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HEALTH POLICY INITIATIVE IN TANZANIA: END-OF-PROJECT REPORT (2009–2013)

August 2013

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- Individual Honorable Members of Parliament who assisted as FP/RH and HIV champions
- Various Standing Committees of the Parliament of Tanzania, including the Public Accounts Committee, Social Services Committee, HIV/AIDS Affairs Committee, Community Development Committee, and Finance and Economic Affairs Committee
- Voluntary parliamentary associations and caucuses, including the Parliamentary Family Planning Club (PFPC), Tanzania Parliamentary Association on Population and Development (TPAPD), and the Tanzania Parliamentary AIDS Coalition (TAPAC)
- Ministry of Health and Social Welfare (MOHSW), particularly the Reproductive and Child Health Section (RCHS)
- Ministry of Community Development, Gender, and Children (MCDGC)
- Parliamentary Standing Committee on HIV/AIDS (PASCHA)
- President's Office Planning Commission (POPC)
- President's Office Public Service Management (POPSM)
- Tanzania Commission for AIDS (TACAIDS)
- Prime Minister's Office of Regional and Local Government (PMORALG)
- Ministry of Education and Vocational Training (MoEVT)

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- Anti Female Genital Mutilation Network (AFNET)
- Association of Journalists against AIDS in Tanzania (AJAAT)
- Center for Development and Population Activities (CEDPA)
- Dar es Salaam Coalition of People Living with HIV and AIDS (DACOPHA)
- Health Promotion Tanzania (formerly Human Development Trust) (HDT)
- Legal and Human Rights Centre (LHRC)
- Medical Women's Association of Tanzania (MEWATA)
- Media Owners Association of Tanzania (MOAT)
- National Association of People Living with HIV and AIDS (NACOPHA)
- Partner Agencies Collaborating Together (PACT)
- Tanganyika Law Society (TLS)
- Tanzanian Religious Leaders Living with HIV or Affected by AIDS (TANERELA)
- Tanzania Rural Women and Children Development Foundation (TARWOC)
- Tanzania Women Lawyers Association (TAWLA)
- Tanzania Media Women's Association (TAMWA)
- The Wanawake na Maendeleo Foundation (WAMA)
- Women Legal Aid Centre (WLAC)

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EXECUTIVE SUMMARY

Task Order 5 of the Health Policy Initiative in Tanzania (HPI/Tanzania) supported the Government of Tanzania (GOT) and civil society to build an enabling environment for the scale-up of prevention, care, and treatment of HIV in Tanzania, and to support advocacy for family planning (FP) and reproductive health (RH).

Implemented by Futures Group, in partnership with the Center for Development and Population Activities (CEDPA) and Health Promotion Tanzania (HDT)¹ between February 2009 and September 2013, HPI/Tanzania led a major effort to improve Tanzania's policy environment for HIV, FP/RH, and GBV. The project sought to respond effectively to the HIV epidemic, overcome barriers hindering Tanzania's ability to guarantee access to FP commodities and services, prevent HIV-related stigma and discrimination, and address the proliferation of gender-based violence (GBV). To reach its overall goal of creating an enabling policy environment for the scale-up of FP/RH and the prevention, care, and treatment of HIV in Tanzania, HPI/Tanzania focused on achieving four key objectives:

Objective 1: Strengthened leadership and governance on priority HIV, FP/RH, and gender and GBV issues and programs.

Objective 2: Accelerated development, adoption, and implementation of priority policies, plans, rules, and regulations for scale-up of HIV, FP/RH, and GBV services.

Objective 3: Increased financial resources and accountability for HIV and FP/RH programs.

Objective 4: Increased use of evidence-based information and data for decision making and advocacy for HIV and FP/RH.

To accomplish these objectives, HPI/Tanzania supported the drafting and implementation of key policies and built capacity for HIV, FP/RH, and GBV policy and advocacy initiatives among a broad range of government and civil society actors, including parliamentarians, government officials, faith-based organizations (FBOs), civil society organizations (CSOs), nongovernmental organizations (NGOs), networks of people living with HIV (PLHIV), youth, and the media.

Thanks to the project's work, Tanzania's policy and regulatory framework for HIV, FP/RH, and GBV is stronger than it was five years ago. Leaders and champions from a variety of backgrounds have stepped forward to advance HIV, FP/RH, and GBV efforts. Parliamentarians, members of the media, religious leaders, women leaders, and PLHIV have all made their voices heard as a result of the project's support. Evidence-based information produced by HPI/Tanzania through RAPIDWomen, FamPlan, and other means has provided a strong basis for successful advocacy and policy formulation. New mechanisms have been introduced to improve the tracking and allocation of FP resources, and FP has been incorporated into Tanzania's Poverty Reduction Strategy Paper (PRSP).

Key achievements

- The project helped close gaps in the policy framework through the adoption of new guidelines and policies, including:
 - National Multisectoral HIV and AIDS Stigma and Discrimination Reduction Strategy 2013–2017;
 - Two new national policies to govern the health sector response to GBV—*National Policy Guidelines for the Health Sector Prevention and Response to Gender-based Violence* and *National Management Guidelines for the Health Sector Prevention and Response to Gender-based Violence*;

¹ CEDPA is now part of Plan International USA; Health Promotion Tanzania (HDT) was formerly known as Human Development Trust (HDT).

- National GBV coordination guidelines (still being drafted by the Ministry of Community Development, Gender, and Children—MCDGC).
- The project fostered implementation of the HIV law, including translating the HIV law into Kiswahili, supporting community-level dissemination of the law through small grants to TAPAC, and training PLHIV networks in the law’s provisions.
- The project created a comprehensive matrix tool to enable USAID to monitor changes in Tanzania’s HIV policy framework.
- The project helped strengthen parliamentary leadership on FP/RH issues, leading to policy changes that support the scale-up of FP/RH programs and services and increased resource allocation and accountability.
- The project partnered with media organizations and PLHIV networks to improve the scope and accuracy of media coverage on HIV, stigma and discrimination, and GBV.
- Religious leaders spoke out against stigma and discrimination and GBV—incorporating these messages into their services, participating in nationally broadcast television and radio programs, and issuing an interfaith declaration committing to unite to combat stigma and discrimination.
- The government adopted a National Family Planning Costed Implementation Program (NFPCIP) was adopted and it is being used by government and non-government organizations to advocate for increased domestic funding for FP commodities and services.
- The MOHSW incorporated a dedicated FP line item into the mid-term expenditure framework (MTEF), making it easier to track government resource allocation for FP goods and services.
- The GOT integrated FP into Tanzania’s Poverty Reduction Strategy Paper (PRSP) for the 2010–2015 period (MKUKUTA II).
- The project leveraged funds from the Packard Foundation to support development and application of RAPIDWomen Model in Tanzania, for which the First Lady of Tanzania acted as the chief spokesperson and advocate, including presiding over the national launch event.

The HPI/Tanzania made significant contributions to Tanzania’s policy environment for HIV, FP/RH, and GBV. Nevertheless, much work remains to be done. To build on the project’s success, HPI/Tanzania recommends providing ongoing support in nine key areas:

1. High-level advocacy on FP to increase domestic budget support and hold the GOT accountable for London FP Summit commitments.
2. Engagement and capacity building with parliamentary policy champions.
3. Implementation of new policies and guidelines.
4. Interministerial dialogue to harmonize approaches and policies on adolescent reproductive health, especially the Ministry of Education and Vocational Training (MOEVT) and the MOHSW.
5. Capacity building for CSOs, particularly institutional capacity in areas such as management and finance.
6. Mobilization of religious leaders to use their influence to combat GBV and S&D for PLHIVs.
7. Collaboration with the GOT to advance task shifting.
8. High-level advocacy on raising the minimum age of marriage (timed appropriately to leverage the constitutional review process).
9. Capacity building with the media to increase scope and accuracy of reporting on HIV, FP/RH, and GBV.

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
AFP	Johns Hopkins University/Advance Family Planning project
AJAAT	Association of Journalists against AIDS in Tanzania
ART	antiretroviral therapy
BAKWATA	Muslim Council of Tanzania
CEDPA	Center for Development and Population Activities
CCT	Christian Council of Tanzania
CSO	civil society organization
DACOPHA	Dar es Salaam Coalition of People Living with HIV/AIDS
FBO	faith-based organization
FGC	female genital cutting
FP	family planning
GBV	gender-based violence
GOT	Government of Tanzania
HTC	HIV testing and counseling
HDT	Human Development Trust
HIV	human immunodeficiency virus
HPI	Health Policy Initiative
HRH	human resources for health
KONEHRA	Kongwa Network for Human Rights Advocacy
LMA	Law of Marriage Act (1971)
LRCT	Law Reform Commission of Tanzania
MCDGC	Ministry of Community Development, Gender, and Children
MDGs	Millennium Development Goals
MEWATA	Medical Women's Association of Tanzania
MKUKUTA II	National Strategy for Growth and Reduction of Poverty (2010–2015)
MMR	maternal mortality ratio
MOAT	Media Owners Association of Tanzania
MOEVT	Ministry of Education and Vocational Training
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
MOJCA	Ministry of Justice and Constitutional Affairs
MP	Member of Parliament
MTEF	Mid-term Expenditure Framework
NACOPHA	National Council of People Living with HIV/AIDS
NFPCIP	National Family Planning Costed Implementation Program
NGO	non-governmental organization
NMSF	national multisectoral strategic framework on HIV and AIDS
OVC	orphans and vulnerable children
PACT	Partner Agencies Collaborating Together
PASCHA	Parliamentary Standing Committee on HIV/AIDS
PCT	Pentecostal Council of Tanzania
PEPFAR	President's Emergency Plan for AIDS Relief
PETS	public expenditure tracking survey
PFIP	partnership framework implementation plan
PFPC	Parliamentary Family Planning Club
PLHIV	people living with HIV
POPC	President's Office Planning Commission
POPSM	President's Office Public Service Management
PRSP	Poverty Reduction Strategy Paper

PSCCD	Parliamentary Standing Committee on Community Development
RCHS	MOHSW Reproductive and Child Health Section
RH	reproductive health
STI	sexually transmitted infection
TACAIDS	Tanzania Commission for AIDS
TAMWA	Tanzania Media Women's Association
TANERELA	Tanzanian Religious Leaders Living with HIV or Affected by AIDS
TAPAC	Tanzania Parliamentary AIDS Coalition
TARWOC	Tanzania Rural Women and Children Development Foundation
TAWLA	Tanzania Women Lawyers Association
TBC	Tanzania Broadcasting Corporation
TFR	total fertility rate
TO1	Task Order 1
TO5	Task Order 5
TPAPD	Tanzania Parliamentary Association on Population and Development
TWG	technical working group
USAID	US Agency for International Development
USG	US Government
WAMA	Wanawake na Maendeleo Foundation

I INTRODUCTION AND BACKGROUND

I.1 Introduction

The Health Policy Initiative (HPI) exercised global leadership and provided field-level programming in policy development and implementation. Within this global mechanism, USAID/Tanzania issued a bilateral task order (Task Order 5) to support the Government of Tanzania (GOT) and civil society to build an enabling environment for the scale-up of prevention, care, and treatment of HIV in Tanzania, and to support advocacy for family planning (FP) and reproductive health (RH).

Implemented by Futures Group, in partnership with the Center for Development and Population Activities (CEDPA) and Health Promotion Tanzania (HDT),² Task Order 5 of the Health Policy Initiative (HPI/Tanzania) began in February 2009 and ends in September 2013. The project sought to overcome barriers hindering Tanzania's ability to respond effectively to the HIV epidemic, guarantee access to FP commodities and services, prevent HIV-related stigma and discrimination, and address the proliferation of gender-based violence (GBV). To accomplish this, HPI/Tanzania supported the drafting and implementation of key policies and built the capacity of government and civil society partners to advance the HIV and FP/RH policy agendas.

HPI/Tanzania's strategies and approaches were aligned with GOT priorities as reflected in key policy documents, including the HIV and AIDS (Prevention and Control) Act of 2008, the National HIV/AIDS Policy of 2001, the National HIV/AIDS Multi-Sectoral Strategy Framework (NMSF) 2008-2012, the National Strategy for Growth and Reduction of Poverty (2010–2015) (MKUKUTA II), the National Population Policy of 2006, the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths 2008-2015, and the Primary Health Services Development Programme 2007–2017.

Project activities contributed to the Health Systems Strengthening component of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), particularly the areas of health systems governance, human resources for health (HRH), health finance, and gender. HPI/Tanzania's work also aligned with the broader health focus of the U.S. Government's (USG) Global Health Initiative Strategy (2010–2015) for Tanzania, specifically its emphasis on women, girls, and gender equality; country ownership; strategic coordination and integration; and innovation.

This report highlights the achievements of HPI in Tanzania for the period from 2009-2013.

I.1.1 Context

While the United Republic of Tanzania has made some impressive strides in recent years, it still faces a host of health and development challenges. With a per capita gross national income of US\$1500, Tanzania remains among the poorest countries in the world and is ranked 152 out of 186 countries on the Human Development Index.³ Efforts to combat poverty are hindered by the HIV epidemic and by lack of access to FP/RH goods and services.

HIV

Tanzania is home to a generalized HIV epidemic, with an estimated national HIV adult (age 15–49) prevalence rate of 5.1 percent in 2011/12, a slight decline from the prevalence rate of 5.7 percent in 2007/08.⁴ The key driver of the epidemic is heterosexual intercourse, especially high-risk behaviors such as multiple concurrent

² CEDPA is now part of Plan International USA; Health Promotion Tanzania (HDT) was formerly known as Human Development Trust (HDT).

³ United Nations Development Programme (UNDP). 2013. *Human Development Report 2013*. Geneva: UNDP.

⁴ TACAIDS. Tanzania HIV/AIDS and Malaria Indicator Survey 2011–2012. Dar es Salaam: Government of Tanzania.

partners, low consistent condom use, and cross-generational sex. Other contributing factors include sociocultural norms and practices, such as early marriage, gender inequities, and gender-based violence.⁵

Prevailing gender norms limit women's and girls' opportunities and decision-making authority, thereby increasing their HIV vulnerability, and also encourage men and boys to engage in high-risk behaviors. As a result, HIV prevalence is higher among women (6.2 percent) than men (3.8 percent). Women also become infected at earlier ages than men, and young women (age 15–24) are twice as likely to be infected as their male counterparts.⁶

High levels of HIV-related stigma and discrimination continue to hinder Tanzania's HIV response, discouraging people from accessing HIV prevention, care, and treatment services or disclosing their HIV status. Stigma and discrimination is common among Tanzanian adults. The 2011–2012 Tanzania HIV/AIDS and Malaria Indicator Survey found only 25 percent of women and 40 percent of men demonstrated accepting attitudes on four standard indicators—whether they would be willing (1) to care for a family member sick with the AIDS virus in their own home, (2) to buy fresh food from a shopkeeper with HIV, (3) to allow a female teacher with HIV to continue teaching, and (4) to not keep the HIV-positive status of a family member a secret.⁷

This stigmatizing atmosphere has hampered efforts to form a strong movement of people living with HIV (PLHIV) in Tanzania. Tanzania's PLHIV community has remained largely fragmented, poorly coordinated, and under-resourced. As a result, the voices of PLHIV are not unified or strongly heard in policy dialogue or advocacy efforts for both access to and the quality of services at community levels.

