispensaries, be it public, FBO or private etc.

In line with national standards for health care service delivery and human rights principles, HTS shall be conducted with the best interests of clients and patients in mind, and shall respond to the needs and risks of clients and patients.

1. In view of that, all HTS must adhere to the following five core principles of HTC: HTC services are **confidential**, meaning that anything discussed between the client(s) or patient(s) and the HTC provider may not be shared with another person.
2. HTS must include accurate and sufficient pre- and post-test **counselling** that addresses the needs and risks of the clients(s) or patient(s) and the setting in which they are receiving services.
3. Clients and patients must be provided with sufficient information about HIV testing and counselling, so that they may give their explicit and voluntary informed **consent** to receive services.
4. HTS must adhere to standard operating procedures and quality control measures for testing to ensure the provision of **correct test results** to all clients and patients.
5. It is the responsibility of HTS programmes and providers to ensure that clients and patients are **connected** with appropriate follow-up HTS. This includes prevention, care, treatment, support and other clinical services, as well as non-clinical services within the community.

6. Follow up of index patient families including children of the KVP for HIV testing and linkages to point of care and treatment for identified HIV positives.

2.2 HIV Care, Treatment, and Support

2.2.1 Antiretroviral Therapy

Antiretroviral therapy (ART) is the key management of HIV infection. ART is highly effective in delaying the onset of AIDS and is shown to decrease morbidity and mortality among the HIV infected population. ART is a biomedical intervention appropriate for all KVP regardless of sexual orientation or identity. KVPs can successfully receive ART and get the same benefits as other persons on ART.³⁶ The National Guidelines for the Management of HIV and AIDS provide a recommended framework for when to start ART for PLHIV, what first line ART regimens to start, issues of co-infection, monitoring ART response, diagnosis of treatment failure, and second line ART regimen for those who failed first line regimen. All HIV positive clients including KVP should be given ART regardless of CD4 count and or clinical stage criteria (Test and Treat) as per the National Guidelines.

The use of ART for HIV in KPs should follow the same general principles and recommendations as for all adults. It is important to ensure that people from KPs have equitable access to HIV treatment and care. Even after initiation of ART, the utility of many of these interventions will remain and should be maintained throughout treatment. A follow-up mechanism should be developed to ensure that the drop-out rate is minimized while maintaining principles of confidentiality.

KEY MESSAGES:

- Health care providers should initiate ART to all KVPs as per National Guidelines.
- Health care workers should provide the integrated package of services in a safe, confidential, non-judgmental manner in line with ethical conduct. If feasible, specific times for clinics for KVPs may be allocated by individual sites.
- Peers should be trained to provide psychosocial support, adherence counselling, and linkages.
- Clients who are stable should be offered the same refill options as the general population.
- As a priority, health care providers shall give or refer opioid dependent PWID to MAT when and where accessible and available.
 - Opioid dependent PWID and non-injecting opioid users living with HIV who are in need of ART have better outcomes and improved adherence to ART when on MAT.
- Health care workers shall closely monitor opioid dependent PWIDS and non-injecting opioid users who are on ART and accessing MAT to monitor drug interactions.
- Health care workers serving KVPs shall support equitable access to ART and treatment

for KVPs as part of the comprehensive care, treatment, and support approach.

- Health care workers shall link HIV infected KVPs with community-based HIV and AIDS services providers.
- Health care workers shall initiate ART for KVP with HIV, including if KVP have HBV and/or HCV co-infection.
- Optimized ART regimen (Tenofovir/Lamuvudine/Efavirenz) should be initiated in all individuals with HIV and HBV co-infection if there is evidence of severe chronic liver disease.
- Adherence counselling and support groups need to be provided to address challenges in adherence among KVP.

Recommended: Refer to National Guidelines for Management of HIV and AIDS 2017

2.2.1.1 ARV-Related Prevention

Oral pre-exposure prophylaxis (PrEP) of HIV is the daily use of ARV drugs by HIV-uninfected people to block the acquisition of HIV. Studies demonstrate the effectiveness of PrEP in reducing HIV transmission among serodiscordant heterosexual couples, MSM, TG women, high-risk heterosexual couples, and PWID. Tanzania will undertake demonstration projects to gain experience in implementing PrEP safely and effectively with the purpose of understanding the acceptability and feasibility of rolling it out widely.

2.3 Post-Exposure Prophylaxis for Occupational and Non-Occupational Exposure

Post-exposure prophylaxis (PEP) is a short term ART regime of 28 days for KVP with possible risk of HIV infection. Taking PEP reduces the likelihood of acquiring HIV infection following potential exposure as a result of occupational hazard (such as needle stick injury) or through non-occupational exposure including sexual assault, sharing of injection equipment among PWID, and possible exposure through consensual sex. The first dose should be taken as soon as possible within 72 hours of exposure. Health facilities should have a person responsible for PEP and a responsible PEP location point known to all staff.

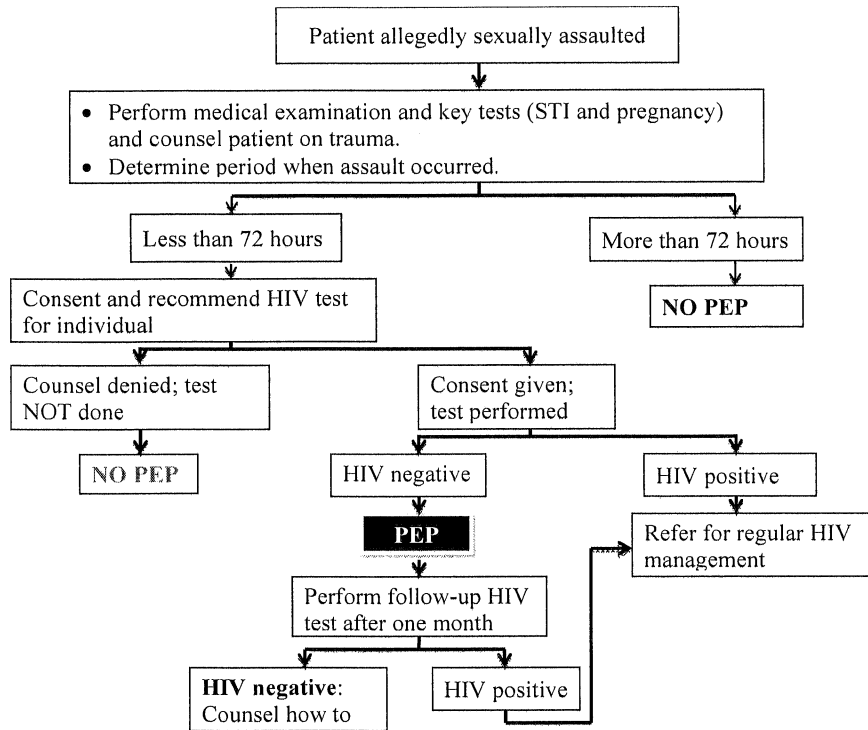
2.3.1 Post-Exposure Prophylaxis for Non-Occupational Exposure

Non-occupational exposure refers to client alleged sexual assault or reported condom spillage or breakage during consensual sex. Follow the procedures below in case of non-occupational exposure.

- Take detailed history of the exposure and document it
- Examine the client systematically
- Provide HIV counselling and testing
- Offer PEP for eligible clients if not more than 72 hours of exposure (Figure 1)
- Counsel on importance of PEP adherence

- Provide psychosocial support or refer to social worker
- Assess the risk of pregnancy and offer emergency contraceptives as (Table 1)
- Administer presumptive treatment for STIs

Figure 1. PEP Algorithm for Non-Occupational Exposure



**Administering PEP on a HIV + individual could lead to resistance development.*

Recommended PEP Regimen

For Adults: TDF 300mg + 3TC 300mg + EFV 600mg once a day for 4 weeks

For Children (based on body weight):

- Less than 3 years: AZT + 3TC + LPV/r twice daily for 4 weeks
- More than 3 years: AZT + 3TC twice daily + EFV once daily for 4 weeks

Key Messages:

- For KVPs presenting within 72 hours of an episode of HIV exposure, health care providers shall provide HIV PEP as per the National PEP Guidelines.
 - Health care providers will initiate shared consent and decision-making with KVP survivors of sexual violence or staff members in prison health facilities to determine whether HIV PEP is appropriate.
 - Health care providers shall be trained or re-trained and sensitized on HIV PEP.
 - Health care providers shall be made aware of stigma so as to offer services free of stigma and prejudice for all KVP survivors of sexual violence or staff members in prison health facilities coming forward for HIV PEP.
 - PEP should be available to all eligible people from KVPs on a voluntary basis after possible exposure to HIV.
- For details on PEP management, refer to the National Guidelines on Post-Exposure**

Prophylaxis Following Occupational and Non-Occupational Exposures to Blood and Other Body Fluids.

2.4 Prevention of Mother-to-Child Transmission (PMTCT) of HIV

HIV infected pregnant and breastfeeding women need to be provided with ART to ensure better health for the mother and to ensure that the exposed child is prevented from becoming infected. Female KVP who are pregnant or breastfeeding should have equal access to ART as that of other women in the general population. Although the number of women prisoners is relatively small in size, their health needs are considerably greater. This is even more the case if the woman is living with HIV and pregnant or the woman is a breastfeeding mother while in prison.

KEY MESSAGE: Female KVPs

1. Health care workers shall implement the full range of PMTCT interventions for female KVPs as per the National Guidelines for Comprehensive Care Services for Prevention of Mother-to-Child Transmission of HIV.
2. Prison health care workers shall offer any child born to a mother living with HIV in prison appropriate PMTCT follow-up services.

Recommended: Refer to the National Guidelines on Prevention of Mother-to-Child Transmission of HIV.

2.5 ART Drug Interactions

Providers should be aware of all drugs that PLHIV are taking when ART is initiated and any new drugs that are added during continued treatment. For many KVPs, this may include recreational drugs, drugs for co-infections and co-morbidities, and cross-sex hormones among TG people.

Possible drug interactions add complexities when prescribing ARV drugs and monitoring treatment. Counselling on possible consequences of drug interactions and an environment that promotes and enables reporting of concomitant medications are critical components of high quality care for all PLHIV.

Tuberculosis

TB-HIV patients who are to be initiated on Rifampicin and were on a Nevirapine-based ART regimen should be switched to Efavirenz-based ART due to increased liver toxicity as a result of interaction of Rifampicin and Nevirapine. For those on boosted LPV/r, the dose of LPV/r should be doubled when using Rifampicin for TB treatment.