In responding to the HIV epidemic and scaling up FP/RH services, Tanzania remains almost entirely donor dependent. Domestic allocations in support of the national HIV response have been negligible. The Tanzania Commission for AIDS (TACAIDS) found that donors supplied 96 percent of Tanzania's HIV/AIDS funding, and that the country was facing a 51 percent HIV/AIDS funding gap under the second HIV/AIDS National Multisectoral Strategic Framework (NMSF 2008–2012). The Ministry of Health and Social Welfare (MOHSW) budget for 2013–2014 includes no domestic allocation for HIV.

In 2009, when HPI/Tanzania began its work, Tanzania had recently adopted policies and frameworks to support scale-up of the national HIV response, including the NMSF 2008–2012; National Costed Plan of Action for Most Vulnerable Children, 2007–2010; and the HIV and AIDS (Prevention and Control) Act, 2008 (the HIV Law) that prohibits discrimination against PLHIV.

Tanzania has also largely decentralized its healthcare system, placing greater decision-making authority in the hands of local government structures. Decentralization has resulted in some improvements in resource allocation, coordination, and communication, particularly in addressing HIV. However, lack of knowledge and skills related to HIV at both the healthcare provider and the community levels have proved obstacles to effective implementation of HIV policies, programs, and quality services.

FP/RH

Lack of leadership and support for FP/RH among decision-makers, and the corresponding lack of domestic funding for FP/RH programs and services, have proved significant barriers to expanding access to FP/RH services. The MOHSW budget for the 2013/14 includes a domestic allocation for FP of Tsh 1 billion (US\$615,006), out of an estimated Tsh 24.4 billion (US\$15,006,150) needed to support FP programs and services according to the National Family Planning Costed Implementation Program (NFPICP).⁸

⁵ TACAIDS. UNGASS Country Progress Report 2010, Tanzania Mainland and Zanzibar. Dar es Salaam: Government of Tanzania.

⁶ TACAIDS. Tanzania HIV/AIDS and Malaria Indicator Survey 2011–2012. Dar es Salaam: Government of Tanzania.

⁷ Tanzania HIV/AIDS and Malaria Indicator Survey 2011–2012.

⁸ Ministry of Health and Social Welfare. (2010). *National Family Planning Costed Implementation Program 2010–2015*. Dar es Salaam: Government of Tanzania.

There is an urgent need to scale-up FP/RH services in Tanzania. The total fertility rate (TFR) in Tanzania is currently 5.4 children per woman, a slight decline from the 5.7 births per woman recorded in 2004–2005.⁹ Overall, the TFR has changed little over the past 15 years.¹⁰ The high fertility rate compounds the challenges posed by the HIV epidemic. It also hinders overall efforts to promote social and economic development, as it places an ever-increasing strain on the country's already overburdened health, education, and economic infrastructure.

Overall contraceptive use among currently married women has gradually increased over the past two decades—from 10 percent in 1992 to 34 percent in 2010.¹¹ There remains significant unmet need for FP—a quarter of currently married women of reproductive age want to space or limit births but are not using any FP method.¹² Overall unmet need remains high and largely unchanged from 1999. As shorter birth intervals are strongly associated with higher infant and child mortality,¹³ enabling women to limit or space births according to their preferences would also contribute to improving the health of infants and children under the age of five years.

Complications during pregnancy and childbirth continue to pose significant risks to women's health. Between 2000 and 2010, for every 1,000 live births in Tanzania, 4–5 women died of pregnancy-resulted causes. Overall, the maternal mortality ratio (MMR) from the 2010 TDHS ranges from 353 to 556 deaths per 100,000 live births. World Bank MMR rankings for 2010 place Tanzania 187 out of 211 countries reporting.¹⁴

Early marriage is common in Tanzania, where the legal age of marriage is 15 years for girls (14 with court approval) and 18 years for boys.¹⁵ Thirty-six percent of women age 25–49 married before the age of 18, and 58 percent married before the age of 20. Rates of early marriage were drastically lower among men: only 4 percent of men age 25–49 married before the age of 18, and 13 percent before age 20.¹⁶ Twenty-three percent of women age 15–19 years have begun bearing children, down slightly from 26 percent in the 2004–2005 TDHS, and the median age at first birth is 19.5 years—meaning that half of women in Tanzania give birth for the first time before the age of 20.¹⁷

Early marriage not only violates girls' human rights,¹⁸ it also jeopardizes their health. It is associated with GBV, as women who are married before age 20 are more likely to report experiences of physical or sexual violence.¹⁹ Teenage pregnancy and early marriage constitute one of the main challenges hindering health,

⁹ 2010 TDHS

¹⁰ The 1999 Tanzania Reproductive and Child Health Survey (TRCHS) found a TFR of 5.6 births.

¹¹ 2010 TDHS

¹² 2010 TDHS

¹³ 2010 TDHS

¹⁴ Trends in Maternal Mortality: 1990-2010. Estimates Developed by WHO, UNICEF, UNFPA and the World Bank. Accessible at <http://data.worldbank.org/indicator/SH.STA.MMRT>

¹⁵ Law of Marriage Act (1971)

¹⁶ Tanzania HIV/AIDS and Malaria Indicator Survey 2011–2012

¹⁷ 2010 TDHS

¹⁸ The human rights of girls related to early marriage are outlined in several international agreements. The Universal Declaration of Human Rights provides that women and men are entitled to equal rights in marriage, and that potential spouses should freely and fully consent to marriage. Girls under the age of consent for other legal binding contracts are unable to provide this free and full consent. The 1990 African Charter on the Rights and Welfare of the Child stipulates that action should be taken to ensure that the minimum age of marriage is 18. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) also mentions the right to protection from early marriage and the CEDAW Committee has recommended 18 years as the minimum age of marriage for the both men and women. The Convention on the Rights of the Child (CRC) does not directly address early marriage. However, early marriage is linked to other rights protected under the convention and is frequently addressed by the CRC Committee.

¹⁹ Hindin, M.S. et al. 2008 "Intimate Partner Violence Among Couples in 10 DHS Countries: Predictors and Health Outcomes." *DHS Analytical Studies* No. 18. Calverton, MD: Macro International.

social, and economic development, particularly of Tanzanian girls and women. Early pregnancy and childbirth present many disadvantages for young girls—often leading to dropping out of school and missing out on further education. As a result, their future prospects for employment are limited, which perpetuates poverty. More immediately, early and frequent pregnancies negatively affect the health of young girls and contribute to maternal and infant mortality in Tanzania.

GBV

GBV remains widespread in Tanzania. A rapid policy scan of GBV and HIV in Tanzania conducted by Task Order I of the Health Policy Initiative (HPI TO I) in 2008 found that GBV, including intimate partner violence and rape, is viewed as a normal part of life by both men and women.²⁰ The 2010 Tanzania Demographic and Health Survey (TDHS) found that 44 percent of ever-married women have ever experienced emotional, physical and/or sexual violence from a partner, and 37 percent have experienced such violence in the past 12 months.²¹

There are clear linkages between HIV and GBV. GBV increases the risk of contracting HIV, as women who experience violence in relationships have a four-fold higher risk of HIV and sexually transmitted infections (STI).²² At the same time, HIV infection is often a trigger for GBV. In Tanzania, HIV-positive women are two and a half times more likely than HIV-negative women to have been physically abused by their partner.²³ Regardless of whether women have experienced GBV themselves, with violence so widespread, the implicit threat of violence may discourage women and girls from negotiating condom use or taking other steps to protect themselves from contracting HIV.

The policy environment for GBV in Tanzania is somewhat supportive. The Tanzania Police Force has instituted reforms to make it more responsive to GBV, and GBV-related training and other efforts to build the capacity of police officers are ongoing. The creation of the Tanzania Police Female Network and establishment of gender desks in several police stations were milestones in making the police force more accessible to GBV survivors. However, the results of this innovation have been mixed. Despite the supportive policy environment, the quality of services, number of facilities, and resources available to GBV survivors remain minimal.²⁴ A July 2009 study conducted by the MOHSW, in collaboration with the United Nations Joint Program on Reduction of Maternal and Newborn Mortality, found a shortage of staff, deficient or little training to provide GBV care, and lack of awareness among health service practitioners of GBV as a human rights issue and a public health problem.²⁵

These problems are exacerbated by significant gaps in the GBV policy framework. Weaknesses in the current legal and policy framework related to GBV prevention, response, and mitigation include, but are not limited to, inadequate funding, gaps in laws and policies, inadequate multisectoral coordination, and lack of well-established referral mechanisms for GBV prevention and response services. When HPI/Tanzania began its work in 2009, no guidelines or protocols existed to guide healthcare providers and police in managing GBV survivors.

²⁰ M. Betron. 2008. *Gender-based Violence in Tanzania: An Assessment of Policies, Services, and Promising Interventions*. Washington, DC: USAID | Health Policy Initiative Task Order I, Futures Group.

²¹ National Bureau of Statistics. 2010 Tanzania Demographic and Health Survey, Dar es Salaam: Government of Tanzania, Figure 16.1.

²² Fleischman, J. (2012). *Gender-based Violence and HIV: Emerging Lessons from the PEPFAR Initiative in Tanzania, A Report of the CSIS Global Health Policy Center*. Washington, DC: Center for Strategic and International Studies (CSIS).

²³ S. Maman, J. Mbwambo, N. Hogan, G. Kilonzo et al. 2002. "HIV-positive women report increased partner violence in Tanzania" *American Journal of Public Health* 92(8): 1331–1337.

²⁴ M. Betron. 2008.

²⁵ MOHSW. 2011. *National Management Guidelines for the Health Sector Prevention and Response to Gender-based Violence*. Dar es Salaam: Government of Tanzania.

1.1.2 Overview of Health Policy Initiative, Task Order 5

HPI/Tanzania led a major effort to improve Tanzania's policy environment for HIV, FP/RH, and GBV. The project combined several technical assistance areas—namely, awareness raising; policy dialogue; and policy formulation, implementation, and monitoring—into a single program. The project's mandate was to improve policy and advocacy for an expanded range of RH issues, including HIV, and to strengthen these policies by promoting multisectoral involvement in policy development processes.

To reach its overall goal of creating an enabling policy environment for the prevention, care, and treatment of HIV in Tanzania, and the scale-up of FP/RH, HPI/Tanzania focused on achieving four key objectives:

Objective 1: Strengthened leadership and governance on priority HIV, FP/RH, and gender and GBV issues and programs.

Objective 2: Accelerated development, adoption, and implementation of priority policies, plans, rules, and regulations for scale-up of HIV, FP/RH, and GBV services.

Objective 3: Increased financial resources and accountability for HIV and FP/RH programs.

Objective 4: Increased use of evidence-based information and data for decision making and advocacy for HIV and FP/RH.

To accomplish these objectives, HPI/Tanzania built capacity for HIV, FP/RH, and GBV policy and advocacy initiatives among a broad range of government and civil society actors, including parliamentarians, government officials, faith-based organizations (FBOs), civil society organizations (CSOs), nongovernmental organizations (NGOs), networks of PLHIV, youth, and the media.

Successfully shifting the policy environment requires responding effectively to changing circumstances—taking advantage of opportunities and responding to challenges as they arise. Throughout the life of the project, HPI/Tanzania adapted and refined its approach to address changes in the external environment. In late 2009, the project developed a Revised Strategic Framework, which tightened the project's strategic focus and clearly articulated the project objectives (as stated above). The framework also enabled HPI/Tanzania to address priorities outlined in the new GOT-USG Partnership Agreement, adopted in May 2010.

In the area of HIV, HPI/Tanzania supported the drafting, adoption, and implementation of key policies, including the HIV Law (the Law was adopted before Task Order 5), the national stigma and discrimination reduction strategy, and implementation of the Government of Tanzania Circular # 2 of 2006 on services to civil servants living with HIV. In conjunction with this effort, the project also enhanced the ability of government and civil society partners to effectively advocate on HIV issues. Key target groups included:

- Parliamentarians (the Parliamentary Standing Committee on HIV/AIDS—PASCHA, and the Tanzania Parliamentary AIDS Coalition—TAPAC);
- GOT ministries, departments, and agencies (MDAs);
- PLHIV (the Dar es Salaam Coalition of People Living with HIV/AIDS—DACOPHA, and the National Council of People Living with HIV/AIDS—NACOPHA);
- Religious leaders (the Christian Council of Tanzania—CCT, the Muslim Council of Tanzania—BAKWATA, the Pentecostal Council of Tanzania—PCT, and the Tanzanian Religious Leaders Living with HIV or Affected by AIDS—TANERELA); and
- Members of the media (the Association of Journalists against AIDS in Tanzania—AJAAT and the Media Owners Association of Tanzania—MOAT).

To tackle the linked challenges of GBV and HIV, HPI/Tanzania sought to strengthen the GBV policy framework by addressing the lack of policies to guide efforts to prevent and respond to GBV. Key partners

included the MOHSW; the Ministry of Community Development, Gender, and Children (MCDGC); and the Tanzania Rural Women and Children Development Foundation (TARWOC).

In the area of FP/RH, the project worked to foster high-level advocacy and leadership in FP/RH in Tanzania, to increase domestic resource allocation for FP, and to support improved mechanisms for overall FP management and coordination. The project participated in and coordinated its efforts with the National Family Planning Technical Working Group (TWG). The FPTWG is a multisectoral advisory entity that is responsible for planning and oversight of the FP program. The project also worked closely with other partner organizations, including the Johns Hopkins University/Advance Family Planning project (AFP), FHI360, and MEASURE Evaluation.

I.2 Achievements

Key achievements of HPI/Tanzania include the following:

HIV

- The GOT adopted the Comprehensive National Multisectoral HIV and AIDS Stigma and Discrimination Reduction Strategy 2013–2017.
- The project fostered implementation of the HIV law, supporting community-level dissemination of the law through small grants to TAPAC, training PLHIV networks in the law's provisions, and partnering with NACOPHA, MOHSW and CSOs with legal aid schemes to identify incidents of HIV-related stigma and discrimination eligible for legal action.
- 10 MPs partnered with local NGOs to address HIV at the district level, resulting in the allocation of Tsh 103,794,300 (around US\$63,834) for HIV programs and increased utilization of HIV testing and counseling (HTC) services.
- Religious leaders from both the Muslim and Christian faiths
 - issued the Interfaith Dodoma Declaration, declaring their commitment to unite to combat stigma and discrimination;
 - incorporated anti-stigma and discrimination and GBV messages into religious services;
 - delivered addresses condemning stigma and discrimination and GBV, which were broadcast on national radio and television channels;
 - adopted comprehensive institutional policies on HIV (CCT and PCT), as well as a workplace HIV policy (CCT) and guidelines for reducing stigma and discrimination (PCT).
- HPI/Tanzania successfully built the institutional capacity of two PLHIV networks—NACOPHA and DACOPHA—and strengthened their media engagement skills.
- In partnership with POPSM, TACAIDS, and NACOPHA, the project supported implementation of Government Circular No. 2 of 2006 on services to civil servants living with HIV, leading to an increased number of civil servants open about their HIV positive status and directly served by their public employers, increased amount of resources allocated and applied by district councils to implement the Circular, expanded diversification of public funding sources for workplace HIV interventions, the emergence of additional credible voices of PLHIV, and enhanced protection of HIV-positive civil servants.
- Evidence-based information developed by the project was used extensively by parliamentarians, religious leaders, PLHIV, and other champions in their advocacy on FP and HIV issues.
- The project partnered with media organizations and PLHIV networks to improve the scope and accuracy of media coverage on HIV, stigma and discrimination, and GBV.

- The project created a comprehensive matrix tool to enable USAID to monitor changes in Tanzania's HIV policy framework.

FP/RH

- The project helped strengthen parliamentary leadership on FP/RH issues, leading to policy changes that support the scale-up of FP/RH programs and services and increased resource allocation and accountability.
- The project contributed to Tanzania's high-level participation in global FP forums, including:
 - facilitation of President Kikwete's participation in the 2012 London FP Summit, where he committed to supporting the scale-up of FP services in Tanzania;
 - participation of a high-level delegation (including the Minister of Health and Social Welfare and the Deputy Minister of Finance) in the International Conference on Family Planning in Dakar, Senegal in November/December 2011.
- The MOHSW incorporated a dedicated FP line item into the mid-term expenditure framework (MTEF), making it easier to track government resource allocation for FP goods and services.
- The government adopted a National Family Planning Costed Implementation Program (NFPCIP) was adopted and it is being used by government and non-government organizations to advocate for increased domestic funding for FP commodities and services.
- The project used FamPlan to develop and update cost estimates for the NFPCIP.
- The GOT integrated FP/RH into Tanzania's Poverty Reduction Strategy Paper (PRSP) for the 2010–2015 period (MKUKUTA II).
- The project was active in advocating for increased resources for FP, which led to:
 - GOT releasing Tsh 4.5 billion (about US\$2.77 million) for procurement of contraceptives in September 2009—Tsh 1.8 billion (US\$ 1.1 million) from domestic resources and Tsh 2.7 billion (US\$1.66 million) from the Basket Fund;
 - MOHSW allocating Tsh 14.3 billion (US\$ 8.8 million) from Health Sector Basket Funds for contraceptives in July 2010;
 - MOHSW increasing domestic funding for FP from Tsh 0.5 billion to Tsh 1.18 billion (US\$ 725,707) for the fiscal year 2011/12, and allocating Tsh 4.0 billion (US\$ 2.46 million) from the Basket Fund to support procurement and distribution of contraceptives; and
 - MOHSW allocating Tsh 1 billion (US\$ 615,006) of domestic resources for family planning for fiscal year 2013/14.
- Parliamentarians created a new, more streamlined body—the Parliamentary Family Planning Club—to coordinate parliamentarians' FP advocacy efforts.
- Efforts to revise the Law of Marriage Act (LMA) revitalized, including identifying key obstacles, generating support among parliamentarians and other high-level decision-makers, and positioning the LMA revision for inclusion in the national constitutional review process.
- The First Lady of Tanzania acted as the chief spokesperson for the RAPIDWomen Model in Tanzania and used it to advocate for FP, including presiding over the national launch event.

GBV

- The MOHSW adopted two new national policies to govern the health sector response to GBV—*National Policy Guidelines for the Health Sector Prevention and Response to Gender-based Violence* and *National Management Guidelines for the Health Sector Prevention and Response to Gender-based Violence*.

- The MCDGC initiated the development of national GBV coordination guidelines.
- With support from HPI/Tanzania, TARWOC (a local NGO) established a comprehensive GBV Drop-in-Center in Iringa region, raising community awareness of GBV and increasing survivors' access to support and services.

2 OBJECTIVE I: STRENGTHENED LEADERSHIP AND GOVERNANCE ON PRIORITY HIV, FP/RH, AND GBV ISSUES AND PROGRAMS

HPI/Tanzania strengthened leadership and governance on priority HIV and FP/RH issues, fostering ownership and sustainability of the national HIV response and FP/RH program. The project worked in consultation and collaboration with key government agencies, including the MOHSW and the TACAIDS. The project also built momentum for change by strengthening the capacity of:

1. *Parliamentarians*—to advocate on HIV and FP/RH issues within the government and to the people.
2. *People living with HIV*—to hold the government accountable for mounting an effective national response to HIV.
3. *The media*—to accurately report on HIV, FP/RH, and GBV issues to support a strong national HIV response, reduce HIV-related stigma and discrimination, and raise public awareness.
4. *Civil society organizations*—to hold government accountable for existing commitments on HIV, FP/RH, and GBV; advocate for increasing those commitments; and improve understanding and responses to these issues at the community level.
5. *Religious leaders*—to use their influential voices to promote change and accountability in all matters concerning HIV, particularly to speak out against HIV-related stigma and discrimination and GBV.

Progress in the area of leadership and governance was also crucial to achieving Objectives 2 (policies and plans) and 3 (increased financial resources and accountability).

Key achievements:

- The project helped strengthen parliamentary leadership on FP/RH issues, leading to policy changes that support the scale-up of FP/RH programs and services (see Section 3.2) and increased resource allocation and accountability (see Section 4.1).
- Parliamentarians created a new, more streamlined body—the Parliamentary Family Planning Club—to coordinate parliamentarians' FP advocacy efforts.
- The project contributed to Tanzania's high-level participation in global FP forums, including;
 - facilitating President Kikwete's attendance of the 2012 London FP Summit, where he committed to supporting the scale-up of FP services in Tanzania; and
 - supporting participation of a high-level delegation (including the Minister of Health and Social Welfare and the Deputy Minister of Finance) in the International Conference on Family Planning in Dakar, Senegal in November/December 2011.
- HPI/Tanzania successfully built the institutional capacity of two PLHIV networks—NACOPHA and DACOPHA—and strengthened their media engagement skills.
- The project partnered with media organizations and PLHIV networks to improve the scope and accuracy of media coverage on HIV, stigma and discrimination, and GBV.
- Ten MPs partnered with local CSOs to address HIV at the district level, resulting in the allocation of Tsh 103,794,300 (around US\$63,834) for HIV programs and increased utilization of HIV testing and counseling (HTC) services.

- Religious leaders from both the Muslim and Christian faiths
 - issued the Interfaith Dodoma Declaration, declaring their commitment to unite to combat stigma and discrimination;
 - incorporated anti-stigma and discrimination and GBV messages into religious services;
 - delivered addresses condemning stigma and discrimination and GBV, which were broadcast on national radio and television channels; and
 - adopted comprehensive institutional policies on HIV (CCT and PCT), as well as a workplace HIV policy (CCT) and guidelines for reducing stigma and discrimination (PCT).

2.1 Parliamentarians

Parliamentarians played a strategic role in HPI/Tanzania's efforts to improve the enabling environment for HIV and FP/RH in Tanzania. By virtue of their position, parliamentarians are able to exert influence, both on the government—particularly the executive branch—and on their constituent communities. HPI/Tanzania leveraged parliamentarians' unique influence to strengthen the legal and regulatory framework, increase domestic resource allocation, and improve implementation of key policies in the areas of HIV and FP/RH. The project employed a dual approach: on the one hand, it engaged parliamentarians as decision-makers, seeking their support for specific policy changes; at the same time, the project encouraged parliamentarians to champion FP and HIV priorities by engaging fellow policymakers and raising awareness in their constituencies. Evidence-based information—central to this approach—was used to influence parliamentarians' positions on key issues and to support their advocacy efforts with other policymakers.

Working with parliamentarians presents unique challenges, among which turnover among members of Parliament (MPs) is perhaps the most significant. From project start-up in January 2009, HPI/Tanzania spent 18 months training and cultivating MPs as policy champions on HIV and (beginning in October 2009) FP issues. Yet, nearly one-third of Tanzania's MPs lost their seats as a result of the general elections of October 31, 2010, including many champions trained by HPI/Tanzania. This disrupted the momentum of the project's efforts, as the project had to begin training and building relationships with a new batch of parliamentarians beginning in early 2011.

2.1.1 HIV

Fostering commitment and leadership among parliamentarians is crucial to enhancing the effectiveness and sustainability of Tanzania's response to the HIV epidemic. HPI/Tanzania sought to enable parliamentarians to hold the GOT responsible for mounting the strongest possible response to the epidemic. The project used a multipronged approach to strengthen parliamentarians' leadership on HIV issues and to leverage their influence to advance the HIV policy agenda and mobilize increased resource allocation to support the national HIV response.

The project engaged with TAPAC to build the ownership and leadership of carefully selected MPs by enabling them to become directly involved in strengthening the HIV responses in their constituencies. The project also worked through the Parliamentary Standing Committee on HIV and AIDS (PASCHA) to engage parliamentarians, particularly to enhance their understanding of GBV issues and support implementation of the HIV and AIDS (Prevention and Control) Act of 2008 (hereinafter referred to as the HIV law).

TAPAC

TAPAC is an organization composed of MPs working on HIV issues. Formed in 2001, TAPAC has since grown to include more than 270 active members, including the Prime Minister and the President. Therefore, HPI/Tanzania saw engaging with TAPAC as an invaluable opportunity to foster high-level leadership and commitment on HIV.

As one strategy to increase Parliament's understanding of and commitment to issues surrounding HIV, HPI/Tanzania linked MPs with CSOs in MPs' home constituencies to take policies to the grassroots for implementation and to gather information for evidence-based advocacy. In 2009, HPI/Tanzania, through TAPAC, provided small grants (under \$15,000) to 10 CSOs in four regions (Dar es Salaam, Coast region, Iringa, and Mbeya). TAPAC, in consultation with project staff, identified 10 target constituencies that were characterized by high prevalence of HIV and/or HIV-related stigma and discrimination, and which were represented by MPs who had been actively engaged on HIV issues, with emphasis on the inclusion of women parliamentarians. After identifying the target constituencies, TAPAC worked with the local district council to identify an NGO in each locality to receive the small grant. HPI/Tanzania supported TAPAC to provide 10 grants to NGOs to work in 10 constituencies in collaboration with their MPs. In July 2009, HPI/Tanzania, through the Center for Development and Population Activities (CEDPA), trained 37 TAPAC members on leadership, governance, and management. The project later supported TAPAC to train 30 NGO representatives from the 10 target constituencies on managing small grants and proposal development.

The small grants initiative enabled MPs to extend their leadership and influence on HIV to the grassroots level. At the same time, it offered a mechanism through which HPI/Tanzania was able to build the organizational capacity of TAPAC, thereby contributing to the sustainability of parliamentarians' leadership on HIV policy advocacy. Moreover, it helped MPs gather evidence-based information to support their advocacy efforts, including arguing for increased funding for HIV. The small grants initiative also aligned with and contributed to HPI/Tanzania's broader effort to foster implementation of the HIV law. The small grants initiative enabled the project to support implementation efforts that reached all the way down to the district and *mtaa* (neighborhood) level.

As a result of these small grants, two district councils and two village governments allocated a total of Tsh. 93,757,000 (US\$57,661) to support orphaned and most-vulnerable children and two district councils allocated Tsh. 17,787,500 (US\$10,939) to support increased stigma and discrimination reduction training and HIV law sensitization. Community members and local organizations in two constituencies donated an additional Tsh. 2,249,800 (US\$1384) in support of orphans and vulnerable children (OVC). In addition, 6,937 individuals were reached through training or community mobilization on a variety of issues, including OVC, stigma and discrimination, the HIV law, HIV prevention, and treatment adherence. Furthermore, 56 incidents of GBV were reported to local authorities; two PLHIV networks, five PLHIV groups, and 11 post-test clubs were formed; 12,710 people were tested for HIV; and recipient organizations reported anecdotally that utilization of HIV testing and counseling (HTC) services and voluntary disclosure of serostatus increased in several localities, as did antiretroviral treatment (ART) adherence in one (Makete).

Initially, HPI/Tanzania planned to award multiple rounds of small grants through TAPAC. However, as Tanzania entered the election period in 2010, the project found it necessary to suspend this activity to avoid becoming entangled in parliamentarians' campaigning efforts. The fact that these results were achieved with only one round of small grants in such a short amount of time demonstrates the potential power of this approach and the importance of continuing to leverage parliamentarians' leadership to strengthen the HIV response and combat HIV-related stigma and discrimination at the district and community levels.

PASCHA

PASCHA is an official organ of the Parliament of Tanzania responsible for HIV issues, created under the Rules and Regulations governing the Parliament. While TAPAC has proved itself a strong partner in efforts to foster leadership among parliamentarians, it became clear over the course of the project's engagement with TAPAC that there was a need for a permanent standing committee on HIV issues within the government itself. As a Parliamentary body, PASCHA plays an essential insider role, which complements TAPAC's efforts. In November 2009, HPI/Tanzania supported a study visit to the Republic of Rwanda for 12 PASCHA members. The trip was intended to enable PASCHA members to learn from Rwanda's innovative efforts to mobilize domestic resources for HIV.

The project also partnered with PASCHA to foster leadership on GBV issues. At the invitation of the National Assembly, the project trained 19 members of PASCHA on GBV issues, including the link between GBV and HIV (Dar es Salaam, October 19-21, 2011). The training was designed to provide PASCHA members with sufficient knowledge to effectively discuss GBV issues in Parliament and raise awareness and disseminate correct information on GBV in their constituencies. Participants resolved to present information on GBV and HIV to their fellow MPs and ward councilors and to actively foster measures to combat and respond to GBV in their constituencies, including:

- Establishing GBV Drop-in-Centers (as recommended in the new GBV guidelines, see Section 6.1), including encouraging local councils to provide budget support
- Visiting police gender desks in their constituencies to assess operations and respond to challenges
- Following up with the GOT to promote the establishment and staffing of district social welfare units in all districts
- Advocating for the creation of a mechanism to ensure the sustainability of GBV programs.

2.1.2 FP/RH

There is a dearth of high-level leadership and commitment on FP in Tanzania. Historically, FP has remained low on the policy agenda and domestic funding for FP commodities and services has fallen woefully short of existing need. HPI/Tanzania²⁶ sought to raise the profile of FP issues and increase funding by fostering parliamentary leadership.

Initially, TPAPD was the project's main partner in this effort. TPAPD is an association composed of parliamentarians that seeks to address issues related to population and development. The Health Policy Initiative began engaging with TPAPD to facilitate advocacy on FP issues under Task Order 1. Building on that initial engagement, HPI/Tanzania worked with TPAPD to identify and train parliamentarians as FP policy champions and to strategize on how to advance the FP policy agenda. In April 2010, the project trained 25 selected MPs to lead FP advocacy efforts. In June 2010, the project held an advocacy workshop for 75 MPs on FP issues in preparation for FY2011/12 budget debates.