Hormones

ARV drugs have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives. Limited data suggest potential drug interactions between contraceptive hormones and many ARV drugs (especially some non-nucleoside reverse transcriptase inhibitors [NNRTIs] and Ritonavir [RTV]-boosted PIs). These interactions may alter the safety and effectiveness of both the hormonal contraceptive and the ARV drug. If women receiving ART decide to initiate or continue using hormonal contraceptives, consistent use of condoms is recommended both to prevent HIV transmission and to compensate for any possible reduction in the effectiveness of the hormonal contraception.

Opioids

WHO recommends methadone and buprenorphine to treat opioid dependence. Co-administering Efavirenz (EFV) decreases methadone concentrations. This could subsequently cause withdrawal symptoms and increase the risk of relapse to opioid use. People receiving methadone and EFV should be monitored closely, and those experiencing opioid withdrawal may need to adjust their methadone dose.

Table 1. Key ARV Drug Interactions and Suggested Substitutions

ARV Drug	Key Interactions	Suggested Management
Boosted PI ATV/r LPV/r DRV/r	Rifampicin	Substitute EFV or double the dose of boosted LPV/r
	Estrogen-based hormonal contraception	Advise additional use of male or female condoms
	Methadone and buprenorphine	Adjust methadone and buprenorphine doses as appropriate
EFV	Methadone	Adjust the methadone dose as appropriate
	Estrogen-based hormonal contraception	Advise additional use of male or female condoms
Nevirapine (NVP)	Rifampicin	Substitute NVP with EFV
	Estrogen-based hormonal contraception	Advise additional use of male or female condoms

2.6 Other Prevention and Care Interventions for KVPs Living with HIV

It is critically important to provide comprehensive care for HIV infected KVP even before the commencement of ART. All people who are HIV infected should benefit from interventions that aim to improve quality of life, prevent further HIV transmission, common opportunistic infections, delay progression of HIV, and prevent mortality. Such interventions include the following:

1. Psychosocial counselling and support
2. Vaccination for selected vaccine-preventable diseases (i.e., hepatitis B, pneumococcal, influenza, and yellow fever)
3. Disclosure, partner notification, and testing and counselling
4. Nutrition
5. Cotrimoxazole prophylaxis for opportunistic infections (OIs)
6. Family planning
7. TB prophylaxis
8. Prevention of fungal infections
9. Opioid substitution therapy (OST)
10. Prevention of sexually transmitted and other reproductive tract infections
11. Water, sanitation, and hygiene
12. Prevention of malaria

KEY MESSAGES: All KVPs

- KVP living with HIV should have access to the same HIV prevention, care, treatment, and support services as the general population.
- Dolutegravir (DTG) does not interact with methadone, whereas EFV dramatically reduces methadone levels; that is why DTG is preferred to EFV in PWIDs using methadone.

Refer to the National Guidelines for Management of HIV and AIDS 2017.

2.7 Needle and Syringe Programmes

Needle and syringe programming (NSP) is a component in the comprehensive package of HIV prevention and harm reduction. NSP has been recommended by WHO as intervention that works well when combined with ARV and MAT. This intervention in Tanzania is currently implemented in a demonstration site.

NSPs may serve as an important point of entry to other services. NSPs aim to engage their PWID clients repeatedly and on a regular basis. Thus, they have multiple opportunities to facilitate access to other health services such as OST overdose prevention (e.g. naloxone) and other drug dependence treatment, HTS, and treatment of HIV, TB, and viral hepatitis.

There should be effective safe disposal of syringes and needles to reduce the amount of contaminated equipment in the community, thus reducing reuse and unintended needle sticks and limiting negative reactions from the community.

KEY MESSAGES: NSP demonstration sites
<ul style="list-style-type: none">• Shall be linked with health service and serve as an important point of entry to receive other services including MAT, HTC, ART, STI, TB, and psychosocial services.• Promote and distribute condom and information, education, and communication materials.• Provided puncture-proof, safe, disposal containers to encourage and facilitate safe disposal by collecting used syringes.• Should be offered in demonstration sites targeting PWIDs.

2.8 Medically Assisted Treatment (MAT), and Other Evidence-Based Drug Dependence Treatment

MAT is an intervention for PWUD/PWID who are opioid dependent. MAT has been shown to be highly effective in reducing injecting behaviors, reducing opioid use, improving retention to ART, improving health outcomes, reducing overdose, reducing criminal activity, and improving psychosocial outcomes. It decreases risk to women who are pregnant and negative consequences to the infant.^{37,38,39} It is also an entry point to other treatment services for PWUD/PWID, such as TB, ART, and other medical, mental, and psychosocial interventions. This provides an opportunity to offer additional benefits to attaining productive livelihoods through interventions, in collaboration with other stakeholders, including occupational therapy, vocational training, and economic empowerment initiatives. MAT uses methadone, buprenorphine, or other medications in the management of opioid dependence. Methadone is a synthetic opioid which reduces opioid withdrawal symptoms and the euphoric effect when opioids are used. Methadone is taken orally once daily and is most effective when it is provided at adequate dose and for sufficient duration. MAT should be available and accessible for opioid-dependent prisoners.

While smoking of opiates has far fewer HIV risk factors, the transition to injecting has considerable risk of HIV infection when PWIDs do not use clean needles and syringes. The potential for sharing injecting equipment also increases. Most drug users are initiated

to heroin through smoking, and later, transition to injection, but more recently, younger heroin users are more frequently being initiated to heroin directly through injection.⁴⁰ MAT for opiate smokers has merit to halt this transition to injecting and protect them from escalated HIV risk.

KEY MESSAGES: PWUD/PWID and all other KVPs who are opioid dependent

- MAT services in Tanzania have shown good retention in services.
- Provide MAT to all opioid dependent PWUD/PWID at risk of HIV. The barriers and special needs of women and young people who use drugs should be taken into consideration. Appropriately tailored services should be provided.
- Health care workers shall support voluntary cessation of MAT only after the client is stabilized.
- Health care workers shall prescribe methadone for pregnant women who are opioid dependent.
- Health care workers shall closely monitor drug interactions with other medications, especially medications for HIV and TB, and make dose adjustments accordingly.
- People in custody who are on MAT shall continue receiving MAT. A coordinating system should be established to allow this to happen. Upon release, prison health care providers shall refer clients to existing MAT services in their communities.

Recommended: Refer to the Guideline on Drug Dependence Treatment.

2.9 Management of Symptomatic STI/RTIs

STIs continue to remain a major public health concern. STIs comprise of a range of infections (viruses, bacteria, fungi) predominantly transmitted through unprotected sexual contact with an infected person. Failure to treat STIs can lead to various health complications and has also been found to increase the sexual transmission and acquisition of HIV infection.⁴¹ IBBSS studies done in Tanzania among FSWs show a high prevalence of STIs, estimated at an average of 26% in 2010 and an average of 38% for herpes simplex in 2013.

A syndromic approach is a cost effective intervention for management of STI/RTIs that focuses on identification of symptoms and signs. The majority of STIs present with symptoms that include urethral discharge, dysuria, genital ulcers, vaginal discharge, and lower abdominal pain. Among KVPs, the management of STI/RTIs will focus on all STI syndromes including anorectal-related syndromes.

Common STI/RTIs Syndromes

STI SYNDROME	SEX	AETIOLOGIC AGENTS
1. Urethral Discharge Syndrome (UDS)	Males	<i>Chlamydia trachomatis</i> <i>Neisseria gonorrhoeae</i>
2. Painful Scrotal Swelling (PSS) (acute epididymoorchitis)	Males	<i>Chlamydia trachomatis</i> <i>Neisseria gonorrhoeae</i>
3. Vaginal Discharge Syndrome (VDS) ¹	Females	<i>Candida albicans</i> <i>Chlamydia trachomatis</i> <i>Gardnerella vaginali</i> <i>Neisseria gonorrhoeae</i> <i>Trichomonas vaginalis</i>
4. Pelvic Inflammatory Disease (PID) (Lower Abdominal Pain)	Females	<i>Anaerobic bacteria</i> <i>Chlamydia trachomatis</i> <i>Neisseria gonorrhoeae</i>
5. Genital Ulcer Disease (GUD)	Males Females	<i>Chlamydia trachomatis</i> <i>Haemophilus ducreyi</i> Herpes simplex virus type-2 <i>Treponema pallidum</i> <i>Klebsiella granulomatis</i>
6. Inguinal Bubos	Males Females	<i>Chlamydia trachomatis</i> <i>Haemophilus ducreyi</i>
7. Anorectal Syndrome	Males Females	<i>Neisseria gonorrhoeae</i> <i>Chlamydia trachomatis</i> Herpes simplex <i>Treponema pallidum</i> Human papilloma virus
8. Neo-natal Conjunctivitis (ophthalmia neonatorum)	Newborn Males and Females	<i>Neisseria gonorrhoeae</i> <i>Chlamydia trachomatis</i>
9. Oropharyngeal Infection	Males Females	<i>Treponema pallidum</i> <i>Neisseria gonorrhoea</i> <i>Chlamydia trachomatis</i> <i>Klebsiella spp</i> Human papilloma virus (HPV)

2.10.1 Screening for Asymptomatic STIs

Many STIs are more likely to be asymptomatic or be undetected in women than in men. As a result, seeking treatment can be delayed and can result in the development of serious complications: cervical cancer and pelvic inflammatory disease, which can result in chronic pelvic pain, infertility, low birth weight, ectopic pregnancy, and associated maternal mortality.⁴²

A systematic evidence review was conducted to assess if screening of FSW using laboratory tests is effective to reduce incidence and prevalence of STIs. The results overall were positive

with a rapid decline and consistent reductions in the prevalence of syphilis, gonorrhea and chlamydia infections.

Among MSM and TG people, asymptomatic urethral and rectal STIs caused by *N. gonorrhoea* and *C. trachomatis* are fairly common and can be a potential risk for acquisition and transmission of HIV. In recent years, developing countries have been increasingly conducting periodic testing to identify and treat asymptomatic forms of urethral or rectal infections with *N. gonorrhoea* and *C. trachomatis*.