After these trainings, the project supported parliamentarians by providing up-to-date strategic information and briefs. These enabled MPs to advocate for increased funding for FP/RH commodities and services and raise awareness of FP issues among their fellow policymakers. The project's briefings, which drew heavily on HPI/Tanzania's application of the RAPID Model,²⁷ helped MPs highlight the contribution of FP to national development goals, including maternal and child health.

In addition to debates on the floor of Parliament, policy champions engaged behind the scenes, through their participation in permanent standing committees. These committees are responsible for preparing and reviewing policy matters (including budgets) prior to introduction to the full Parliament. The project partnered with MP champions to use these committees to gather information on the status of FP in draft budgets and push for increased funding levels.

In September 2009, the government of Tanzania released Tsh 4.5 billion (about US\$2.77 million) for procurement of contraceptives. Of this, Tsh 2.7 billion was from the Basket Fund (about US\$ 1.66 million) and Tsh 1.8 billion (about US\$1.1 million) came from the government's own resources. While announcing the

²⁶ Task Order 1 was the initial global funding mechanism for HPI/Tanzania and served as the primary mechanism to support USAID FP/RH, HIV, and maternal health activities in policy dialogue, formulation, and implementation. It had two main components: global technical leadership in health policymaking and implementation and country-level applications in the field. Funding for RP/RH activities under Task Order 5 in Tanzania began in 2010.

²⁷ The RAPID Model is a computer model that analyzes country-specific data to explore the effects of high fertility and rapid population growth on education, the economy, healthcare, urbanization and housing, agriculture, food security, and natural resources. For more information on HPI/Tanzania's use of the RAPID Model in Tanzania see Section 5.1.

new funds, the National Family Planning Coordinator within the MOHSW attributed the success to the advocacy efforts by HPI/Tanzania and other FP stakeholders. These drew attention to the decline in FP resource allocation and the acute shortage of contraceptive products. In FY2010/11, the MOHSW allocated and released Tsh 14.3 billion (US\$ 8.8 million) for contraceptives from Health Sector Basket Funds, after members of Parliament demanded more resources for FP. In FY2011/12, the budget also included a modest increase in domestic funding for FP (from Tsh 0.5b in FY/2010/11 to Tshs 1.18b), and the MOHSW allocated Tsh 4.0 billion (about US\$2.46 million) from the Basket Fund to support procurement and distribution of contraceptives. Unfortunately, in FY2013/14, the MOHSW budget reduced its FP allocation to Tsh 1 billion (US\$ 615,006). Some of the MPs trained by HPI/Tanzania raised concerns during the budget debates about Tanzania's overdependence on donors. The Minister of Health responded that in the current environment of scarce resources, the MOHSW is trying to allocate resources in areas not supported by donors.

Parliamentary Family Planning Club (PFPC)

While TPAPD was a willing partner in FP advocacy efforts, it had several drawbacks as the main forum for parliamentary advocacy efforts on FP. First, TPAPD's overall mandate is population and development. While its focus on population served as an entry point for engaging parliamentarians on FP issues, those issues are not TPAPD's primary concern. Moreover, the association offers membership to all MPs, regardless of their interest in population or FP issues. These characteristics hindered TPAPD's ability to effectively coordinate and mobilize parliamentarians' FP advocacy efforts. As a result, at a February 2011 advocacy meeting hosted by HPI/Tanzania in collaboration with the MOHSW and the Johns Hopkins University/Advance Family Planning (AFP) project, parliamentary champions decided to form a new body to spearhead their FP advocacy efforts.

The PFPC was launched in August 2011, with financial and technical support from HPI/Tanzania, in collaboration with the MOHSW and AFP. The PFPC is a smaller, more focused organization, composed of MPs who are actively committed to and engaged on FP issues. As such, it is inherently more efficient and less costly, as training and advocacy efforts can be targeted at those parliamentarians with demonstrated interest in FP issues.

Box 1. Partnership with Advance Family Planning

HPI/Tanzania's goals and strategies in the area of FP advocacy were similar to those of the Johns Hopkins University/Advance Family Planning project (AFP). Therefore, HPI/Tanzania collaborated with AFP to avoid duplication of effort and to carry out joint activities to maximize impact. HPI/Tanzania and AFP periodically worked together to engage parliamentarians. AFP helped support the formation of the PFPC. AFP and HPI/Tanzania also partnered up to hold the GOT responsible for commitments made by President Kikwete at the London Family Planning summit.

At the end of August 2011, the current Parliamentary session was brought to a close. HPI/Tanzania had hoped to continue working with PFPC when Parliament was convened again in November 2011. Unfortunately, disbursement of FP funds from USAID was significantly delayed—the funds were not received until June 2012, which was too late to engage parliamentarians for the 2012/13 budget year. Advocacy activities with parliamentarians were modestly resumed in partnership with AFP and HDT in an effort to impact the 2013/14 FP budget. A product of HPI/Tanzania's work on budget advocacy was a booklet on *Influencing Government Health Budgets in Tanzania – A Guide for Civil Society*, published in July 2013. This booklet outlines the process of government budget development at the national and local levels in Tanzania and will be used in advocacy activities by HDT, EngenderHealth's RESPOND project, DSW, Deloitte's Tunajali project, and others.

Global Forums

HPI/Tanzania also used global forums as an avenue to increase the commitment and leadership of high-level policymakers on FP issues. In 2011, USAID requested the project's support to encourage Tanzania to send a high-level delegation to the International Conference on Family Planning in Dakar, Senegal. The project, in partnership with the PFPC, facilitated the participation of the Minister for Health and Social Welfare and the Deputy Minister for Finance in the Dakar conference. The inclusion of the ministerial level representative

from both ministries was particularly important, as it set the stage for future high-level advocacy engagement on FP funding.

The project provided financial, logistical, and technical support for the two ministers' participation, facilitated two round-table discussions on the use of the RAPID Model for FP advocacy, and project staff made two oral presentations—one on engaging parliamentarians to increase resources for FP, the other on advocating for the inclusion of FP in Tanzania's PRSP (MKUKUTA II).

The momentum started at the International FP conference provided a strong foundation to advance Tanzania's FP/RH agenda at the July 2012 London Summit on Family Planning. HPI/Tanzania reached out to government officials to facilitate the invitation for President Jakaya Kikwete's participation in the summit. President Kikwete did attend the London summit, where he committed to:

- Ensuring strong political commitment to FP at all levels, underscoring that FP is a core element for development;
- Increasing resource allocation and disbursement FP services to reduce donor dependence;
- Strengthening contraceptive commodity security and logistic systems to ensure continuous availability of quality contraceptives with the desired mix of FP methods;
- Implementing new strategies to address disparities and inequalities in accessing FP;
- Expanding access to quality FP services through strengthened public and private facilities, outreach, and community based services; and
- Building community and leadership capacity to support FP through mobilization and education campaigns including relaunching the Green Star campaign—a nationwide communication campaign used to promote awareness and utilization of FP commodities and services.

In partnership with AFP, HPI/Tanzania continued to closely follow and advocate for the commitments made at the London FP Summit. The project worked with AFP and Tanzania's FP Technical Working Group (FPTWG) to ensure that advocacy efforts are made to prioritize and meet these commitments. The project held several one-on-one consultative meetings with AFP, the FP unit at the MOHSW, and the President's Office Planning Commission (POPC) to determine the status of implementing the FP2020 commitments. Using the information from those meetings, HPI/Tanzania and AFP prepared a roadmap on the activities needed to formalize and implement the London summit commitments. The roadmap has been shared with FP partners, the POPC, and the MOHSW, and Tanzania's FP2020 commitments was the key entry point HPI/Tanzania, AFP, and Human Development Trust (HDT) used in their work with parliamentary standing committees and the PFPC during the 2013/14 government budget debates. FP2020 renewed focus on FP in Tanzania, and a national conference on FP will be held in October 2013. While this will occur just after the project's closeout, HPI/Tanzania staff are bringing lessons learned to the conference planning by sitting on the Scientific Committee and by collaborating with AFP and HDT to write abstracts for papers to be presented there.



Honorable Jenista J. Mhagama (Chair, PFPC) leads discussion on the 2013/14 FP Budget and FP2020 to the PFPC

2.2 People Living with HIV (PLHIV)

HPI/Tanzania strengthened the leadership of PLHIV networks on HIV issues. The project worked primarily with two PLHIV organizations—the National Council of People Living with HIV/AIDS (NACOPHA) and the Dar es Salaam Council of People Living with HIV/AIDS (DACOPHA). The project assessed the networks' organizational capacity and provided targeted training, coaching, and mentoring to address identified needs. The project also built network members' skills in priority topics, such as media engagement, PLHIV rights, and treatment adherence. In addition to strengthening the networks as organizations, HPI/Tanzania partnered with NACOPHA on advocacy, policy development, and implementation. This effort focused primarily on safeguarding PLHIV rights and combating stigma and discrimination by supporting implementation of the HIV law and drafting the national stigma and discrimination strategy (see Section 3.1.2).

2.2.1 NACOPHA

Registered in September 2005, NACOPHA is an umbrella organization whose membership is made up of individual PLHIV coordinated through PLHIV networks and district clusters operating across Tanzania. It seeks to serve as a unifying body, bringing together the messages and interests the country's many and varied PLHIV networks to enable the creation of a clear, united voice for PLHIV advocacy.

The 2009 capacity assessment, carried out by HDT, classified NACOPHA as an “emerging” organization—in which structures for governance, management practices, human resources, financial resources, and service delivery are partly in place but implementation may need to be strengthened. The assessment noted that NACOPHA has the potential to effectively mobilize funds, provide services, and undertake strategic advocacy. However, it identified leadership challenges, implementation of strategic plans, monitoring and evaluation systems, and advocacy as areas in need of support.

HPI/Tanzania provided trainings for NACOPHA to address these areas of weakness. In 2009, through a subcontract with CEDPA, HPI/Tanzania trained 28 NACOPHA board members, secretariat, and HIV network affiliates on governance, grants management, general management, and leadership. The training was designed to strengthen NACOPHA's capacity to lead and support other PLHIV networks. In 2010, the project held capacity building workshops for 21 NACOPHA members on proposal development and resource mobilization and supported a three-day workshop to prepare a business plan to ensure the sustainability of the council and its member networks and clusters.

Media engagement

HPI/Tanzania also trained NACOPHA representatives in media engagement to strengthen the network's ability to convey PLHIV perspectives and advocacy messages through the media. The project held two trainings on media engagement for PLHIV, in 2009 and again in 2012. Topics included interviewing, preparing and holding a press conference, developing concise messages, and writing press releases.

As a result of the second training, during Tanzania's national World AIDS Day events in 2012, NACOPHA representatives successfully engaged the Prime Minister, Hon. Mizengo Pinda, as well as a variety of news outlets and organizations. For example, Star TV and Tanzania Broadcasting Corporation (TBC) aired interviews with NACOPHA members who demonstrated newfound confidence in delivering their messages. Their new skills also led several media organizations to seek interviews and conversations with these individuals beyond World AIDS Day.

Policy development and implementation

Although the decrease in project funding in 2011 did not permit continued focus on capacity building with NACOPHA, HPI/Tanzania continued to collaborate with it as a valued partner. In 2012-2013, HPI/Tanzania joined with NACOPHA to facilitate the drafting and implementation of key policies, notably the national stigma and discrimination reduction guidelines and the HIV law (see Section 3.1).

2.2.2 DACOPHA

Under Task Order I, the Health Policy Initiative supported the foundation of the Dar es Salaam Coalition of People Living with HIV/AIDS (DACOPHA). The network, which was established in April 2008, is composed of three district networks—Kinondoni District (KINDIPHA), Temeke District (TEDINEPA), and Ilala (IDINEPHA). Their aim is to coordinate, build capacity of, and provide support to organizations, members, and other people who are affected by HIV so as to reduce new infection rates and fight stigma and discrimination.

HPI/Tanzania strengthened DACOPHA's capacity in two ways—first, by assessing and strengthening its organizational capacity through a subcontract with HDT, and second by providing training for coalition members and caregivers on PLHIV rights and treatment adherence. In 2009, HPI/Tanzania collaborated with DACOPHA to train 15 coalition members and caregivers of PLHIV to become trainers at the community level on PLHIV rights and treatment adherence. Participants went on to train 469 individuals at the community level in 2009, as well as an additional 420 individuals in 2010. As a result of the second training, 150 participants who had discontinued treatment resumed treatment.

An organizational capacity assessment carried out by HDT in 2009 classified DACOPHA as an “emerging” organization. It found that the network had great potential in the area of media and public relations and identified three main areas of weakness—managerial process, human resources, and financial management. HDT strengthened DACOPHA's institutional capacity through two phases of coaching and mentoring designed to meet these needs. With HDT's support, provided in August and September 2010, DACOPHA revised its constitution, drafted a new strategic plan, established a clear mission and vision, drafted operational policies, and worked to strengthen its financial systems.

2.3 Media

The mass media can play a key role in the fight against HIV—educating the public about HIV, GBV, and stigma and discrimination, challenging stigmatizing portrayals of PLHIV, and drawing attention to violations of PLHIV rights. The media can also help increase recognition of the problem of GBV and encourage survivors to speak out and seek support. HPI/Tanzania partnered with media organizations and PLHIV networks to improve the scope and accuracy of media coverage on HIV, stigma and discrimination, and GBV in Tanzania. The project enhanced the media's role in the national HIV response by building journalists' capacity in investigative reporting, HIV-related stigma and discrimination, and GBV. It also improved PLHIV networks' ability to engage effectively with the media and speak in a unified voice. Moreover, HPI/Tanzania used media engagement strategies to magnify the impact of other project activities. For example, utilization of broadcast media extended the reach of religious leaders' messages on stigma and discrimination and GBV capacity building efforts with journalists supplemented the project's efforts to foster implementation of the HIV law and raised awareness of the new GBV policy and management guidelines.



Box 2. Media work shines spotlight on remote areas

In September 2010, AJAAT sent 12 selected journalists into the field—to Morogoro (Morogoro Rural), Tanga (Pangani), and Mtwara (Mtwara urban and Tandahimba)—to apply their new investigative journalism skills. The journalists unearthed stories on HIV-related stigma and discrimination and GBV experienced by individuals living in remote areas. By the end of September, they had already published 23 news and feature articles.

The importance of these field visits and the stories they generated lies in their ability to make stigma and discrimination and GBV issues real for those who read them. Community responses to the stories demonstrate the powerful potential of this approach.

For example, in Arumeru District a journalist identified and published a story about a local widow who was being severely abused by her brother-in-law. The widow, Happiness Soine, had been assaulted repeatedly for almost a decade in an effort to drive her off the farm she inherited following her husband's death. Frightened of the potential backlash from family and the community should she involve the police, Soine had been unable to stop the abuse. However, in the wake of a vicious attack witnessed by her children, she found the courage to share her story with one of the AJAAT-trained journalists. Shocked by the story, the Regional Police Commander immediately spoke out against GBV and arrested the perpetrator. Community members rallied to support Soine, providing material and social support to help her recover from the abuse and claim her inheritance rights. However, ultimately the story and the community's response didn't just benefit Soine. They also showed that the community and the legal system are ready and willing to support survivors of GBV. This may encourage more individuals who experience such violence to seek help.