High prevalence of syphilis has been identified among MSM and TG people. Rates among MSM have been increasing in several countries, particularly among HIV infected MSM.⁴³

KEY MESSAGES: All KVPs

- KVPs with symptomatic STI/RTIs should be properly examined, including anal and oral examination for those practicing anal and/or oral sex, and treatment provided according to national guidance for the syndromic management approach. Examination of KVPs will not be complete without anorectal examinations.
- Community-based interventions help to ensure that the benefits of interventions for STI/RTIs management are sustained and risk of reinfection is minimized.
- Training is required for health care workers to deal with STI/RTIs among KVPs.
- KVP-related health care issues should be integrated in pre-service training curricula for various cadres of service providers.
- KVP-friendly services should be provided for successful management of STI/RTIs.
- Health care providers should be respectful, nonjudgmental, and sensitized to the need of patients.
- Health care workers should provide active referral and linkages and integrate services to facilitate access to comprehensive health care for KVPs who have STI/RTIs.
- Health care providers should counsel KVPs with STI/RTIs sexual partners on compliance with treatment, risk reduction, and condom use.
- Health care providers should give follow-up appointments for re-assessment for all STI/RTI syndromes.
- KVP women with lower abdominal pain, who have fever, missed period, abnormal vaginal bleeding, recent delivery, miscarriage, or abortion should be referred to in-patient department.
- Neonates with ophthalmia neonatorum should be re-examined three (3) days after starting treatment. Their parents should be treated for discharge syndrome.
- Health care providers should offer KVPs with STI/RTIs and their sexual partners counselling and testing for HIV infection.
- Provide periodic screening among KVPs for asymptomatic STIs, particularly syphilis, *T. vaginalis*, *N. gonorrhoea* and *C. trachomatis*.
- STI screening should not be coercive or mandatory.

Recommended: Refer to flow charts for STI management.

2.10.2 Prevention, Diagnosis, and Treatment for Viral Hepatitis

Hepatitis C

While the primary focus is on HIV, it is important to include other major blood borne viruses such as hepatitis B virus (HBV) and hepatitis C virus (HCV) in comprehensive HIV prevention, care, and treatment. It is estimated that more than 185 million people around the world are infected with HCV. Sixty-seven percent (67%) of those being PWID, of whom 350,000 die each year. Most people infected by the virus are unaware of their infection status, and for those who have been diagnosed, treatment remains unavailable. It is estimated out of 16 million people from 148 countries who actively inject drugs, 10 million are infected with HCV.⁴⁴ This is far greater than those PWID infected with HIV, which is estimated at 3 million. Globally, an estimated up to 90% of new HCV infections were linked to injecting drug use and the majority were found in low and middle income countries.^{45,46} HCV co-infection is common among PWID who are also infected with HIV.⁴⁷ A study done in Dar es Salaam among PWID show that HCV antibody was positive (indicating past exposure but not confirmed current infection) at 28% prevalence, and that co-infection (HIV and HCV) was 17% overall.⁴⁸ Co-infection of HIV and HCV is of concern because HIV accelerates HCV-related disease progression and mortality. There is no vaccine for HCV and, while there is treatment, it is prohibitively expensive for most people to afford in low and middle income countries.

Route of Transmission

Mother-to-Child

The risk of transmission of HCV from a mother to her child occurs in 4–8% of births to women with HCV infection and in 17–25% of births to women with HIV and HCV co-infection.

Other

Other routes of transmission of HCV include intranasal drug use and other modes of blood borne transmission, such as acquisition by health care workers, cosmetic procedures (such as tattooing and body piercing), and scarification.

Co-infections

HIV and HCV

HIV and HCV have common routes of transmission, and it is estimated that, globally, 4–5 million persons are co-infected with these two viruses.⁴⁴ With the widespread use of ART, which

reduces the risk of HIV-associated OIs, HCV-related liver disease has started to overtake AIDS-defining illnesses as a leading cause of death in some high-income countries.

HBV and HCV

HBV and HCV co-infection is commonly found in HBV-endemic countries in Asia, sub-Saharan Africa, and South America. Up to 25% of HCV-infected persons may be co-infected with HBV in some areas.⁴⁶⁻⁵¹

TB and HCV

Groups at increased risk of infection with HCV are also at risk of infection with TB. TB is endemic in many countries where blood products are not screened routinely. TB is the most common AIDS-defining illness and the leading cause of HIV-associated mortality. PWID are more at risk of developing TB, regardless of their HIV status. Among PWID who develop TB, two out of three will have HCV antibodies. PLHIV who inject drugs have two to six times increased risk of developing TB compared with non-injectors. Prisoners, who have a high risk of acquiring HCV, are also at increased risk of co-infection with TB; incarceration is associated with a 23 times higher risk of TB than in the general population. Appropriate care for persons being considered for HCV treatment includes screening for active TB, as the co-management of such persons needs sound clinical judgment and provision of treatment that takes into consideration the side-effects and interactions of the drugs used to treat HIV, TB, and viral hepatitis.

Hepatitis B

HBV infection is caused by the hepatitis B virus, an enveloped DNA virus that infects the liver and causes hepatocellular necrosis and inflammation. HBV infection can be either acute or chronic, and may range from asymptomatic infection or mild disease to severe or rarely fulminant hepatitis. Acute hepatitis B is usually a self-limiting disease marked by acute inflammation and hepatocellular necrosis, with a case fatality rate of 0.5–1%. Chronic hepatitis B (CHB) infections encompass a spectrum of disease, and is defined as persistent HBV infection (the presence of detectable hepatitis B surface antigen [HBsAg] in the blood or serum for longer than six months), with or without associated active viral replication and evidence of hepatocellular injury and inflammation.

Infection with HBV may present as either hepatitis B “e-antigen” (HBeAg) -positive or -negative disease. The prevalence of HBeAg-negative disease has been increasing over the past decade as a result of ageing of the HBV-infected population, and accounts for the majority of cases in some regions, including Europe.

Key messages: All KVPS

- Community programmes as well as health facility staff should create awareness of HVB and HVC prevention with all KVP.
- KVP with active HBV or HCV infection should receive treatment according to available and affordable treatment regimens.
- HBV vaccination shall be offered to KVP at risk of HBV infection.
- HBV vaccine should be offered to any KVP who has experienced sexual violence within 14 days of event.

2.10.3 Prevention, Diagnosis, and Treatment of Tuberculosis

TB remains a leading killer of people with HIV. People living with HIV and infected with TB are 20 to 40 times more likely to develop active TB compared to people not infected with HIV living in the same country.⁴⁹ PWUD/PWID and prisoners are highly vulnerable to TB. TB is reported to be 30-100 times more common in prison than in the wider community. Of increasing concern is that the prevalence of multidrug-resistant TB can be up to 10 times higher inside prisons. A combination of late diagnosis and treatment of infectious cases, as well as overcrowding and poor ventilation, has resulted in TB as a major cause of sickness and death in prisons.^{50,51}

Key Messages: All KVPs

- Prisons health facilities shall intensify active case-finding, provide isoniazid prevention therapy and provide effective TB prevention and control measures in line with the National Guidelines.
- Community programmes and health facility staff should sensitize PWID and prisoners on their risk to TB and of the importance of regular screenings.
- Facilities providing services to PWID, as well as closed-setting institutions, including prisons, should implement the national TB control strategy.
- Facilities providing services to PWID, as well as closed-setting institutions, including prisons, should implement case-finding for both TB and HIV.⁵²
- KVPs living with HIV should be screened for TB; KVP living with TB should be encouraged and advised to have an HIV test.
- KVPs living with HIV but without symptoms of active TB (no current cough, fever, weight loss, or night sweats) should be offered isoniazid prevention therapy.
- All KVPs with HIV and active TB, regardless of CD4 count, should start anti-TB treatment immediately and then ART within the first 2 weeks.
- Prisoners should be screened for TB symptoms using standard TB screening questions upon entry into prisons, and every 6-12 months thereafter.
- Prisoners with active pulmonary TB should be segregated until they are no longer infectious.

- TB patients should be made to avoid overcrowding and ensure spaces are well ventilated and have natural light.
- PWUD/PWIDs should have equitable non-stigmatizing and non-discriminatory access to the full range of TB services through a well-integrated and coordinated means that links them to HIV prevention, care, and treatment, as well as drug dependence treatment.
- Specific adherence support measures for PWID on TB medicines should include drug observed therapy, linkage to MAT, adherence counselling, and adherence reminders by service providers, peers, and outreach workers.

Recommended: refer to the National Guidelines on Prevention, Diagnosis, and Treatment of Tuberculosis.

2.11 Voluntary Medical Male Circumcision and Early Infant Male Circumcision

VMMC is an important component of comprehensive HIV prevention in areas with a high prevalence of heterosexually-transmitted HIV infection. The goal of VMMC and early infant male circumcision (EIMC) scale-up in Tanzania is to reduce the incidence and prevalence of HIV and AIDS by helping to prevent new HIV infections. VMMC and EIMC programmes help to accomplish these aims by reducing men's biological risk of HIV acquisition and by promoting life-long behavioral risk-reduction strategies.

Minimum Package of VMMC/EIMC Services for HIV Prevention

The following is the minimum package of services that all facilities offering VMMC services for HIV prevention must incorporate and provide:

- Education to clients to better understand the link between VMMC and HIV prevention.
- Offer of HIV testing and counselling so that clients may know their HIV status.
- Referrals to appropriate services such as care and treatment for clients who test HIV positive.
- Screening for STIs (and treatment, when indicated) since STIs increase the risk of acquiring or transmitting HIV.
- Risk reduction counselling and promotion of safer sex practices.
- Promotion and provision of male and female condoms together with the promotion of their correct and consistent use.
- Surgical care that is safe and of high quality, performed by trained and competent staff in settings that are adequately equipped and environmentally suitable for minor surgical procedures. Appropriate post-operative care and care of any associated adverse events.

Minimum Package of EIMC Services

The following is the minimum package of services that all facilities offering EIMC services for HIV prevention must incorporate and provide:

- Comprehensive information to parents or guardians on advantages and risks of EIMC.
- Offer HIV testing and counselling to parents or guardians to ensure identification of HIV-exposed infants.
- Linking HIV-positive parents to HIV care and treatment services.
- Counselling on the post-operative care of circumcised infants and identification of related complications, danger signs and where to go for follow-up care, if required.
- Surgical care that is safe and of high quality, performed by trained and competent staff in settings that are adequately equipped and environmentally suitable for minor surgical procedures.
- Appropriate post-operative care and care of any associated adverse events.
- Referrals to appropriate services such as immunization, well baby care, and HIV care and treatment for HIV-exposed infants and/or those infants found to be HIV-positive through Early Infant Diagnosis (EID).

KEY MESSAGES: All Male KVPs

- Health care providers should offer VMMC to all male KVPs as per the standard HIV intervention offered to other men.
- Health care providers should offer circumcision as a complimentary HIV preventative measure.
- Health care workers should offer EIMC to babies born to KVPS according to the National Guidelines.

2.12 Emergency Contraceptives

Emergency contraception, or post-coital contraception, refers to methods of contraception that can be used to prevent pregnancy in the first five (5) days after sexual intercourse. It is intended for use following unprotected intercourse, contraceptive failure or misuse (such as forgotten pills, or breakage or slippage of condoms), rape, or coerced unprotected sex. Any woman or girl of reproductive age may need emergency contraception to avoid an unwanted pregnancy.