2.3.1 Using broadcast media to support work with religious leaders

HPI/Tanzania encouraged religious leaders to use their influential position to speak out against stigma and discrimination and GBV (see Section 2.4). The project used mass media to amplify the reach and impact of their messages. As described above, the project facilitated religious leaders' participation in talk shows on GBV issues. The talk shows were broadcast on ITV, which enjoys about 74 percent national coverage and viewership. HPI/Tanzania also encouraged prominent religious figures to speak out against stigma and discrimination.

As a result, in November and December 2012, Dr. Valentino Mokiwa, the Archbishop of the Anglican Church in Tanzania, and Bishop Charles Salala, of the Africa Inland Church of Tanzania, delivered high profile sermons denouncing stigma and discrimination. Videos of these sermons were broadcast in May and June 2013 on national radio and television (Magic FM, Star TV, and Channel Ten). Star TV claims 54 percent viewership in the Mwanza and Lazke Zone areas and Channel Ten claims 65 percent of national viewership; both Magic FM and Channel Ten reach as far as Istanbul. To reach the Muslim community, HPI/Tanzania engaged prominent cleric Sheikh Abu Mohamed Idd, who hosts a weekly talk show called "Arrisalah" ("The Message"). With the project's support, he led four one-hour shows on HIV-related stigma and discrimination.

2.4 Religious Leaders and Faith-based Organizations

Religious leaders, by virtue of their influential position in Tanzanian society, are crucial allies in the response to HIV. Futures Group has a long history of engaging religious leaders as allies in Tanzania's HIV response—first under POLICY Project and later, under Health Policy Initiative Task Order I. CCT and BAKWATA were central to this effort. CCT is an overarching organization for four Christian denominations (Anglican, Lutheran, Mennonite, and Moravian), while BAKWATA is the supreme Muslim council in Tanzania. Task Order I also worked with the Tanzania Network of Religious Leaders Living with HIV or Affected by AIDS

(TANERELA), an interfaith network that aims to empower HIV-positive religious leaders to live openly and positively, overcome self-stigma and shame, and become agents of change in their congregations and communities. Under Task Order 1, Health Policy Initiative partnered with CCT and BAKWATA to create and roll out a HIV-related stigma and discrimination reduction curricula for use in Sunday schools and Madrassas, and to develop and adopt stigma and discrimination guidelines. The project also reached out to the PCT.²⁸

Building on this strong foundation, HPI/Tanzania placed greater emphasis on encouraging prominent religious leaders to speak out against stigma and discrimination in their sermons and *hotubas*, using broadcast media to amplify the public impact of these messages. The project also expanded its work with religious leaders to include GBV.

An important milestone for 2009 was the Dodoma Declaration, in which nearly 60 religious leaders agreed to join together to reduce HIV-related stigma, promote HTC, and encourage sero-status disclosure. HPI/Tanzania worked with TANERELA to produce the workshop that led to the Declaration. During the workshop, a committee of representatives from different faiths formed to monitor implementation of the Declaration and action plans. Additionally, 41 participants accessed HTC services either during or just after the workshop.

In July 2009, following the Dodoma Declaration and with the project's support, CCT and PCT adopted comprehensive institutional policies on HIV. HPI/Tanzania also helped CCT write a workplace policy for its employees, PCT to develop guidelines for reducing stigma and discrimination, and TANERELA to devise a three-year strategic plan. In December 2009, BAKWATA launched its HIV/AIDS stigma and discrimination reduction policy guidelines, which charted 10 guiding points and 11 declarations by Islamic scholars. The purpose of these guidelines was to provide definitive guidance for the Muslim community in Tanzania regarding stigma and discrimination.

On March 15–19, 2010, HPI/Tanzania held a TOT for 20 religious leaders from CCT, TANERELA, PCT, and BAKWATA covering basic knowledge on HIV, advocacy against stigma and discrimination, and mainstreaming HIV issues in a religious context. As a result of the training, the four organizations developed an action plan for conducting step-down training.

HIV post-test clubs encourage and support religious leaders to access HTC services and disclose their HIV status, enabling them to offer greater support for HTC and disclosure in their communities. In July 2010, HPI/Tanzania and TANERELA conducted a three-day workshop for 100 religious leaders from BAKWATA, CCT, and PCT, in which each organization identified role models who were tasked with advocating for the establishment of post-test clubs. With the project's support, post-test clubs were established in three regions: Tanga, Kigoma, and Kilimanjaro.

In June 2011, HPI/Tanzania collaborated with the Tanzania Interfaith Partnership (TIP) to organize a high-level workshop for religious leaders on stigma and discrimination reduction communication. The workshop drew participants from four major religious institutions in Tanzania, namely CCT, PCT, BAKWATA, and the Tanzania Episcopal Council (TEC). In addition to updating the participants on the current status of HIV-related stigma and discrimination in Tanzania, the workshop enhanced participants' strategic communication skills, enabling them to craft stigma and discrimination reduction messages for inclusion in their sermons and *hotubas*. During the workshop, each organization prepared an action and message tracking plan. As a result of

²⁸ Outreach to the Pentecostal community was particularly important, as this denomination of Christianity places great faith in the power of prayer and miraculous healing from God, leading to commonly held beliefs that religious people cannot contract HIV—and therefore have no need to go for HIV testing—and that HIV can be healed through prayer, making ART unnecessary. These beliefs have contributed to high levels of HIV-related stigma and discrimination and made many Pentecostal leaders reluctant to disclose their HIV status.

this activity, more than 160 sermons or *hotubas* incorporated stigma-reduction messages in the three months after the workshop, reaching approximately 8,500 congregation members.

Religious leaders and the media

As described above (see Section 2.3.1), HPI/Tanzania used media to magnify the impact of religious leaders' anti-stigma and discrimination and GBV messages.

2.5 Gender and Gender-based Violence (GBV)

Gender-based violence is a daily reality for many women in Tanzania, and acceptance of GBV remains high among both men and women.²⁹ The 2010 TDHS found that 39 percent of women age 15-49 have ever experienced physical violence since age 15, and one-third of women (33 percent) have experienced physical violence in the previous 12 months. More than half (54 percent) of women and four in ten men (38 percent) agreed that wife beating by a husband is justified in at least some situations.³⁰

Overall, HPI/Tanzania sought to develop and improve implementation of GBV policies, reduce acceptance of GBV, and strengthen leadership on GBV issues, particularly at municipal and district levels. Nationally, HPI/Tanzania's work focused on drafting health sector guidelines on GBV (see Section 6.1) and building the capacity of women leaders to address GBV issues. As described above, the project also engaged members of the media to improve their understanding of GBV and raise the profile of the issues in the national dialogue (see Section 2.3) and encouraged religious leaders to use their influence to support efforts to end GBV (see Section 2.4). In tandem with these national-level efforts, the project also fostered local leadership on GBV in the highly affected Iringa region.



GBV Ambassador Deves Swebe, Kwakilosa Ward.
Photo courtesy of HPI/Tanzania staff.

2.5.1 Fostering local-level leadership on GBV in Iringa

In Tanzania, lack of leadership on GBV issues is particularly acute at the subnational levels. In 2008, a regional situational assessment carried out by HPI/Tanzania identified lack of leadership on GBV as a key barrier to mounting an effective response to GBV.³¹ In response, the project worked with the regional NGO in Iringa, TARWOC, to strengthen the engagement and commitment of local leaders. HPI/Tanzania and TARWOC raised awareness of GBV among leaders at district (councilors) and ward (development committee members) levels and encouraged them to play an active role in fighting GBV.

Support from local leaders and HPI/Tanzania helped TARWOC establish a Drop-in-Center for GBV survivors in Iringa. As an extension of the center, TARWOC identified and trained a new cadre of

²⁹ While GBV can affect both men and women, given its disproportionate impact on women, HPI/Tanzania TO5's GBV efforts were mostly geared to address GBV against women.

³⁰ TDHS, 2010

³¹ Betron, M. 2008. Gender-based Violence in Tanzania: An Assessment of Policies, Services, and Promising Interventions. Washington, DC: Futures Group, HPI/Tanzania, Task Order 1. The report is available at: <http://www.healthpolicyinitiative.com/index.cfm?ID=publications&get=pubID&pubID=666>.

community leaders as ‘GBV ambassadors.’ These ambassadors served as front-line counselors and referral agents. They sensitized their fellow community members on GBV issues and encouraged them to make use of the GBV Drop-in-Center. They were also instrumental in gathering data and information on incidents of GBV. The impact of their leadership efforts can be seen in the increase in accessing services and reporting GBV recorded by the Drop-in-Center (see Section 6.2).

2.5.2 Fostering women’s leadership on GBV

In addition to engaging local leaders, TARWOC and HPI/Tanzania also increased the engagement of women leaders on GBV issues at national and regional levels. In 2008, TARWOC organized the first national women leaders conference on GBV. On March 13–14, 2012, HPI/Tanzania and TARWOC held a follow-on national women leaders conference on GBV in Iringa. The



“Our times were different, there was not much openness nor were there opportunities like those that exist today, so women must seize the opportunities and move forward,” Mama Nyerere, shown here, remarked at the conference. Photo courtesy of HPI/Tanzania Staff.

conference brought together 87 participants (mostly women) around the theme “Invest in Women and Girls: Fight Gender-based Violence.” The meeting was designed to build participants’ commitment and capacity to advocate against GBV. Attendees adopted 19 resolutions to guide the national GBV response, which TARWOC subsequently presented to the Prime Minister and the Deputy Minister for Community Development, Gender and Children.

On April 4–6, 2013, HPI/Tanzania and TARWOC hosted a subsequent women leaders conference in the Mara region, which has the highest prevalence of GBV in the country, including high rates of female genital cutting (FGC). This conference focused more specifically on building regional-level leadership on GBV. Around 130 women leaders attended the meeting, including MPs, District Commissioners, District Councilors, political leaders, professionals, NGO representatives, regional government officials, FGC practitioners, women living with HIV, and development partners. Mama Maria Nyerere, the wife of the late Mwalimu Julius K. Nyerere, the first President and founder of the nation, officiated the meeting. Participants also crafted action plans on GBV for six districts and adopted 11 resolutions on GBV. One indication of the conference’s impact was an anecdote shared by an MP from Tanzania’s Coastal region. The MP reported that, in a recent conversation, the President of Tanzania brought up the conference and questioned the MP closely as to why similar initiatives had not been launched in the Coastal region.



Regional Commissioner of Njombe, Captain Assey Msangi facilitated and opened the Njombe Womens Conference. Photo courtesy of HPI/Tanzania staff.

HPI/Tanzania and TARWOC held a final women leaders conference together in Njombe, June 7-9, 2013. The main goal of the conference was to discuss and formulated strategies for developing women and girls in Njombe region and to come up with a plan of action to be included in Njombe District Plans for implementation in the region. The

three-day conference brought together approximately 100 members of Parliament, district and regional level leadership, NGO representation, and donor representatives. Captain Assey Msangi, the Regional Commissioner of Njombe, officiated the meeting. Each district developed action plans to address specific GBV challenges in their areas, and conference participants crafted 16 resolutions including that Domestic Councils should earmark 5 percent of domestic revenue for women's development, centers for GBV survivors should be established, and education on sexual and reproductive health should be provided in schools and communities in order to empower girls and young women.

3 OBJECTIVE 2: ACCELERATED DEVELOPMENT, ADOPTION, IMPLEMENTATION OF PRIORITY POLICIES, PLANS, RULES, AND REGULATIONS FOR SCALE-UP OF HIV, GBV, AND FP/RH SERVICES

Policy development and implementation are at the very heart of HPI/Tanzania's efforts to improve the enabling environment for scaling up HIV, FP/RH, and GBV programs. The project facilitated accelerated drafting, adoption, and implementation of key policies, plans, and guidelines. It accomplished this by providing technical assistance for the drafting of key policies, advocating alongside government and civil society partners to secure the adoption and monitoring of policy reforms, to support program implementation. The leadership generated by the project among parliamentarians, religious leaders, the media, PLHIV networks, and other CSOs was instrumental in achieving its policy goals. The project also worked to strengthen policy frameworks for task shifting/task sharing and combating GBV.

Key achievements:

- The GOT adopted the Comprehensive National Multisectoral HIV and AIDS Stigma and Discrimination Reduction Strategy 2013–2017
- The project enhanced awareness and implementation of the Government Circular No. 2 of 2006, strengthening protections for HIV-positive civil servants
- The project fostered implementation of the HIV Law, supporting community-level dissemination of the law through small grants to TAPAC, and training PLHIV networks in the law's provisions, in collaboration with MOHSW, NACOPHA, and agencies with legal aid schemes.
- The MOHSW incorporated a dedicated FP line item into the mid-term expenditure framework (MTEF), making it easier to track government resource allocation for FP goods and services
- The National Family Planning Costed Implementation Program (NFPCIP) was adopted and used to advocate for increased domestic funding for FP commodities and services
- The GOT integrated FP/RH into Tanzania's Poverty Reduction Strategy Paper (PRSP) for the 2010–2015 period (MKUKUTA II)
- The MOHSW adopted two new national policies to govern the health sector response to GBV—*National Policy Guidelines for the Health Sector Prevention and Response to Gender-based Violence* and *National Management Guidelines for the Health Sector Prevention and Response to Gender-based Violence*
- The MCDGC initiated the development of national GBV coordination guidelines
- The project created a comprehensive matrix tool to enable USAID to monitor changes in Tanzania's HIV policy framework
- Efforts to revise the Law of Marriage Act (LMA) revitalized, including identifying key obstacles, generating support among parliamentarians and other high-level decision-makers, and positioning the LMA revision for inclusion in the national constitutional review process

3.1 HIV

Under Task Order 1, the Health Policy Initiative and several other partners supported drafting and passage of the HIV and AIDS (Prevention and Control) Act, which Tanzania's Parliament unanimously adopted in February 2008 and signed into law on April 4th of the same year. The 2008 HIV Law provides for HIV prevention, care, and treatment and protects the rights of PLHIV.³² It also defines the roles and responsibilities of all sectors in addressing HIV. However, there are various challenges around implementation of the HIV Law. Many of the provisions of the act, such as stigma and discrimination, have not been applied to support the national response efforts or PLHIV. When HPI/Tanzania began its work in February 2009, little had been done to put the measure into practice; therefore, the project made supporting implementation of the HIV law one of its main policy priorities.

The project used multiple avenues to pursue implementation of the HIV law. In October 2009, the project hired three Legal and Human Rights Center (LHRC) lawyers to translate the HIV law into Kiswahili. The project used this translation to develop targeted informational materials for parliamentarians and health practitioners. The project facilitated the creation of a government-civil society Advocacy and Action Committee (AAC) to catalyze implementation of the act. The project also incorporated the HIV law into its efforts to foster leadership among religious leaders. On August 2–4, 2010, HPI/Tanzania oriented 30 religious leaders from CCT, PCT, and BAKWATA on the HIV law to enable them to raise awareness of the law among their congregations. The project also used the media to support implementation of the HIV law by encouraging journalists to use the HIV law in HIV reporting (see Section 2.3).

HPI/Tanzania supported community-level dissemination of the law through its small grants project with TAPAC (see Section 2.1.1). The project also partnered with DACOPHA on advocacy and dissemination. On March 9–11, 2010, the project held a three-day TOT dissemination workshop for 25 PLHIV network representatives. The workshop helped the networks better understand the HIV law, with emphasis on its PLHIV rights and anti-stigma and discrimination provisions. These representatives went on to train 240 members of eight PLHIV networks in March and April 2010.

To ensure enforcement of the HIV law by the judiciary, HPI/Tanzania partnered with the MOHSW and NACOPHA to identify cases of HIV-related rights violations that could be pursued through legal action. The goal was to generate a body of case law to give the law “teeth” and encourage courts to apply its provisions. In February 2013, HPI/Tanzania, in collaboration with NACOPHA, organized a meeting to discuss possible mechanisms for providing legal assistance to PLHIV affected by stigma and discrimination. Seven NACOPHA members, as well as representatives of the MOHSW, Women Legal Aid Centre (WLAC), Tanganyika Law Society (TLS), the Tanzania Women Lawyers Association (TAWLA), and the Legal and Human Rights Centre (LHRC) attended the meeting. At the meeting, legal experts identified such cases, but also advised that before stigma and discrimination cases can be pursued successfully, the MOHSW must develop regulations that clarify the scope and meaning of the HIV law's provisions. Therefore, participants recommended that HPI/Tanzania and other policy groups assist the government in developing such regulations. This will be an important area for further support following the close of HPI/Tanzania.

Sections 3.1.2 and 3.1.3 below summarize the project's support for drafting the National Multisectoral HIV and AIDS Stigma and Discrimination Reduction Strategy and implementing Government Circular No. 2, which were designed for policy formulation and policy implementation respectively.

³² *The 2008 HIV Law also had a controversial aspect in that it criminalized willful transmission of HIV; globally, experts have concluded this approach – criminalizing transmission of HIV – is difficult to litigate, and it can further stigmatize PLHIV, reduce motivation for HIV testing, and negatively impact public health approaches to improving HIV prevention, care and treatment.*

3.1.1 Monitoring Policy Implementation

In March 2010, the GOT and the USG signed a new Partnership Framework to guide future collaborations on HIV. Later, the partners developed a Partnership Framework Implementation Plan (PFIP), which outlines in greater detail how the Partnership Framework would be operationalized. As input to the PFIP, in 2009, at the request of PEPFAR, HPI/Tanzania conducted a baseline policy assessment to help monitor progress under the PFIP. The assessment identified existing government policies bearing on the implementation of HIV prevention, care, treatment, and impact mitigation programs; the implementation status of those policies; and key policy gaps. Results of the assessment were offered in the form of a Policy Reform Baseline Table, which summarized six development and implementation stages: (1) identification of problem; (2) definition of problem; (3) development of policy document; (4) legislative/regulatory endorsement; (5) implementation/enforcement; and (6) evaluation. The table was incorporated into the PFIP to facilitate monitoring progress on key policies.

In February and March 2012, at PEPFAR's request, HPI/Tanzania updated the Policy Reform Baseline Table to reflect progress since 2010. This initiative was followed through annually up to 2012. In 2012, HPI/Tanzania reviewed 48 select health policies and rendered feedback to USAID and the MOHSW.

3.1.2 National Stigma and Discrimination Strategy

Stigma and discrimination against HIV-positive and affected individuals not only violates their human rights, it fuels the spread of HIV and hinders efforts to respond to the epidemic. Tanzania has made substantial progress in addressing stigma and discrimination. Nonetheless, according to the Tanzania HIV and Malaria Indicator Survey 2011/12, stigma and discrimination remain major barriers to Tanzania's national HIV response. People associated with HIV continue to experience negative attitudes and harmful actions that undermine their health and ability to lead a productive life. Stigma and discrimination discourage people from seeking HIV counseling and testing and treatment services. Moreover, those PLHIV who do seek health services may encounter stigmatizing attitudes and receive substandard care.

The lack of a national strategy has hindered efforts to combat HIV-related stigma and discrimination in Tanzania. In the absence of such a strategy, measures addressing stigma and discrimination were scattered throughout various laws and regulations, and approaches by different organizations. This made it difficult to enforce existing protections and limited actors' ability to coordinate their efforts. To address this gap in the policy framework, HPI/Tanzania partnered with TACAIDS to draft a national HIV stigma and discrimination strategy and the project provided significant technical assistance and support for consensus building during stakeholder consultations and revision.

In February and March 2011, HPI/Tanzania recruited two consultants to work with TACAIDS to draft the strategy. The consultants conducted a literature review and undertook situational assessments in four regions (Iringa, Shinyanga, Kilimanjaro, and Dar es Salaam). During the field assessments, the consultants found that stigma and discrimination had considerably declined in urban communities but were still high in rural areas. This observation is also supported by the findings of TDHS 2010. The consultants used the findings of the literature review and field assessments to draft the strategy with TACAIDS.

In June 2011, HPI/Tanzania and TACAIDS organized a two-day meeting for stigma and discrimination partners to review and improve the draft strategy. Following the meeting, project consultants integrated recommendations from partners and formed a steering committee to oversee the revision process. The steering committee was composed of eight participants from the President's Office Public Service Management (POPSM); the Association of Tanzanian Employers; TACAIDS; RCHS; and NACOPHA. In August 2011, the committee met to review and discuss the draft strategy. From March 21–23, 2012, HPI/Tanzania and TACAIDS organized a technical consultation meeting to integrate comments provided by TACAIDS management (and other partners) and finalize the strategy. Following the meeting, the strategy began making its way through the internal process for adoption, certification, and signing at TACAIDS. Unfortunately, despite ongoing follow-up from HPI/Tanzania staff, the TACAIDS review process took over a

year, which also was complemented by concurrent related processes including development of the new National HIV and AIDS Multisectoral Strategic Framework 2012 – 2017, updating the National HIV/AIDS Policy of 2001, and twice TACAIDS changed its staff overseeing the activity due to organizational restructuring and staff retirement. TACAIDS approved the final National Multi-Sectoral HIV and AIDS Stigma and Reduction Strategy 2013–2017 in April and the minister responsible for HIV/AIDS affairs in the Prime Minister's Office approved it in May 2013.

This strategy is a major commitment to address HIV-related stigma and discrimination. It outlines 13 concrete areas of action to be undertaken by government agencies and other partners. HPI/Tanzania supported TACAIDS to print the strategy, and developed a 4-page summary in Kiswahili to facilitate dissemination.

3.1.3 Government Circular No. 2 (2006)

Government of Tanzania Circular No. 2 of 2006 on Services to Civil Servants Living with HIV and AIDS (Circular No. 2), which was developed with PEPFAR support to the GOT, outlines the government's obligations regarding the provision of services to civil servants living with HIV, including workplace procedures for HTC, disclosure, care, and treatment. However, implementation of the measure had been considerably low. As a result, civil servants and government agencies remained largely unaware of its provisions, and civil servants have little access to the HIV services outlined in the circular.

In June 2011, at a stakeholder consultation meeting to review the draft national stigma and discrimination reduction strategy, a participant from POPSM drew attention to Circular No. 2 and noted that little has been done to implement it. HPI/Tanzania recognized this as a significant opportunity: first, to help scale up HIV service delivery as outlined by the Circular; and second, to generate credible and influential new PLHIV voices from the civil service. In Tanzania, the reluctance of well-respected, influential members of society to disclose their HIV-positive status has undermined efforts to respond to the HIV epidemic. Since civil servants are educated, with reliable income, and respected in Tanzanian society, it was predicted that identifying and supporting the HIV-positive civil servants to speak out could contribute tremendously to discouraging stigma and discrimination as well as holding the GOT accountable on various HIV policy issues.

HPI/Tanzania partnered with POPSM, TACAIDS, and NACOPHA to foster implementation of Circular No. 2. The project and its partners convened a series of meetings with district council and ministry employees to assess awareness and implementation of Circular No. 2. HPI/Tanzania, TACAIDS, and NACOPHA held two-day meetings with 15 district councils in the regions of Ruvuma, Tanga, and Iringa, which were attended by 483 civil servants. The partners also sponsored a one-day meeting held in Dar es Salaam with 94 civil servants from 21 ministries and independent agencies.

3.2 Family Planning and Reproductive Health (FP/RH)

Beginning in the second year of the project, HPI/Tanzania was able to integrate FP/RH into its policy development and implementation efforts. Throughout the project, HPI/Tanzania was an active member of the national FP Technical Working Group, keeping a pulse on all FP activities and determining how to best complement interventions with appropriate advocacy within its mandate. The project's policy development and implementation efforts were intertwined with its efforts to secure increased resource allocation to support the scale-up of FP/RH programs (see Section 4). The project focused on finalizing and implementing the National Family Planning Costed Implementation Program (NFPCIP) in collaboration with FHI 360, relaunching efforts to revise the Law of Marriage Act (1971) to raise the legal age of marriage for girls from 15 to 21, and partnering with AFP to increase budget allocations for FP goods and services (see Section 2.1.2)

3.2.1 National Family Planning Costed Implementation Program (2010–2015)

HPI/Tanzania played a lead role in advocating for the creation of the National Family Planning Costed Implementation Program (2010–2015) (NFPCIP). The NFPCIP was designed to improve management of FP efforts in the country by identifying priority activities and their implementers, estimating FP activity costs over time, and documenting both available and needed resources. The need for an NFPCIP emerged as the government sought to hasten achievement of the FP/RH goals outlined in the National Road Map/Strategic Action Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania (2008–2015). Drafting of the NFPCIP began in 2008 and Health Policy Initiative has played an active role in its drafting as well as serving as the team leader for the policy and advocacy section of the Task Force responsible for developing the NFPCIP. HPI/Tanzania activities entailed drafting a working paper describing the rationale and structure of the proposed NFPCIP, and conducting analyses using project models, including FamPlan, for estimating costs of contraceptive commodities, and RAPID, for estimating the social and economic impact/benefits of improved use of FP services. The NFPCIP was approved by the MOHSW on March 30, 2010. After adoption, HPI/Tanzania continued collaborating with FHI360 to support implementation of the NFPCIP. FHI360 took on the role of coordinating overall efforts to monitor implementation, while HPI/Tanzania headed up the strategic action area on policy and advocacy. At the request of FHI360, HPI/Tanzania continued to reapply the FamPlan model to keep NFPCIP estimates up to date, and most recently presented these data at the FPTWG meeting in March 2013.

The NFPCIP was crucial for efforts to mobilize additional resources for FP/RH programs and services. The project included the NFPCIP in its training of parliamentary policy champions, who used the plan to advocate for increased FP/RH funding (see Section 2.1). Not only has the NFPCIP been a vital tool for FP/RH advocacy in Tanzania, but it has also served as a model for many other countries which have equally sought to document and cost their national FP program needs.

From October 5–7, 2010, HPI/Tanzania collaborated with the President’s Office Planning Commission and the MOHSW to organize a Family Planning Budget Consultative Meeting, which drew participants from family planning partners as well as the MOF. The meeting aimed to (1) discuss the contribution of family planning in achieving Tanzania’s development goals; (2) discuss the rationale and recommendations for creating FP targets and related activities through the 2011/12 MOHSW budget framework; (3) familiarize FP partners with the budget process, including current status of the process; and (4) establish and clarify roles, responsibilities, and timeframe for advocacy toward financing of FP services and activities in the budget cycle.

Outcomes of the meeting included preparing a summary concept note on the rationale for integrating the NFPCIP into the current budget development process, developing a roadmap for implementation of the measures outlined in the concept note, and sharing information as well as forming a small technical committee to follow up on all the processes.

3.2.2 Law of Marriage Act (LMA)

In Tanzania, while the current legal age of marriage for boys is 18 years, girls are legally eligible to marry at 15 (14 with court approval).³³ Not only does the existing regulation violate girls’ right to equality before the law, it also supports the practice of early marriage,³⁴ which undermines young women’s health and human rights, limits their life opportunities, and impedes overall economic and social development. Tanzania has among the highest adolescent fertility rates in the world³⁵—a situation in which early marriage is a significant

³³ Section 13(1) and (2)

³⁴ Early marriage or child marriage is defined as the marriage or union between two people in which one or both parties are younger than 18 years old (McIntyre, 2006; ICRW, 2005).

³⁵ 2011 world development indicators show Tanzania as having the ninth highest fertility rate (births per 1,000 of women ages 15–19) of the countries surveyed (World Bank, 2011).

contributing factor. Early marriage is associated with increased gender-based violence (GBV),³⁶ while early pregnancy and childbirth negatively affect young women's health and contribute to Tanzania's high maternal and infant mortality.

The CEDAW Committee monitors compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In its 2007 progress report on Tanzania, the Committee highlighted the long delay in amending the LMA as an area of particular concern, and urged the GOT to act with dispatch to amend the measure (CEDAW, 2007: pars. 111–112).

The current legal age of marriage is established by the Law of Marriage Act (LMA). Adopted in 1971, the LMA governs matters pertaining to marriage, including the legal age of marriage, divorce procedures, and guidelines for the division of property following dissolution of the marital union. In 2010, at the request of USAID, HPI/Tanzania began working to raise the legal age of marriage in Tanzania from 15 to 21 years³⁷ by facilitating revision of the LMA. In addition to its provisions on early marriage, the LMA contains several other problematic components. While HPI/Tanzania focused specifically on changing the legal age of marriage, its work was, by definition, intertwined with and affected by efforts to amend other aspects of the law.

HPI/Tanzania engaged with high-level policymakers and civil society partners to jump-start efforts to raise the minimum age of marriage. Multiple previous attempts to do so had floundered; therefore, the project had to begin by discovering where the process had gone astray and how to get it back on track. It did so by identifying (through the use of the Spitfire methodology) the key government officials with whom to engage.

The project engaged on two fronts simultaneously. First, it engaged the Law Reform Commission of Tanzania (LRCT) and the Ministry of Justice and Constitutional Affairs (MOJCA) to discover the current status of LMA reform and how to move it forward. However, recognizing that this effort could be slow, the project also moved forward with engaging parliamentarians through the Parliamentary Standing Committee for Community Development, which oversees sectoral operations related to the LMA—laying the groundwork for easing approval of the desired amendments once introduced to Parliament. HPI/Tanzania reached out to three key civil society stakeholders to support its efforts—Tanzania Women Lawyers' Association (TAWLA), Medical Women's Association of Tanzania (MEWATA), and the Tanzania Media Women's Association of Tanzania (TAMWA). In July 2011, HPI/Tanzania held an advocacy meeting for 22 members of the Parliamentary Standing Committee on Community Development (PSCCD).