Table 2. Emergency Contraceptives and Doses

Methods of Emergency Contraception	Dose
Progestine only pills	Levonorgestrel taken as a single dose (1.5mg) OR

	alternatively, Levonorgestrel taken in 2 doses (0.75mg each, 12 hours apart) OR Ulipristal acetate, taken as a single dose at 30mg.
Combined oral contraceptive pills with high dose of oestrogen (50µg)	High-dose combined pills. Take 2 high-dose birth control pills (50mcg of ethinylestradiol each). Repeat 12 hours later e.g. Ovral® 2 tabs every 12 hours (total 4 tabs per day).
Combined oral contraceptive pills with low dose of oestrogen (30µg)	Take 4 low-dose birth control pills (30g of ethinylestradiol each). Repeat 12 hours later. Nordette® 4 tabs every 12 hours (total 8 tab per day).
Copper-bearing intrauterine devices	This is the most effective method of emergency contraception available; they can be used within 5 days after unprotected intercourse.

Note: The survivor can be given any of the above four regimens. Emergency contraception is most effective when given within 72 hours and up to 120 hours (5 days) of assault.

2.13 Social and Behavior Change Communication for HIV Prevention Interventions

Behavioral interventions include a range of communication programmes to change behavior. These programmes use various communication channels (e.g., mass media, community-level, and interpersonal) to disseminate messages designed to encourage people to reduce behaviors that increase risk of HIV and increase behaviors that are protective (e.g., benefits of using a condom correctly and consistently, benefits of using ART). Behavioral interventions also are aimed to increase the acceptability and demand for biomedical interventions i.e. demand creation.

Behavioral change interventions can be delivered as part of the other interventions in the comprehensive package. They may take place face-to-face or through broadcast mass media and social media. Content and approach, as well as medium, should be based on the National Communication Guide for Key and Vulnerable Populations of 2014. Although the logic of behavioral interventions is primarily based on individual awareness and decision-making about risk, such interventions can operate also at the community level. For example, interventions may involve training opinion leaders to communicate with their peers, thus changing perceptions of social norms about risk and risk avoidance.

BCC strategies, approaches, and methods enable KVPs to play an active role in achieving, protecting, and sustaining their own health and empowering them to make decisions, modify

behavior, and change social conditions by transferring knowledge, skills and techniques. To be effective, BCC strategies must be community-centered and acceptable to KVPs. Well-developed BCC materials play an important role in supporting BCC goals.

Behavioral interventions should contribute to an increased number of protected sexual acts, encourage adherence to biomedical components that prevent HIV transmission, and enhance individual- and group-level ownership and sustainability of programmes as well as behavioral change. BCC materials should segment the intended audiences; develop targeted messages and approaches using a variety of communication channels to promote positive behaviors; generate demand for and sustain individual, community, and societal change; and support the maintenance of healthy behaviors.

Community support groups such as PLHIV groups, alcohol rehabilitation groups, sober houses, post-test clubs, and economic empowerment groups increase access to information and education in the prevention of HIV/STIs. They offer compassionate support services for persons affected by HIV and they support community building activities. They play a pivotal role as part of the referral network to ensure that KVPs are able to access necessary services.

Essential Behavioral Interventions

- Peer Education
- Targeted IEC for KVP
- Demand Creation for Biomedical Interventions
- Comprehensive Condom Programming
- Harm Reduction
- Risk Assessment, Risk-Reduction Counselling, and Skills-Building

2.14 Comprehensive Condom Programming

Condom use is one of the most effective means available of reducing sexual transmission of HIV. Scientific evidence suggests that male latex condoms have an 80 percent or greater protective effect against HIV and other STIs. Condom use is therefore a key component of Tanzania's HIV and AIDS prevention strategy to reduce HIV transmission via sexual contact. Consistent and correct use of a male or female condoms during sex reduces sexual transmission of HIV and STIs. Increasing the availability, accessibility, affordability, and use of male and female condoms among KVPs through targeted distribution programmes is an essential component of the HIV response.

The challenges to condom use in Tanzania revolve around four critical factors: 1) Accessibility, including the potentially high cost of condoms, low demand, unavailability, stock outs, and gaps in integrating condom use into reproductive health programming; 2) Lack of correct knowledge of usage, efficacy, and stigma related to condom usage; 3) Attitudes including persistent risky sexual behavior and religious beliefs; and 4) Inadequate capacity for women and girls to negotiate condom use due to traditional and cultural factors that perpetuate gender inequality.

To improve KVPs condom availability and accessibility, the programme will need to ensure adequate supply of condoms, preferably through public free condoms that are socially and commercially marketed and distributed by CBOs working with KVP groups, KVP networks, outreach services, peer educators, contraceptive community distributors, and through social marketing organizations targeting hotspots such as bars, hotels, markets, and truck stops.

Condom Disposal

The following guidance should be provided to KVPs on condom disposal:

- Remove the condom so that fluids do not spill.
- For a male condom, remove with the tip pointed down. Pull from the tip, and gently ease the ring off. Condoms with a reservoir tip are specially designed to help retain fluids at the tip of the condom, and they may help during this process.
- For a female condom, squeeze and twist the outer ring, so that the fluids do not leak out. Pull the condom out gently. The inner ring of the female condom should help to hold any fluids in.
- Put the condom in a piece of tissue or a paper towel.
- Put the condom in the garbage. Do not flush it down the toilet. Do not throw it outside. Do not reuse or recycle condoms.

Key Messages: All KVPs
<ul style="list-style-type: none">• Advocate for wide accessibility, availability, and affordability of male and female condoms.• Promote messages on consistent and correct use of condoms for all KVP and their sexual partners or clients.• Health care providers should inform all KVP of the correct and consistent use of condoms for safer sex.• Community-based HIV service (CBHS) providers and peer educators should conduct condom demonstrations with all KVPs accessing any HIV and STI services.• Peer educators should promote and distribute condoms and report on progress and

challenges.

Recommended: Use Tanzania guideline on condom programming

2.15 Information, Education, and Communication (IEC)

IEC is an important component of HIV prevention packaging and, when combined with other interventions such as condom promotion, can successfully assist and sustain positive change in the reduction of HIV risk behaviors.⁵³ Information and skills should be shared and disseminated to KVPs with the intent of influencing adoption of HIV prevention healthy practices.

IEC is an integral element in promoting sustainable behavior change among KVPs. It is therefore important to integrate IEC into all HIV prevention interventions. Given the dynamic nature of HIV, all interventions including IEC should reflect emerging developments, recommendations, and technologies (e.g., WHO recommendations). Throughout the HIV cascade of care IEC is an important element in supporting prevention of new HIV infections and ensuring KVPs are tested for HIV and those who test HIV positive are enrolled and retained in HIV care. IEC should be developed to suite the local context and match the needs of KVPs, such as raising awareness about HIV, STIs, and other key health issues.

For IEC to be effective it should be administered nonjudgmentally based on known, factual, researched information to the targeted KVPs. Paying respect to social and cultural norms within the limits of the existing policy environment is of paramount importance in the course of implementing IEC.

KVP	Groups	General Message	Specific Messages	Media/Chanel/Approach
Key Population	FSW	<ul style="list-style-type: none"> • Correct and Consistent Condom Use • Condom Negotiation Skills • STI/RTI Prevention and Control • HIV Prevention (HTC and ART) 	<ul style="list-style-type: none"> • FP • PMTCT • Economic Empowerment • Cervical Cancer Prevention Services • Child Care and Protection 	<ul style="list-style-type: none"> • One on one peer Education • Small/Large Group IPC Sessions • Interpersonal Communication Materials • Mobile Phone Technologies (SMS, Hotline, IVR) • Closed Groups Social Media • Resource Center
	PWID/PWUD	<ul style="list-style-type: none"> • GBV (HIV Related) • Stigma and Discrimination • Multiple/ Concurrent Partnerships • SRH Promotion • Demand Creation 	<ul style="list-style-type: none"> • Needle Sharing Challenges • Family/ Community Reintegration • Demand Creation for MAT Services 	<ul style="list-style-type: none"> • One on One Peer Education • Family

	MSM	for HTC <ul style="list-style-type: none"> • Referral and Linkage to Other Services (MAT, ART, Gender Desk, Legal, Faith) • Promotion of Health Seeking Behavior 	<ul style="list-style-type: none"> • Psychosocial Support 	<ul style="list-style-type: none"> • One on One Peer Education • Interpersonal Communication Materials • Mobile Phone Technologies (SMS, Hotline, IVR) • Resource Center
Vulnerable Population	Prisoners		<ul style="list-style-type: none"> • Psychosocial Support • VMMC 	<ul style="list-style-type: none"> • One on One Peer Education • Health Talk Sessions • Tailored IPC • Educational Audio/Visual Materials
	Mine and Plantation Workers		<ul style="list-style-type: none"> • Healthy Relationships • TB Prevention and Care • VMMC 	<ul style="list-style-type: none"> • One on One Peer Education • Work Site Health Talks • Small/Large Group IPC Sessions • Edutainment Sessions • Interpersonal Communication Materials • Mobile Phone Technologies (SMS, Hotline, IVR) • Resource Center
	Fishermen		<ul style="list-style-type: none"> • Healthy Relationships • VMMC 	<ul style="list-style-type: none"> • One on one Peer Education • Edutainment Sessions • Small/Large Group IPC Sessions • Interpersonal Communication Materials • Mobile Phone Technologies (SMS, Hotline, IVR) • Resource Center
	Long Distance Truck Drivers		<ul style="list-style-type: none"> • Healthy Relationships • VMMC 	<ul style="list-style-type: none"> • One on One Peer Education • Small/Large Group IPC Sessions • Interpersonal Communication Materials • Mobile Phone Technologies (SMS, Hotline, IVR) • Billboards
	Construction Workers		<ul style="list-style-type: none"> • Healthy Relationships • TB Prevention and Care • VMMC 	<ul style="list-style-type: none"> • One on One Peer Education • Work Site Health Talks • Small/Large Group IPC Sessions • Interpersonal Communication Materials • Mobile Phone Technologies (SMS, Hotline, IVR)

	Vulnerable Children		<ul style="list-style-type: none"> • Delay Sexual Debut • ASRH Education • Psychosocial Support • Address VAC 	<ul style="list-style-type: none"> • Resource Center • One on One Peer Education • Peer Clubs • Small/Large Group IPC Sessions • Interpersonal Communication Materials • Mobile Phone Technologies (SMS, Hotline, IVR) • Resource Center
	AGYW		<ul style="list-style-type: none"> • Delay Sexual Debut • FP • Transactional Sex • Cross Generational Sex • SRH Educational Sessions 	<ul style="list-style-type: none"> • One on One Peer Education • Small/Large Group IPC Sessions • Interpersonal Communication Materials • Mobile Phone Technologies (SMS, Hotline, IVR) • Social Media • Resource Center

Structural Interventions

HIV prevention efforts with KVP cannot fully succeed without addressing underlying drivers of HIV risk and vulnerability. In addition to behavioral and biomedical approaches which target high-risk individuals and groups, HIV prevention interventions must simultaneously address structural factors. For KVPs, many factors that influence a person’s risk are largely outside that person’s control. Particularly for KVPs, poverty, violence, social, legal, and other contextual factors both increase vulnerability to HIV and obstruct access to HIV services. By limiting access to information, prevention services and commodities, and care and treatment, these factors affect how well individuals or populations can protect themselves from, and cope with, HIV infection. Structural interventions address social, economic, political, and environmental factors that affect the individual. These approaches must be implemented in combination with behavioral and biomedical approaches and should be based on scientifically derived evidence and wisdom and community ownership.