The meeting helped members of the PSCCD understand the genesis of the proposed amendments to the LMA. It also increased their knowledge and awareness of the negative impacts on health and human rights of the current legal age of marriage. TAWLA presented the rationale for changing the law and raising the minimum age of marriage from 14/15 to 21. TAMWA presented information on rights of the girl child as established by international conventions and ratified by Tanzania, and how the current legal age of marriage stands in violation of these commitments. MEWATA offered the medical rationale for raising the minimum age of marriage. Their testimony was supported by representatives of the LRCT, who were able to speak on the findings of the LRCT's inquiry into the LMA.

PSCCD members demonstrated a high level of interest and engagement, both during and after the advocacy meeting. After the meeting, HPI/Tanzania helped PSCCD members form a task force to engage in high-level advocacy on the minimum age of marriage. The task force could follow up with the MOJCA and the MCDGC

³⁶ An analysis of data from 10 country Demographic and Health Surveys (DHS) found that in six countries (Bangladesh, Bolivia, Dominican Republic, Kenya, Rwanda, and Zimbabwe), women who married before the age of 20 were more likely to report experiences of physical or sexual violence when they started living with their current husbands/partners. These findings and other research show that early marriage is associated with gender-based violence (Hindin et al., 2008).

³⁷ The stated goal of 21 years is in keeping with the recommendations of the Law Reform Commission outlined in its report on the findings of its inquiry into the LMA (LRCT, 1994).

on tabling of the White Paper. Moreover, it could engage with religious leaders, other MPs, and the President, fostering support and generating momentum to carry the process forward. HPI/Tanzania planned to provide additional advocacy trainings to the task force to enable them to effectively carry out this high-level advocacy. Unfortunately, delays in the disbursement of project funds from USAID prevented the project from holding the planned trainings.

Unfortunately, the project also encountered challenges in its engagement with government agencies, which made it difficult to generate momentum on LMA reform. In 2012, HPI/Tanzania made some significant progress on this front when the then Minister of Justice and Constitutional Affairs requested that the project partner with the MOJCA's internal task force on the minimum age of marriage. However, this work was halted abruptly in March 2013, when the Attorney General's office intervened, barring further work on LMA reform unless integrated into the constitutional reform process. The difficulties encountered in efforts to revise the LMA illustrate the challenges of policy work. In the end, it is government decision-makers and not project representatives who make policy decisions. As a result, the outcomes of policy work are always uncertain and subject to influence by forces beyond the project's control. A more detailed account of HPI/Tanzania's work on the LMA can be found in a report published July 2013: *Advocating for a Change to Tanzania's Legal Age of Marriage: Efforts under the Health Policy Initiative*.

HPI/Tanzania's efforts did revitalize the age of marriage reform effort and laid the groundwork for parliamentary support of the measure. To capitalize on these gains, however, there is an urgent need for significant and timely support for continued high-level advocacy. The draft constitution comes before the Parliament early next year. If the age of marriage is to be changed, significant support must be mobilized, both among the public and among parliamentarians. Failure to do so will be a lost opportunity to effect a much-needed change.

3.2.3 Addressing Adolescent Reproductive Health with WAMA

In addition to working to raise the minimum age of marriage, HPI/Tanzania partnered with the Wanawake na Maendeleo Foundation (WAMA), to address the problem of early marriage and pregnancy in the Mtwara region. WAMA was founded by Tanzania's current First Lady, Mama Salma Kikwete. In 2009, the First Lady requested USAID/Tanzania support to address the problem of pregnancy among female students, particularly in the Mtwara region. In response, USAID/Tanzania requested HPI/Tanzania to serve as the lead contact with WAMA and help define the advocacy agenda.

The project began by working with WAMA to prepare a Kiswahili summary of TDHS 2010 data regarding adolescent health and teenage pregnancy. Through an HPI/Tanzania subcontract, WAMA organized a consultative meeting in Mtwara from January 31–February 4, 2012. The overall purpose of the meeting was to strengthen advocacy efforts toward reduction of teenage pregnancy rates—particularly in the Mtwara region. During the meeting, 35 representatives of international implementing agencies working in Mtwara, as well as local, regional, and district authorities discussed the TDHS 2010 data, the importance of FP, and what could be done to improve the situation in Mtwara. The meeting produced a draft joint strategy for addressing adolescent reproductive health, including FP and teenage pregnancy. The plan was to use this strategy in Mtwara and, later, nationwide.

3.3 Task Shifting /Task Sharing and Human Resources for Health

Tanzania suffers from an acute shortage of human resources for health (HRH). This shortage impedes the scale-up of HIV and FP/RH services and undermines the overall quality and availability of health services. Task shifting (also called task sharing) can address the critical HRH situation in the short-term, while working towards substantive long-term solutions. Various countries in southern Africa have ratified and begun implementing WHO recommendations on task shifting. In Tanzania, while the MOHSW and other key stakeholders have acknowledged the need for task shifting, little progress has been made toward adopting it.

In 2008, Tanzania formed a National Task Shifting Task Force in response to a report drafted under the leadership of Tanzania's chief medical officer, which confirmed the efficacy of task shifting as a solution to the HRH crisis. In 2011, the task force asked HPI/Tanzania to assess Tanzania's policy, legal, and regulatory framework to determine the extent to which it supports task shifting and to recommend steps.

In November 2012, HPI/Tanzania issued the assessment report. The analysis found that the legal and regulatory framework is largely silent on task shifting and most existing policies neither explicitly support nor reject task shifting; however, several aspects of current legal and regulatory frameworks could be used to support task shifting. For example, Section 14 of the Medical Practitioners Act grants the MOHSW the power to authorize nurses to undertake medical tasks and procedures normally conducted by more specialized medical practitioners; however, the MOHSW has rarely used this power and there is little awareness of its existence. Also, regulatory councils for medical practitioners could facilitate task shifting through their power to approve specialized training curricula and qualifications.

Informants in focus group discussions and interviews unanimously agreed that task shifting should be formalized, adopted, and regulated. However, they identified potential barriers, including the following:

- *Lack of a standardized program for training and certification to guarantee essential standards of care.* At present, separate regulatory councils govern specific categories of health professionals in Tanzania, and there is no overall system requiring licensing and regulation of all healthcare professionals. As a result, certain cadres of health practitioners—such as clinical officers and assistant clinical officers—constitute a large percentage of service providers, yet are not regulated by the Medical Council of Tanganyika or any other body.
- *Hesitation among medical personnel and professional associations.* This hesitation is largely due to concern that task shifting will compromise professional standards and quality of care.
- *Financial resource requirements.* Task shifting demands resources to support the provision of incentives and salaries to encourage service providers to take on extra tasks. As a result, decision-makers may be reluctant to support task shifting.

Task shifting in Tanzania will likely be a large endeavor, but an essential one given the country's critical shortage of human resources. As a first step, HPI/Tanzania recommended the government put in place supportive policy, legal, and regulatory frameworks. This should be accomplished through a gradual process to ensure that all stakeholders are brought on board. This will enhance ownership of the resulting framework, which in turn will facilitate the smooth implementation of task shifting.

4 OBJECTIVE 3: INCREASED FINANCIAL RESOURCES AND ACCOUNTABILITY FOR HIV AND FP/RH PROGRAMS

HPI/Tanzania worked with champions, leaders, and key stakeholders to increase Tanzanian financial resources for priority FP/RH and HIV needs. Through technical assistance, strengthening the leadership of government and civil society (see Section 2), and through the contribution of evidence-based information and data (see Section 5), the project fostered high-level advocacy and support for increased domestic allocation of resources for FP/RH and HIV programs.

Key achievements:

- The MOHSW incorporated a dedicated FP line item into the mid-term expenditure framework (MTEF), making it easier to track government resource allocation for FP goods and services.
- The National Family Planning Costed Implementation Program (NFPCIP) was adopted and used to advocate for increased domestic funding for FP commodities and services.

- The GOT integrated FP/RH into Tanzania's Poverty Reduction Strategy Paper (PRSP) for the 2010–2015 period (MKUKUTA II).
- In September 2009, the GOT released Tsh 4.5 billion (about US\$2.77 million) for procurement of contraceptives—Tsh 1.8 billion from domestic resources (about US\$1.1 million) and Tsh 2.7 billion (about US\$1.66 million) from the Basket Fund.
- In July 2010 the MOHSW allocated and subsequently released Tsh 14.3 billion (US\$ 8.8 million) for contraceptives from Health Sector Basket Funds.
- In FY2011/12, the MOHSW increased domestic funding for FP from Tsh 0.5 billion to Tsh 1.18 billion (about US\$1.1 million) and allocated Tsh 4.0 billion (about US\$2.46 million) from the Basket Fund to support procurement and distribution of contraceptives.

4.1 FP/RH

Successfully scaling up FP/RH programs and services requires progressively increasing domestic resources. Yet, lack of domestic funding and high-level lack of political support have constituted major barriers to scaling up FP/RH services in Tanzania. The country relies heavily on donors to support its FP/RH programs and services, with domestic resource allocations accounting for a fraction of overall need. As a result, Tanzania has been facing acute shortages of contraceptive commodities.

Addressing this budget gap has been a key focus of HPI/Tanzania's work on FP/RH policy, and a major strategy to do so was to successfully cultivate parliamentarians as champions for FP/RH funding (see Section 2.1). In addition to cultivating parliamentary leadership, the project also helped bring about key policy changes to support increased resource allocation. HPI/Tanzania helped draft the NFPCIP, which became a major advocacy tool for FP/RH budget support (see Section 3.2.1). The project was also instrumental in reforming the MOHSW budget structure to include a dedicated FP/RH line item and incorporating FP/RH as a priority issue in Tanzania's PRSP—MKUKUTA II (2010–2015). To further the capacity of local NGOs to continue this budget advocacy work, HPI/Tanzania collaborated with HDT in the final year of the project to develop a guide to health sector budget advocacy in Tanzania (see Section 4.1.3).

4.1.1 Reform of MOHSW Budget Structure

To enhance accountability and support advocacy for increased funding for FP in Tanzania, HPI/Tanzania led FP/RH partners' efforts to introduce a specific budget line item on FP commodities and services into the MTEF of the MOHSW.

Until 2011, the MOHSW budget framework did not include a specific FP/RH line item. Instead, FP/RH resource allocations in the MTEF were clustered as 'Reproductive Health,' which posed a problem in measuring progress in the country's commitment to repositioning family planning.

Between July 2010 and July 2011, HPI/Tanzania collaborated with the POPC to organize three consultative meetings with MOHSW, MOF, and FP/RH partners, at which the rationale for a dedicated FP line item was presented. Arguments presented emphasized the role of FP in achieving national development goals set by the National Development Vision 2025, MKUKUTA, and the Millennium Development Goals (MDGs). HPI/Tanzania also mobilized MPs through the PFPC to advocate for the creation of an FP line item during Parliament's review of the MOHSW budget.

As a result of these efforts, on July 12, 2011, Parliament approved the FY2011/12 MOHSW budget, including a dedicated line item for FP, with an allocation of Tsh 0.5 billion (US\$307,503). The creation of the FP line item has made it possible to easily monitor MOHSW resource allocation for FP commodities and services, which is crucial to successful advocacy efforts. The line item has also been used by development partners to assess the GOT's commitment to repositioning FP.

4.1.2 MKUKUTA Tracking and Advocacy

Tanzania's PRSP, the MKUKUTA, sets the priorities that guide the country's policies and investments over its five-year span. Recognizing the influence of the MKUKUTA, HPI/Tanzania worked to ensure that MKUKUTA II (2010–2015) included FP/RH as a national priority. In part due to the efforts of HPI/Tanzania and its partners, MKUKUTA II recognizes the importance of investing in FP/RH programs and services to meet overall development goals.

Analysis carried out under Task Order I of the Health Policy Initiative demonstrated how meeting unmet need for FP/RH services supports the achievement of the MDGs by easing the pressures on resources and services imposed by rapid population growth. HPI/Tanzania used this analysis, in combination with additional strategic information and evidence to demonstrate how the current neglect of FP/RH programs and services is compromising Tanzania's ability to meet national development targets. The project emphasized the need to strengthen FP/RH programs and fulfill unmet need for commodities and services, allowing Tanzanians to meet their individual reproductive aspirations, while, at the same time contributing to broader development goals. In 2013, HPI/Tanzania updated calculations on FP's contribution to the MDGs and cost savings for social services with the latest available data, and concluded that a government investment of \$385 M USD between 2014 and 2025 in FP/RH would result in a savings of \$774 M USD in other social sector costs (health, education, water & sanitation).

4.1.3 Advocacy Booklet on Budget Process

HPI/Tanzania collaborated with HDT to publish a user-friendly booklet on health sector budget advocacy in Tanzania. The booklet is designed to help civil society advocates understand the budget process to enable them to engage more effectively with government. While the idea emerged from HPI/Tanzania's experience advocating for increased government funding for family planning, the booklet is equally useful for maternal health, HIV, or other health issues. The booklet was reviewed by several organizations working on health sector advocacy, including Save the Children, DSW, AFP, the Tunajali II project (managed by Deloitte), and the Wajibika project (managed by Abt Associates). The booklet was recognized as a much needed and effective tool for budget advocacy in Tanzania, and it was finalized and printed in July 2013. Several partners requested multiple copies to include into their advocacy training activities, and HDT, AFP, and Futures Group will officially launch the booklet during presentations on health sector budget advocacy at the upcoming National Family Planning Conference in October 2013.

4.2 Public Expenditure Tracking Surveys (PETS)

Effectively tracking public funds committed for responses on HIV prevention, care, and treatment in Tanzania is imperative given the massive amounts of donor funding flowing into the country to support the national HIV response. In 2008, funding for HIV/AIDS services was expected to equal 10 percent of all public expenditure in the country, or about three percent of Tanzania's gross domestic product (GDP). By monitoring and assessing inputs, processes, outcomes, and outputs of government budgets, public expenditure tracking surveys (PETS) can improve both accountability and efficiency—increasing transparency, reducing corruption, and encouraging greater community participation in planning and budgeting processes. PETS is particularly useful where, as is the case in Tanzania, responsibility for health services has been delegated to regional and/or local authorities.

In 2009, HPI/Tanzania, in partnership with Partner Agencies Collaborating Together (PACT)—Tanzania, trained 18 participants from 14 partner organizations on PETS. Participants gained the knowledge and skills needed to (1) monitor service delivery by the local government; (2) include citizens in the budget process; and (3) track HIV/AIDS funds. Following the training, in October 2009, HPI/Tanzania contracted PACT to help participants apply these skills by applying PETS in four districts—Iringa municipality, Njombe, Hai, and Simanjiro. PACT used a PETS model that it had established for Tanzania and used successfully under other project funding. However, in mid-2010 USAID determined that the model was unsustainable because it

involved small grants to the participating NGOs to help cover transport and communications costs. As part of its FY2011 funding cuts USAID terminated funding for the activity.