Structural approaches to HIV prevention have been employed throughout the epidemic, but such strategies have only recently emerged as an internationally recognized, distinct area of HIV prevention. A growing body of literature now describes and categorizes structural approaches and integrates these approaches into comprehensive HIV prevention with KVPs.

Key Interventions

- Support economic empowerment activities such as loans, savings groups, and cash transfer
- Addressing stigma and discrimination
- Community empowerment
- Addressing gender-based violence against KVPs
- Education on HIV services

CHAPTER 3

3.1 Community-Based HIV and AIDS Services (CBHS) for KVPs

An existing CBHS system will be used for peer education for KVP services. The system uses CBHS providers who are well trained using a national curriculum on comprehensive package of community HIV and AIDS services. These CBHS providers are an essential link between the community or NGO and facility-based services, and are most effective when they maintain contact with peers over time.

CBHS providers are expected to perform outreach services in collaboration with health care workers in the catchment area. In cases where NGOs provide additional support to the community, the outreach team must be recognized and endorsed by the health facility In-Charge. There are cases where CBHS providers will be going to the community specifically to provide services such as health education and promotion and distribution of condoms and IEC materials.

In addition, there should be a joint plan of outreach activities between the CBHS providers and the health facilities concerned. Community-based outreach services should be provided by trained health personnel as a service delivery method, not as a stand-alone intervention. They should be linked to primary health facilities allocated within a hotspot area in the catchment areas for sustainability and continuum of care.

Delivery of health services to all KVPs is of prime importance. Any KVP activity should ensure that all KVPs receive the minimum services required to be able to develop health-seeking behavior, as well as reduce the incidence of STIs, and thereby the incidence of HIV. CBHS providers and health care workers are responsible for delivering the minimum services to every KVP within their localities. In the context of an HIV prevention and care programme, it is necessary to have a combination of services, focusing on increasing health-seeking behavior, encouraging safer sex practices, and economic strengthening activities. Interventions can provide additional services to this package as per guidelines.

3.2 Scope of CBHS

It is recognized that CBHS is a broad concept with various sectors contributing to the holistic process of care given to people infected and affected by HIV in their communities and home settings. Community-based HIV and AIDS services entail increased community mobilization in HIV and AIDS preventive services; patient identification, adherence to treatment, and patient follow-up for those on HIV care and treatment services; reduction of stigma and discrimination-

related issues such as GBV and VAC; increased awareness and access to services for KVPs as well as facilitation of client referral, linkage, and networking between facilities and community, including data collection and reporting at the family and community level. This guideline focuses on provision of quality HIV and AIDS prevention, care, and treatment services interventions as well as prevention-related interventions across the continuum of care.

In view of the above mentioned scope of work, it is recommended that the CBHS provider develop a work plan for their daily/weekly activities to enable time and room for family welfare.

3.3 Selection Criteria for Community-Based HIV and AIDS Service Providers

Service Providers shall bear the following attributes:

1. Should be a member and resident of the communities they are going to serve
2. Ability to read and write
3. Accepted and trusted by community members/specific target group including PLHIV, pregnant women, adolescents and youth, MSM, SW, and PWID
4. Good communication and interpersonal relationship skills
5. Willing to volunteer in CBHS initiatives with minimal incentives
6. Honest and reliable (trustworthy)
7. Non-discriminating with respect to gender, tribe, job, color, political affiliation, and any other form of discrimination as defined by the community
8. Energetic and with ability to work
9. Ability and willingness to work in challenging environment and conditions
10. Previous experience in HBC programme or any health-related voluntary work will be an added advantage

The following are important standards:

- CBHS are voluntary and should not be imposed on anyone.
- CBHS providers must be reliable people who respect and cooperate with professional orders and work well with other actors in CBHS and care and support activities.
- CBHS should be pursued so as to provide required care in a home environment, not just as a way to divert the burden of chronically ill patients from hospitals to communities.
- CBHS providers should not in any way engage in deceitful behavior. It is completely unacceptable to lie or give wrong information about patient care.
- In monitoring, supervision, and evaluation, the reporter must be faithful and honest about the information reported.
- A patient's rights, values, and culture should be respected at all times.

3.4 Process of Selection for CBHS Providers

1. Job advertisement through the ward executive office (WEO) to all community members in order to show Voluntarism
2. All applications are received and applicants are called for oral interview by health care worker (HCW), implementing partner, and the village executive office (VEO) at the facility
3. Selected names are presented to the WEO, village multi-sectoral AIDS committee (VMAC), and facility staff/implementing partner for final selection
4. Recruited and selected providers should be gender balanced

3.5 Incentives for CBHS Providers

CBHS providers are individual persons who volunteer to support health issues in specific geographic areas. Despite their volunteerism, they deserve to get non-monetary and/or monetary incentives to facilitate timely and comprehensive delivery of CBHS services. The programme acknowledges the transport cost incurred by CBHS providers to deliver services within their geographical location.

Working tools:

- Bags to carry stationary and supplies
- Writing pad, pens, and data collection tools
- CBHS kits
- Bicycle

Non-monetary incentives:

- T-shirts
- Certificates and performance awards
- Introduction and recognition to wards and district authorities
- Training and refresher training
- Regular supportive supervision and mentorship
- Study tour within districts/regions

Monetary incentives:

- One fourth (1/4) of the minimum government salary scale

3.6 Minimum Package for Community-Based HIV and AIDS Services

CBHS for PLHIV, KVPs, their families, and the community at large involve an interlinked set of services that form a health promotion, prevention, and continuum of care approach. It reinforces the linkages in a continuum to all the HIV and AIDS health and social services. CBHS programming should be able to directly assist primary care givers, clients, and the community in providing the core HIV and AIDS services. As shown in the table below, a formal CBHS programme should provide a CBHS minimum package (in the table) under one or more core interventions.

Table: CBHS Minimum Package and Services

CBHS Package	Services
<p>COMMUNITY HIV TESTING AND COUNSELLING (CHTC) SERVICES</p>	<ul style="list-style-type: none"> • Community sensitization and mobilization for HIV testing and counselling • Pre-test information • Counselling for HIV testing at home or community • Home/community-based HIV testing performed by trained health care providers and counselors • Referral from home to facility for HIV testing • Infection prevention control services (IPC) • Referral of HIV positive clients from the community to CTC/RCH-PMTCT • Linkage to support groups (PLHIV, HIV positive pregnant women, SWs, PWIDs, and MSM) • Counselling on status disclosure • Promoting male involvement
<p>COMMUNITY COMPLIMENTARY SERVICES TO ART</p>	<ul style="list-style-type: none"> • Adherence counselling and monitoring • Referral (side effects/laboratory monitoring) • Identification and linkage of new clients to HTC and CTC • Tracking and tracing LTFU and missed appointment clients • Linking to support groups • Health education and promotion • Counselling on status disclosure • Positive health, dignity, and prevention (PHDP)

<p>COMMUNITY eMTCT/PEADIATRIC HIV SERVICES</p>	<ul style="list-style-type: none"> • Identification and linkage all pregnant mothers to antenatal care (ANC) • Counselling all pregnant mothers on infant feeding options and maternal nutrition • Adherence counselling and monitoring • Tracking and tracing of LTFU and missed appointment clients • Family planning services • Promote male involvement and participation in elimination mother-to-child transmission (eMTCT) of HIV • Early childhood identification and referral for care and treatment • IPC services • Linkage of all breastfeeding mothers to immunization clinics • Health education and promotion • Counselling on status disclosure • PHDP
<p>PALLIATIVE CARE</p>	<ul style="list-style-type: none"> • Pain and other distressing symptoms management and control • Emotional and spiritual support • Linkage to support groups • Health education and promotion • Palliative care education for primary care givers and family as a whole • Family counselling for terminally ill patients and bereavement counselling • Referral on legal services including will writing
<p>COMMUNITY TB/HIV COLLABORATIVE SERVICES</p>	<ul style="list-style-type: none"> • Health education and promotion • TB/HIV assessment and referral to health facility • Counselling on status disclosure • Adherence counselling • IPC services • Tracking and tracing LTFU and missed appointment clients
<p>COMMUNITY NUTRITION SERVICES</p>	<ul style="list-style-type: none"> • Nutritional education/IEC materials • Identification and referrals for all clients with nutritional disorders • Nutritional counselling • Adherence counselling of nutritional disorders • Linkage to support groups (chronic diseases)

	<ul style="list-style-type: none"> • Replacement and therapeutic feeds
SOCIO-ECONOMIC SUPPORT	<ul style="list-style-type: none"> • Mobilization and groups formation • Motivation and education of local government authorities (LGAs) • Linkage to support groups and community nutritional programmes
COMMUNITY STI SERVICES	<ul style="list-style-type: none"> • STI client identification and referral to health facility • STI risk behavior assessment • Partner notification • IPC services • Health education and promotion • Adherence counselling
COMMUNITY KVP AND OTHER VULNERABLE GROUPS SERVICES (People with Disabilities, OVC, Miners, Fishermen, Truck Drivers, Adolescents, Elderly, etc.)	<ul style="list-style-type: none"> • Health education, identification, and referral to health facility (HTC, ART, methadone, sober house, etc.) • Linking to support groups • Motivation and education of IGAs • PHDP • Community sensitization and campaigns for all learning institutions on HIV and AIDS prevention, care, treatment, and support • Collaborate with law enforcement agents to improve preventive HIV services for KVPs • Link people with disabilities (PWD) to community and health care services • Advocate with village health committees, KVPs, most vulnerable children (MVC), etc., for user friendly environments for PWDs to access health services • Mobilize and sensitize mining, fishing, and learning institution groups on care, treatment, prevention and support
COMMUNITY GBV SERVICES	<ul style="list-style-type: none"> • Client identification and referral to health facilities (HTC, ART, PEP, RCH, etc.) • Link to psychological support and legal services, e.g., police gender desk • Health education to families and communities
COMMUNITY PSYCHO-	<ul style="list-style-type: none"> • Psychosocial care • Linkage to support groups and other community-based support

SOCIAL SUPPORT	<p>services</p> <ul style="list-style-type: none"> • Counselling
IEC and SBCC	<ul style="list-style-type: none"> • Community sensitization and mobilization on prevention, care, treatment and support on HIV and AIDS services • Distribution and dissemination
COMMUNITY VMMC SERVICES	<ul style="list-style-type: none"> • Awareness creation • Linkage and referrals to health facilities for HTC, VMMC, ART

CHAPTER 4

4.1 Monitoring and Evaluation

Monitoring and evaluation (M&E) of the National Programme for KVPs is an essential part of programme implementation. M&E is required in order to manage and be accountable for resources, improve service delivery, and ultimately assess programme impact. M&E provides information to policy makers about cost-effectiveness and sustainability of programmes. It allows implementers and donors to track the HIV epidemic among KVPs and to assess the extent to which programming is implemented and objectives are achieved. Information obtained from M&E data also ensures that programmes are accountable to the communities that they serve. Furthermore, surveillance and M&E all play a role in improving information to assist assessment of trends in the epidemic and establish links between programme work and resources.

This M&E section for KVPs contains a list of **sixteen core indicators** that:

1. Allows MoHCDGEC and other relevant ministries to monitor trends in the HIV and AIDS epidemic among KVPs;
2. Provides information to programme managers and health care workers at national, regional, district, and community levels to track their work and observe its effects;
3. Provides the basis for KVP programme improvement;
4. Tracks contributions of other major programmes and projects to measure their influence in KVP programme outcomes and impact; and
5. Permits reporting to multi-national entities (e.g., Millennium Development Goals) on the outcomes of national commitments.

Interventions and programmes targeting KVPs will be implemented by MoHCDGEC in collaboration with various stakeholders. This M&E will guide all partners involved in the HIV response for KVPs in Tanzania in how to contribute to one national M&E system by developing sustainable M&E capacity for programme improvement, coordination, and management, as well as accountability and information sharing in the country.

4.2 Indicators for Monitoring Programmes for KVPs

Indicators were selected from sets of internationally validated indicators for monitoring KVP programmes and agreed upon by all stakeholders. A detailed indicator matrix which consists of indicator, definition, sources of data, and frequency of reporting is attached in Annex 2.

4.3 Data Source

4.3.1 Collection

KVP client recording forms that are filled out at the facility where KVP-friendly HIV services are provided make up the KVP data source. The main source of data starts at health facility.

Information to be collected includes:

- Socio-demographic information: age, sex, marital status, education level, occupation
- Drug use risk behaviors: use of unclean needles/syringes, sharing of needles/syringes and other injection equipment
- Type of drugs used: cannabis, khat, alcohol, benzidiazapine (valium), cocaine, etc.
- Sexual risk behaviors: number of sexual partners, anal sex practices, and condom use
- Previous and current HIV and drug use services accessed
- Services provided to KVPs: HIV and AIDS testing and counselling, STI screening, ART, TB screening, viral hepatitis B and C screening, drug dependence treatment, drug addiction counselling, social services, and others

4.3.2 Recording

Routine recording of KVP-exclusive services shall use standardized data collection tools, which are developed by NACP in collaboration with KVP stakeholders basing on WHO guidelines. Recording of HIV services which are not exclusive for KVPs, such as HIV care and treatment, will be conducted using routine recording systems of those services.

4.3.3 Data Collection Tools

Various data collection tools have been designed as follows:

1. **Client Recording Card:** Extension workers or peer educators of a health facility or organization implementing KVP programmes will fill out this card during visits or interactions with clients. The client card records client information at the first contact and during follow ups. The purpose of this card is to record and maintain client information which includes demographic information, drug and sexual risk behaviors, and other information over a period of time.
2. **Client Recording Form:** This form summarizes client information into one source document for a health facility or organization implementing KVP programming. It is kept at the health facility or at the organization where KVP services are provided.

The form filled out during the first interaction will serve as the baseline for the four target indicators that are defined in the KVP guidelines. The form will be filled out further during subsequent meetings with the same client to reflect the progress made as a result of the interventions provided. The client record form is kept at the point of service.

3. **KVP Facility Register:** This register summarizes client information on prevention services provided to KVPs. The KVP facility register will capture summary data of each client and will be used to feed into the web-based database, both of which will be kept at the selected facilities providing KVPs services.
4. **Monthly or Quarterly KVP Reporting Form:** This form will be filled out by the staff of a health facility or organization implementing KVP programming at the end of each month or quarter. Most of the information on this form will be summarized from the Client Record Form. Information collected through the organization or community will be compiled and submitted to the facility on a monthly basis with the respective client form used to generate the summary report. Remaining details will be filled in by the health facility or organization implementing KVP programming from its records.

4.3.4 Reporting

Data on KVP interventions from the community or organization where services are provided will be sent to the health facility in the catchment area on monthly basis. Reports will be compiled on a quarterly basis by facility staff and sent to service provision points as well as to the District Medical Officer's (DMO) office at the district level. The DMO's office, through the District AIDS Control Coordinator (DACC) will enter facility data to the DHIS, print the district report, verify, and disseminate at the district level for use. The DMO's office will also send feedback to the reporting facilities. At the regional level, the Regional AIDS Control Coordinator (RACC) will print out the report from DHIS, verify, and disseminate for use. Likewise, at the national level, NACP will print out the report from DHIS, verify, and disseminate for use. All levels shall provide feedback on the quality of the data and any other information that will facilitate improvement of the system.

4.4 Information Dissemination and Use

Reports must be disseminated for use at each level. At service provision points in communities, organizations, and health facilities, reports are synthesized and interpreted to come up with actionable statements that will be used to improve KVP services. Actionable statements will be discussed in the community, organization, and health facility settings to determine strategies for improvement. At district and regional levels, aggregated reports will be interpreted and disseminated within CHMTs and RHMTs for informed planning. Opportunities for dissemination in other national, regional, and district meetings shall be identified and used.

The reports produced by the MoHCDGEC are disseminated annually to stakeholders and partners through annual reports. This M&E cycle is synchronized with the annual planning and programming cycle, thus maximizing the opportunity for the M&E results to be used for decision making. From this perspective, therefore, KVP data and information from health facilities, umbrella organizations, and other public sectors and institutions must also reach the DMO's office for entry into DHIS in time to be included in the dissemination process. The dissemination plans for KVP information will be developed and agreed upon by all stakeholders in the country.

Dissemination of reports is expected to serve the following purposes:

- Provide feedback to various implementers on lessons learned, efforts made, progress, gaps, and challenges faced in the national response to HIV/AIDS
- Share and use data and information for better targeting and planning of HIV/AIDS interventions that target KVPs at district and community levels in the country
- Provide feedback on the efforts and resources committed to the national response and highlight issues that still require intervention
- Increase awareness and public commitment to the national response
- Enhance networking, harmonization, and resource mobilization for the national response

The MoHCDGEC will synthesize the reports and select KVP indicators that show performance of the national response, lessons learned, as well as areas to be strengthened. MoHCDGEC will integrate this into the Annual Health Sector Performance Profile reports for dissemination in the Joint Annual Health Sector Review, call a national workshop with stakeholders and donors to discuss the report, and come up with an improved implementation plan.

4.5 Coordination

4.5.1 The Role of National AIDS Control Programme (NACP) M&E Unit

- Coordination, supervision, and provision of technical assistance and guidance on monitoring and evaluation and tracking progress made in the KVP programme activities at all levels.
- Creation of a functional KVP M&E system, that links with other HMIS systems.
- Supervision and data auditing: The supervision mainly focuses to the reporting agencies to ensure that the data provided is audited for verification and credibility purposes, but also providing technical assistance in data collection, analysis and reporting.
- Development of standardized tools and methodology for collecting data and information production and reporting of KVP programme activities.

- Developing data quality assessment (DQA) protocol(s) that will coordinate and guide data collection, analysis and processing for quality assurance purposes.
- Generation of national information products, as agreed and demanded by both the national and international stakeholders, and disseminating these products in a user friendly and in a timely manner.
- Coordinate and support all capacity building and training in M&E at both national and district levels.
- Establish and maintain functional linkages with other relevant partners involved in KVP M&E

4.5.2 Regional/District levels

- Coordinate KVP recording and reporting systems at regional/district level
- Manage KVP data export to NACP
- Coordinate KVP M&E capacity building (eg. training and mentorship) at the regional/district level
- Coordinate KVP data quality audits at regional/district level
- Liaise with stakeholders concerning implementation of KVP programme monitoring system
- Support, in collaboration with the HIV Research Officer, the coordination of surveys at regional/district level
- Advise on KVP M&E issues at regional/district level
- Analyze and present KVPS M&E data as requested at regional/district level
- Disseminate KVP information products at regional/district level
- Promote KVP data use during decision making and planning of HIV interventions and use data for decision making at regional/district level
- Liaise with NACP on all KVP M&E issues at regional/district level

4.5.3 Community Level: CBOs and NGOs

- Ensure proper recording and reporting of KVP activities at primary health care facility
- Ensure timely reporting as per agreed reporting deadline during reporting month/quarter
- Liaise with HMIS focal person or DACC at district level on all KVP M&E issues
- Ensure quality of recorded and reported collected data

4.5.4 HIV Implementing Partners

- Ensure compliance with the national HIV programme monitoring system
- Support regional/district M&E efforts for implementation of KVPS interventions
- Keep daily records of implementation of KVPS activities
- Promote the use of programme monitoring system data when planning KVPS interventions

Annex 1: Comprehensive Packages of HIV and Health Services Recommended for all KVP

People Who Use or Inject Drugs

Comprehensive Services for PWUD/PWID		
The HIV prevention, care, treatment, and support services outlined below should be made available to PWUD/PWID using available National Guidelines.		
Behavioral	Biomedical	Structural
<ul style="list-style-type: none"> • Condom Education and Demonstration • Targeted IEC • SRHS • Establishment of Peer Support Groups similar to PLHIV Support Groups • Counselling and Other Forms of Psychosocial Support • Stigma and Discrimination Reduction Programmes 	<ul style="list-style-type: none"> • ART and ARV Prophylaxis • HTS and Linkage to Care, Treatment, and Support Services for Identified Positive KVPs • STI Syndromic Screening and Presumptive Treatment • Prevention, Diagnosis, and Treatment of OIs/TB • Vaccination, Diagnosis, and Treatment of Viral Hepatitis • VMMC • Palliative Care including Symptomatic Management • CBHS • Nutrition • Comprehensive Condom Programming • SRHS • MAT 	<ul style="list-style-type: none"> • Rehabilitation (Occupational Therapy, Vocational Training, Income Generation, and Employment) • Legal Advice and Support • Interventions Addressing Gender, Economic, and Social Inequality • Laws Protecting the Rights of PLHIV • Cash Transfer Programmes • Personal Development and Family Reintegration
<p>Cross Cutting Elements:</p> <ul style="list-style-type: none"> ➤ MAT ➤ NSP in demonstration sites currently only ➤ Overdose Management ➤ Drug Detoxification ➤ Relapse Prevention 		

➤ Socio-Economic and Related Reintegration Services

Men Who Have Sex with Men and Transgender People

MSM and transgender people are disproportionately burdened by HIV in Tanzania, and are likely to experience social and health disadvantages that may include depression, substance misuse, social isolation, and disconnection.

Comprehensive Services for Men Who Have Sex with Men (MSM) and Transgender People (TG)

The HIV prevention, care, treatment, and support services outlined below should be provided to MSM and TG.

Behavioral	Biomedical	Structural
<ul style="list-style-type: none"> • Comprehensive condom Programming • Targeted SBCC/IEC • SRHS • Personal Development and Family Reintegration • Counselling and Other Forms of Psychosocial Support • Stigma and Discrimination Reduction Programmes 	<ul style="list-style-type: none"> • ART and ARV Prophylaxis • HTS • STI Syndromic Screening and Presumptive Treatment • Prevention, Diagnosis, and Treatment of OIs/TB • Vaccination, Diagnosis, and Treatment of Viral Hepatitis • Community Based HIV and AIDS Services • Palliative Care including Symptomatic Management • VMMC • Nutrition • Basic Health Care: TB, Viral Hepatitis, Injection Site Care • SRHS 	<ul style="list-style-type: none"> • Mental Health Services, Counselling, and Care • Legal Advice & Support • Rehabilitation (Occupational Therapy, Vocational Training, Income Generation, and Employment) • Interventions Addressing Gender, Economic, and Social Inequality • Laws Protecting the Rights of PLHIV

Cross Cutting Elements:

- KVP Friendly Health Facilities

- Case Management
- Peer Education
- Prevention of Violence
- Life Skills Training

Sex Workers

For effective HIV and sexual health programmes it is important to include sex workers as partners, as they can develop solutions that will more accurately respond to the environment where they live and work.

Comprehensive Services for Sex Workers

The HIV prevention, care, treatment, and support services outlined below should be made available to sex workers.

Behavioral	Biomedical	Structural
<ul style="list-style-type: none"> • Comprehensive Condom Programming • Targeted SBCC/IEC • SRHS • Personal Development and Family Reintegration • Counselling and Other Forms of Psychosocial Support • Stigma and Discrimination Reduction Programmes 	<ul style="list-style-type: none"> • ART and ARV Prophylaxis • HTS • STI Syndromic Screening and Presumptive Treatment • Prevention, Diagnosis, and Treatment of OIs/TB • Vaccination, Diagnosis, and Treatment of Viral Hepatitis • Community Based HIV and AIDS Services • Palliative Care including Symptomatic Management • VMMC • Nutrition • Basic Health Care: TB, Viral Hepatitis, Injection Site Care • SRHS 	<ul style="list-style-type: none"> • Mental Health Services, Counselling, and Care • Legal Advice and Support • Rehabilitation (Occupational Therapy, Vocational Training, Income Generation, Savings and Loan, and Employment) • Interventions Addressing Gender, Economic, and Social Inequality • Laws Protecting the Rights of PLHIV • Cash Transfer
<p>Cross-Cutting Elements:</p>		

- KVP Friendly Health Facilities
- Case Management
- Peer Education
- Life Skills Training
- Referrals to Services
- Family Planning Services

Prisoners

The HIV prevention, care, treatment, and support services outlined below should be made available to prisoners and prison staff using available guidelines published. Peer development and capacity building of prison staff are the basic and initial components to be implemented, supported by specific advocacy activities focused on key policy makers and prison authorities to allow for the further implementation of a comprehensive package of services for HIV prevention, care, treatment, and support for prisoners and prison staff.

Comprehensive Services for Prisoners and Prison Staff		
Behavioral	Biomedical	Structural
<ul style="list-style-type: none"> • Comprehensive Condom Programming • Targeted SBCC/IEC • SRHS • Personal Development and Family Reintegration • Counselling and Other Forms of Psychosocial Support • Stigma and Discrimination Reduction Programmes 	<ul style="list-style-type: none"> • ART and ARV Prophylaxis • HTS • STI Syndromic Screening and Presumptive Treatment • Prevention, Diagnosis, and Treatment of OIs/TB • Vaccination, Diagnosis, and Treatment of Viral Hepatitis • Community Based HIV and AIDS Services • Palliative Care including Symptomatic Management • VMMC • Nutrition • Basic Health Care: TB, 	<ul style="list-style-type: none"> • Mental Health Services, Counselling, and Care • Legal Advice and Support • Rehabilitation (Occupational Therapy, Vocational Training, Income Generation, Savings and Loan, and Employment) • Interventions Addressing Gender, Economic, and Social Inequality • Laws Protecting the Rights of PLHIV • Cash Transfer

	Viral Hepatitis, Injection Site Care <ul style="list-style-type: none"> • SRHS 	
Cross Cutting Elements: <ul style="list-style-type: none"> ➤ KVP Friendly Health Facilities ➤ Case Management ➤ Peer Education ➤ Life Skills Training ➤ Service Referrals 		

Adolescent Girls and Young Women

Behavioral	Biomedical	Structural
<ul style="list-style-type: none"> • Comprehensive Condom Programming • Targeted SBCC/IEC • SRHS • Personal Development and Family Reintegration • Counselling and other Forms of Psychosocial support • Stigma and Discrimination Reduction Programmes 	<ul style="list-style-type: none"> • ART and ARV Prophylaxis • HTS • STI Syndromic Screening and Presumptive Treatment • Prevention, Diagnosis, and Treatment of OIs/TB • Vaccination, Diagnosis, and Treatment of Viral Hepatitis • Community Based HIV and AIDS Services • Palliative Care including Symptomatic Management • Nutrition • Basic Health Care: TB, Viral Hepatitis, Injection Site Care • SRHS 	<ul style="list-style-type: none"> • Vocational Training, Income Generation, and Employment • Interventions Addressing Gender, Economic, And Social Inequality • Laws Protecting the Rights of AGYW • Access to Health Services

Other Vulnerable Populations

The HIV prevention, care, treatment, and support services outlined below should be made available to orphans and vulnerable children, women who practice anal sex, partners of female sex workers, refugees and migrant workers; specifically long truck drivers, miners and mining communities, fisher folk and fishing communities, plantation workers, workers at road construction sites, and people with disabilities.

Comprehensive Services for Other Vulnerable Populations		
The HIV prevention, care, treatment, and support services outlined below should be made available to other vulnerable population.		
Behavioral	Biomedical	Structural
<ul style="list-style-type: none"> • Comprehensive Condom Programming • Targeted SBCC/IEC • SRHS • Personal Development and Family Reintegration • Counselling and Other Forms of Psychosocial Support • Stigma and Discrimination Reduction Programmes 	<ul style="list-style-type: none"> • ART and ARV Prophylaxis • HTS • STI Syndromic Screening and Presumptive Treatment • Prevention, Diagnosis, and Treatment of OIs/TB • Vaccination, Diagnosis, and Treatment of Viral Hepatitis • Community Based HIV and AIDS Services • Palliative Care including Symptomatic Management • VMMC • Nutrition • Basic Health Care: TB, Viral Hepatitis, Injection Site Care • SRHS 	<ul style="list-style-type: none"> • Rehabilitation (Occupational Therapy, Vocational Training, Income Generation, Savings and Loan, and Employment) • Interventions Addressing Gender, Economic, and Social Inequality • Laws Protecting the Rights of PLHIV
Cross-Cutting Elements: <ul style="list-style-type: none"> ➤ KVP Friendly Health Facilities ➤ Case Management ➤ Peer Education ➤ Life Skills Training ➤ Referrals to Other Health Services 		

INDICATOR MATRIX :KEY AND VULNERABLE POPULATIONS INTERVENTION IN TANZANIA

S/N	Indicators	Indicators definition		Disaggregation	Data Source
		Numerator	Denominator		
1	Number of KVP who received HTC services and received their result during the reporting period	number of KVP who have been tested for HIV during reporting period and know there status	NA	age , sex, type of KVP	KVP Client Form,KVP Reporting form
2	Number of KVP tested HIV positive during the reporting period	number of KVP who tested HIV positive during reporting period and know there status	NA	age , sex, type of KVP	KVP Client Form,KVP Reporting form
3	Number of HIV positive KVP linked to Care and treatment services	Number of KVP tested positive and enrolled to CTC	NA	age , sex, type of KVP	KVP Client Form,KVP Reporting form
4	Number of KVP clients newly enrolled to health facilities for HIV services during the reporting period	Number of KVP clients enrolled to services during the reporting period	N/A	By Age, Sex, KVP type (FSW, MSM, PWID)	KVP Client Form,KVP Reporting form
5	Number of KVP clients newly enrolled to CTC during the reporting period	Number of KVP clients newly enrolled to CTC during the reporting period	N/A	By Age, Sex, KVP type (FSW, MSM, PWID)	KVP Client Form,KVP Reporting form
6	Number of KVP clients newly initiated on ART during the reporting period	Number of KVP clients newly initiated on ART during the reporting period	N/A	By Age, Sex, KVP type (SW, MSM, PWID)	KVP Client Form,KVP Reporting form
7	Prevalence of HIV among KVPs (IBBS).	number of KVP respondents who have tested positive for HIV	Number of KVP who have tested for HIV	age , sex, type of KVP	National survey report
8	% of people who inject drugs (PWID) receiving opioid substitution therapy (OST).	Number of PWID on OST	Number of opioid dependent PWID	Sex(Male or Female), Age	KVP Client Form,KVP Reporting form
9	% of people who inject drugs (PWID) on opioid substitution therapy (OST) for at least 6 months.	Number of people from the cohort still in treatment 6 months after starting OST	Number of people starting OST during the time period defined as the cohort recruitment period	Sex(Male or Female), Age	KVP Client Form,KVP Reporting form
10	Number of female KVP clients who received modern family planning method within reporting period disaggregated by method	Number of KVP of reproductive age who received a modern contraceptive method during the reporting period, disaggregated by method and age	NA	By contraceptive method (Pills, Implanon, Jadelle Depo-provera Injectables, IUCD, Tubaligation, Emergency Contraceptive Pills)	KVP Client form
11	Percentage of female KVP clients with demand satisfied for a modern method of contraception	KVP of reproductive age who are currently using a modern method of contraception	KVP of reproductive age who want no more children or want to postpone having a child	Disaggregated by KVP type	KVP Client form

12	Number of condom outlets available in catchment areas.	Number of condom outlets available in catchment areas	N/A		Routine program data - condom ledger
13	Number of condoms distributed to KVP members during the reporting period	Total number of condom pieces distributed	N/A	Male/female condoms KP group	KVP Client Form, KVP Reporting form
14	Percentage of KVP members who reported using a condom during their last high risk sexual encounter	Number of MSM who reported using a condom at their last anal sex Number of SW who reported using a condom with most recent client Number of PWID who reported using a condom at last sex	Number of MSM who reported having anal sex in the past 6 months Number of SW who reported having commercial sex in the past 12 months Number of PWID who reported injecting in the past 1 month and having sex in the past 1 month	KP type, Sex	Special survey
15	% of health facilities capacitated that are providing KVP-friendly services	--# Trained providers present on day of assessment / or number retained in their posts at that facility --Appropriate IEC materials available and displayed --% of mystery clients reporting received friendly services --% of providers rejecting stigmatizing attitudes towards service provision for KVPs / reporting readiness to provide KVP friendly services **refer to KVP friendly guidelines for more information and checklist	Number of health facilities capacitated to provide KVP friendly services		Routine assessment at (National) level
16	Percentage of key and vulnerable populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of key and vulnerable populations reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	Total estimated number of key and vulnerable populations in the catchment area	Type of KVP, Age and Sex	Program monitoring tools (R&R) e.g KVP client form and KVP Reporting Form

References

- ¹ Ministry of Health and Social Welfare, National AIDS Control Programme. Third Health Sector HIV and AIDS Strategic Plan (HSHSP III), 2013 – 2017. Ministry of Health and Social Welfare Dar es Salaam, The United Republic of Tanzania. 2013
- ² Mathers B et al. For the 2007 Reference Group to the UN on HIV and Injecting Drug Use. Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *The Lancet* 2008, 372: 1733–45.
- ³ Mathers B et al. For the 2009 Reference Group to the UN on HIV and Injecting Drug Use. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *The Lancet* 2010, 375: 1014–28.
- ⁴ WHO. Towards universal access by 2010: how WHO is working with countries to scale-up HIV prevention, treatment, care and support. WHO Geneva, Switzerland, 2010.
- ⁵ Global report: UNAIDS report on the global AIDS epidemic 2011
- ⁶ Mathers BM et al. Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet*. 2008;372:1733–45
- ⁷ Mohd Hanaiah K et al. Global epidemiology of hepatitis C virus infection: new estimates of age-specific antibody to HCV seroprevalence. *Hepatology*, 2013, 57(4):1333–1342.
- ⁸ Ferreira AD et al. Projeto AjUDE-Brasil II. Profile of male Brazilian injecting drug users who have sex with men. *Cad Saude Publica*. 2006 ;22:849–60
- ⁹ Beyrer C et al. The Global HIV Epidemic among men who have sex with men, The World Bank, Washington, DC. 2011.
- ¹⁰ Baral SD et al. Worldwide burden of HIV in transgender women: a systematic review and meta analysis. *Lancet Infectious Diseases*. 2013, 13:214 – 222.
- ¹¹ Global HIV Prevention Working Group. Bringing HIV Prevention to Scale: An urgent Global Priority. 2007.
- ¹² Araújo MA et al. Symbolic violence experienced by men who have sex with men in the primary health service in Fortaleza, Ceará, Brazil: negotiating identity under stigma. *AIDS Patient Care STDS*. 2009, 23(8):663–668.
- ¹³ Amjadeen, L. Report on the Survey “Monitoring Behaviours of MSM as a Component of Second Generation Surveillance” [in Ukrainian]. Kyiv: International HIV/AIDS Alliance in Ukraine. 2005.
- ¹⁴ Betron, M. and E. Gonzalez-Figueroa. Task Order 1 Gender Identity, Violence, and HIV among MSM and TG: A Literature Review and a Call for Screening. Washington, DC: Futures Group International, USAID |Health Policy Initiative, Task Order 1. 2009.
- ¹⁵ UNAIDS (2009), UNAIDS Action Framework: Universal Access for men who have sex with men and Transgendered people, Geneva, Switzerland.
- ¹⁶ Baral et al. Burden of HIV among female sex workers in low and middle income countries with HIV infection countries: a systematic review and meta-analysis. *Lancet Infectious Diseases*. 2012, 12: 538-549.
- ¹⁷ Ghys PD et al. HIV surveillance among female sex workers. *AIDS* 2001;15(3):s33–40.
- ¹⁸ Commission on AIDS in Asia. Redefining AIDS in Asia: crafting an effective response. 2008
- ¹⁹ Estebanez P. et al. HIV and female sex workers. *Bulletin of the World Health Organization* 1993;71(3-4): 397–412
- ²⁰ UNAIDS. UNAIDS Guidance Note on HIV and Sex Work. Geneva, 2009
- ²¹ Harcourt C and Donovan B. The many faces of sex work. *Sexually Transmitted Infections*, 2005, 81(3):201–206.

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- ²² Baral S et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. *Lancet Infectious Diseases*, 15 March 2012; doi:10.1016/S1473-3099(12)70066-X.
- ²³ Ibid
- ²⁴ UNFPA and UNAIDS 2011. Building partnerships on HIV and sex work. Report and recommendations from the first Asia and the Pacific Regional Consultation on HIV and Sex Work. Bangkok, Thailand.
- ²⁵ Baral SD et al. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infectious Diseases*. 2013, 13:214 – 222.
- ²⁶ Beyrer et al. Global epidemiology of HIV infection in men who have sex with men. *Lancet*, 2012, 380: 367-377.
- ²⁷ UNODC, ILO, UNDP, WHO, UNAIDS. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Policy Brief. UNODC, Vienna, 2013.
- ²⁸ Macher A and Goosby A. The Incarcerated: A Report from the 12th World AIDS Conference. 2004
- ²⁹ Martin V et al. Predictive Factors of HIV- infection in Injection Drug Users Upon Incarceration, *European Journal of Epidemiology*, 1998, Vol. 14, Issue 4, pp 327-331
- ³⁰ Sahajian, F et al. Psychoactive substance use among newly incarcerated prison inmates, *Sante Publique*, 2006, 18 (2): 223-34
- ³¹ Sarang A, et al. Drug injecting and syringe use in the HIV risk environment of Russian penitentiary institutions: qualitative study. *Addiction* 2006;101:1787-96
- ³² Kang S.Y et al. HIV transmission behaviors in jail/prison among puerto rican drug injectors in New York and Puerto Rico. *AIDS Behaviour* 2005, 9, (3): 377-386
- ³³ Dolan J et al. HIV in prison in low-income and middle-income countries. *Lancet Infectious Diseases*, 2007, 7 : 32-43.
- ³⁴ UNODC, 2010.
- ³⁵ WHO, Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach, WHO, 2011, p16.
- ³⁶ WHO, UNAIDS, UNODC. Evidence for action on HIV/AIDS and injecting drug use Policy Brief: Antiretroviral Therapy and Injecting Drug Users. Geneva, World Health Organization 2005
- ³⁷ Ward J et al editors. 1998. *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*. Amsterdam: Harwood Academic Publishers.
- ³⁸ Heimera R et al. Structural interventions to improve opiate maintenance. *International Journal of Drug Policy*. Volume 13, Issue 2: 103-111, 2002.
- ³⁹ Lawrinson P et al. Key findings from the WHO collaborative study on substitution therapy for Opioid dependence and HIV/AIDS. *Addiction*, 103, 1484–1492. 2008.
- ⁴⁰ Bowring A et al. Assessment of risk practices and infectious disease among drug users in Temeke District, Dar es Salaam, Tanzania: Prepared for Médecins du Monde France. Melbourne: Centre for Population Health, Burnet Institute. 2011
- ⁴¹ WHO. Management of sexually transmitted infections. Regional Guidelines. WHO Regional Office for South-East Asia, New Delhi, India. 2011.
- ⁴² Wasserheit JN. The significance and scope of reproductive tract infections among Third World women. *International Journal of Gynecology and Obstetrics (Supplement)*, 1989, 3:145–168.
- ⁴³ Defraye A et al. Surveillance of sexually transmitted infections among persons living with HIV. *International Journal of Public Health*, 2010, 56:169–174

-
- ⁴⁵ Hellard M et al. Hepatitis C Treatment for Injection Drug Users: A Review of the Available Evidence *Clinical Infectious Diseases*. (2009) 49 (4): 561-573.
- ⁴⁶ Hepatitis C Virus Projections Working Group. Estimates and projections of the hepatitis C virus epidemic in Australia 2006. Canberra: Hepatitis C Sub-Committee, Ministerial Advisory Committee on AIDS Sexual Health and Hepatitis, 2006.
- ⁴⁷ Alter MJ. Epidemiology of viral hepatitis and HIV co-infection. *Journal of Hepatology*, 2006, 44, Supplement 1(0):S6-S9.
- ⁴⁸ Bowring A et al. Assessment of risk practices and infectious disease among drug users in Temeke District, Dar es Salaam, Tanzania: Prepared for Médecins du Monde France. Melbourne: Centre for Population Health, Burnet Institute. 2011
- ⁴⁹ WHO. Update Tuberculosis Facts 2009. World Health Organization, Geneva, 2009
- ⁵⁰ WHO and International Committee of the Red Cross. Tuberculosis control in prisons: a manual for programme managers. WHO 2000.
- ⁵¹ WHO. Status paper on prisons and tuberculosis. Copenhagen, WHO Regional Office for Europe, 2007
- ⁵² WHO, UNODC, UNAIDS. Policy guidelines for collaborative TB and HIV services for injecting and other drug users - an integrated approach. Geneva, World Health Organization, 2008.
- ⁵³ Aggleton P et al. HIV/AIDS and injecting drug use: Information, education and communication. *International Journal on Drug Policy*, 2005, 16(1):S21-S30