5 OBJECTIVE 4: INCREASED USE OF EVIDENCE-BASED INFORMATION AND DATA FOR DECISION MAKING AND ADVOCACY FOR HIV AND FP/RH SERVICES

The use of evidence-based information and data was integral to HPI/Tanzania's policy and advocacy approach. Many project activities contributed in some way to achieving this objective. For example, providing evidence-based information and data was key to HPI/Tanzania's engagement of parliamentarians, who were able to use this information to advocate for increased FP resources (see Section 2.1). The compelling nature of the evidence and information generated by the project enabled it to successfully foster leadership and advocacy among a range of other stakeholders, including religious leaders (see Section 2.6), PLHIV (see Section 2.2), and the media (see Section 2.3). The project's evidence-based information was also instrumental to achieving Objective 4—increased financial resources and accountability for FP/RH and HIV programs.

Key achievements:

- Use of RAPID Model to advocate for FP resources.
- Use of FamPlan to develop and update cost estimates for the NFPCIP.
- The First Lady of Tanzania acted as the chief spokesperson for the RAPIDWomen Model in Tanzania and used it to advocate for FP, including presiding over the national launch event.
- Evidence-based information developed by the project was used extensively by parliamentarians, religious leaders, PLHIV, and other champions in their advocacy on FP and HIV issues.

5.1 Using Models and Frameworks to Support Advocacy and Evidence-based Decision Making

Evidence-based information and data were central to HPI/Tanzania's efforts to strengthen commitment for FP programs. Futures Group models, particularly FamPlan and RAPID, were used extensively in policy dialogue and advocacy on family planning and reproductive health issues in Tanzania in 2009. For example, the models' analysis factored into resource allocation decisions, including the emergency allocation of Tsh 4.5 billion (about US\$2.77 million) in September 2009 for procurement of contraceptives. Model analyses were incorporated into the background document produced to encourage inclusion of FP in Tanzania's PRSP, the MKUKUTA. They were also used to develop costing scenarios for the National FP Costed Implementation Program (see Section 3.2.1).

5.1.1 RAPIDWomen

The RAPID Model was a major tool in HPI/Tanzania's advocacy, beginning under Task Order 1 and continuing under Task Order 5. Futures Group leveraged funding from the Packard Foundation to develop a new type of RAPID model—RAPIDWomen—and pilot tested it in Kiswarawe, Tanzania and elsewhere.

Based on the original RAPID Model, RAPIDWomen is an interactive software tool that links FP/RH and women-centered strategies, thereby demonstrating how investing in these types of programs can increase quality of life for women, girls, and families, as well as overall development. For instance, the model can determine how certain strategies affect women's health and education, child survival, economic variables, and the UN Human Development Index. The model can be used to create an evidence base for women's rights advocates, government leaders, and women's organizations to advocate for increased investments in family planning/reproductive health and other women-centered interventions in their countries.

On August 24, 2012, in Dar es Salaam, the First Lady presided over the launch of the RAPIDWomen Model in Tanzania. This was a crowning achievement for HPI/Tanzania. Given the First Lady's prominence and influence, her public embrace of RAPIDWomen and its results represented an important step forward in the effort to foster high-level leadership on FP/RH issues. Moreover, her prominence ensured substantial media coverage of the launch, helping to spread the message about the central role FP/RH can play in supporting the development of Tanzania, and the importance of using women-centered approaches to development. The launch was attended by the Minister of Health; the Minister of Education; the Minister of Justice and Constitutional Affairs; and the Minister of Community, Development, Gender, and Children; as well as permanent secretaries from several other government ministries. Women parliamentarians and other women leaders and representatives of USAID/Tanzania also attended.

5.1.2 Monitoring and Evaluating Efforts to Reposition Family Planning

In 2001, USAID, WHO, and others joined with national governments to “reposition” Family Planning, in effect, to increase political and financial commitments to family planning by (1) advocating for policy change, (2) strengthening leadership, and (3) improving capacity to deliver services. To provide countries with a mechanism for evaluating their efforts to reposition family planning, the MEASURE Evaluation Population and Reproductive Health project developed a results framework—the *Framework for Monitoring and Evaluating Efforts to Reposition Family Planning*, in 2011, and field tested it in Tanzania. It was later applied in nine other countries. In partnership with MEASURE Evaluation, HPI/Tanzania hosted a workshop in March 2013 to re-apply the M&E framework. This workshop created a forum for monitoring progress and advocacy around FP and documenting policy and advocacy milestones. The team's report notes several policy achievements that were accomplished with support from HPI/Tanzania—development of the NFPCIP to help track the level of resources needed to support family planning in Tanzania, inclusion of an FP line item in the national budget, and inclusion of FP indicators in MKUKUTA II. MEASURE also piloted a visual depiction or “dashboard” of the FP Repositioning methodology. HPI/Tanzania wrote a report and an accompanying two-page summary brief. In addition, the project updated a global 2008 brief with 2013 data to calculate FP's contributions to Tanzania reaching its MDGs and potential social sector cost savings if further investments in FP are made. These briefs give FP advocates an easy reference tool on Tanzania's progress on repositioning FP and areas for further emphasis.

6 CROSS-CUTTING: POLICY AND ADVOCACY-BASED INTERVENTIONS IMPLEMENTED TO DECREASE GENDER-BASED VULNERABILITIES TO HIV AND INEQUITIES IN ACCESSING HIV-RELATED SERVICES

A number of studies have shown that GBV is a sad reality in the lives of far too many Tanzanian women and girls, as well as of men, particularly boys. A 2005 multi-country study carried out by the WHO found that 56 percent of women in rural areas and 41 percent of women in urban areas in Tanzania had ever experienced physical or sexual violence by an intimate partner.³⁸ Various assessments indicate that many forms of GBV, including intimate partner violence and rape, are considered normal and are met with acceptance by Tanzanian men as well as women.³⁹ In fact, women and girls are frequently blamed for causing or provoking GBV. Partly due to “blame and shame,” survivors rarely report GBV to authorities or seek other kinds of treatment or support. HPI/Tanzania worked in close collaboration with the MOHSW and multisectoral partners to improve and expand the services available for GBV survivors and to prevent GBV.

³⁸ World Health Organization (WHO). 2005. *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Initial Results on Prevalence, Health Outcomes, and Women's Responses*. Geneva: WHO.

³⁹ Betron, M. 2008.

Key achievements:

- The MOHSW adopted two new national policies to govern the health sector response to GBV—*National Policy Guidelines for the Health Sector Prevention and Response to Gender-based Violence* and *National Management Guidelines for the Health Sector Prevention and Response to Gender-based Violence*.
- The MCDGC initiated the development of national GBV coordination guidelines.
- A comprehensive GBV Drop-in Center was established in Iringa region, raising community awareness of GBV and increasing survivors' access to support and services.

6.1 National Guidelines for the Health Sector Response to and Prevention of Gender-based Violence (2011)

Tanzania's ability to respond effectively to GBV has been hindered by significant gaps in the policy framework. A 2008 policy scan identified the lack of guidelines on GBV as a major barrier preventing the health sector from offering appropriate care to survivors of GBV.⁴⁰ HPI/Tanzania helped close this gap by supporting the creation and adoption of national health sector guidelines on GBV.

In April 2010, HPI/Tanzania helped the Reproductive and Child Health Section of the Ministry of Health and Social Welfare (MOHSW) establish a multisectoral technical working group to draft the new GBV guidelines. Chaired by the MOHSW, the group included representatives of the government, civil society organizations, and development partners. Both HPI/Tanzania and the United Nations Joint Program on Reduction of Maternal and Newborn Mortality provided technical and financial assistance to support the group's efforts.

Initial stakeholder consultations revealed that two separate health sector policies were needed:

National Policy Guideline for the Health Sector Prevention and Response to GBV

The policy guidelines outline the roles and responsibilities of the MOHSW and its key partners in the planning and implementation of comprehensive GBV services at all levels.

National Management Guidelines for the Health Sector Prevention and Response to GBV

The national management guidelines detail clinical procedures for handling the care and treatment of GBV survivors. The guidelines furnish medical providers with protocols to manage GBV survivors and train medical staff on the establishment of service delivery points and management of GBV survivors. The guidelines can be used to identify and mobilize the required resources, materials, and drugs for GBV service delivery points. Moreover, the policy offers inspectors and supervisors a standardized framework for monitoring, evaluating, and supporting the performance of managers and providers of GBV services.

In July 2010, technical working group members and stakeholders came together to frame the main components of the two documents. HPI/Tanzania hired two consultants to draft preliminary versions of the policies based on this input. Afterwards, the project, through the technical working group, facilitated review and revision of the draft guidelines. This entailed consultations with stakeholders from a variety of sectors. Building consensus proved difficult given the wide range of—often contradictory—views, interests, and definitions related to GBV, held by these stakeholders.

In September 2011, the MOHSW approved the National Policy Guideline for the Health Sector Prevention and Response to GBV and National Management Guidelines for the Health Sector Prevention and Response to GBV, which were launched in December 2011. In 2013, HPI/Tanzania supported the development and launch of Kiswahili translations of the policy and management guidelines. This is an important step forward, as the guidelines provide the foundation upon which a comprehensive health sector response to GBV can be

⁴⁰ Betron, M. 2008.

established. However, adoption of the guidelines is only the first step. The challenge now is to ensure that these policies are put into practice.

Consultations with stakeholders while drafting the health sector GBV policy and management guidelines revealed an additional gap in the policy framework. The Ministry of Community Development, Gender, and Children needs guidelines to help it effectively coordinate the GBV activities of multisectoral actors. In response, the Health Policy Initiative began supporting the ministry to draft National GBV Coordination Guidelines. The guidelines are crucial to fielding an effective national response to GBV. Unfortunately, this drafting process will not be completed before the close of the project. Therefore, it is vital that other mechanisms to be found to support completion of the guidelines.

6.2 Fostering Community-based Responses to GBV in Iringa

Tanzania's GBV management guidelines recommend establishing drop-in centers at regional level to provide services to survivors of GBV. As HPI/Tanzania continued to facilitate finalization of the guidelines, the project partnered with TARWOC to support the establishment of a regional GBV drop-in center in Iringa. The Drop-in Center model piloted by HPI/Tanzania in Iringa is one of several new approaches to GBV service delivery being introduced in Tanzania. The Drop-in Center model is designed to provide GBV survivors with a safe and confidential temporary shelter while their needs are being assessed, as well as a range of other services and referrals.

In March 2011, HPI/Tanzania and TARWOC held meetings for 97 local leaders municipal and district councilors in 20 target districts—16 municipal and 4 rural—to discuss plans for the center and sensitize them on GBV issues. The councilors agreed to support establishment of the GBV drop-in center and to take a more active role addressing GBV in their communities. At their recommendation, HPI/Tanzania and TARWOC held a second round of meetings with 425 ward development committee members in May and June 2011.

The TARWOC GBV Drop-in Center opened on October 17, 2011, and is staffed by a receptionist, two social workers, two nurse/counselors, a center manager, and support staff. By March 23, 2012, when the USAID Mission Director visited the center, the center had already served 105 GBV survivors and provided outreach services to the community.

As the center was being established, HPI/Tanzania and TARWOC worked with ward leaders to recruit and train 20 'GBV ambassadors' (one from each ward). The ambassadors carried out community mobilization activities to increase understanding and awareness of GBV and encourage utilization of the new center. The two Drop-in Center social workers provided supervision and support for their efforts.

In May 2012, HPI/Tanzania held a five-day workshop on reporting and M&E for the 20 GBV ambassadors and five TARWOC staff members. The workshop was designed to help the ambassadors document GBV prevalence and monitor utilization of the Drop-in Center. Using their new skills, ambassadors reported reaching 3,570 individuals with community mobilization activities between May and September 2012.

In March 2013, HPI/Tanzania and TARWOC extended the GBV ambassadors program to the *mtaa* (neighborhood) level, partnering with village and ward executive officers to identify and train 180 additional GBV ambassadors. The training was facilitated by the original ambassadors, under the supervision of TARWOC staff.

In the final months of the project, HPI/Tanzania worked with TARWOC to draft a sustainability plan to help it continue its GBV-focused work at the Drop-in Center beyond the close of the project. To inform development of this plan, HPI subcontracted HDT to assess the center's capacity and operations. The HDT assessment found that the Drop-in Center has achieved recognizable impacts in its first two years of

operation and its contributions have been praised by community leaders. However, TARWOC is still an emerging local NGO and needs more capacity building in the areas of management and financial systems. Substantial sustainability challenges must be overcome if the center is to continue serving the Iringa community. The sustainability plan, supported by the HDT assessment, recommended strengthening operational policies and procedures and pursuing additional funding opportunities to reduce the center's dependence on TARWOC.

Futures Group, through its various projects, will continue to work with TARWOC and USAID to find a means to help the GBV Drop-in Center carry on its important work.

7 RECOMMENDATIONS

Over its five-year span, HPI/Tanzania made significant contributions to Tanzania's policy environment for HIV, FP/RH, and GBV; however, policy work is a long-term, often unpredictable endeavor. Therefore, much work remains to be done. In some cases, events did not play out as originally planned—often due to forces beyond the project's control. In others, the project's work proceeded as planned, and in the process HPI/Tanzania discovered additional areas of need. This section outlines recommendations for how ongoing support could be applied to build on HPI/Tanzania's success.

1. **Provide ongoing support for high-level advocacy on FP.** HPI/Tanzania's cultivation and support of high-level policy FP champions led to important policy changes. However, despite this progress, lack of political leadership on FP remains a significant barrier to scaling up FP programs and services in Tanzania. There is a need to provide ongoing support for high-level advocacy on FP issues. This support should focus on increasing domestic budget support for FP and holding the GOT accountable for commitments made at the London FP Summit.
2. **Continue to build the capacity of parliamentary policy champions.** Building on a long history of successful engagement with parliamentarians under the POLICY Project and HPI TOI, HPI/Tanzania made considerable headway in cultivating champions in parliament and building their capacity to advocate effectively for FP/RH and HIV priorities. HPI/Tanzania would encourage USAID to build on this progress to continue to engage and build the capacity of parliamentarians as policy champions, particularly to strengthen and make use of the PFPC and PASCHA.
3. **Foster implementation of new policies and guidelines.** HPI/Tanzania was instrumental in the drafting and adoption of several key policies, including the national stigma and discrimination guidelines; health sector policy and management guidelines for GBV; and national coordination guidelines on GBV. However, there is a need for ongoing support to ensure that these policies are put into practice.
4. **Support harmonization of MOEVT and MOHSW approaches and policies on youth sexual and reproductive health and rights.** HPI/Tanzania's work on adolescent reproductive health in the Mtwara region revealed a need to harmonize the approaches and policies of different ministries on this issue, particularly the MOEVT and the MOHSW. Current MOEVT practices support the expulsion of students for pregnancy or the use or possession of FP methods, which undermines the MOHSW's efforts to reduce teenage pregnancy, increase access to FP, and prevent HIV. Providing support for interministerial dialogue could be a fruitful area for future investment.
5. **Invest in building the capacity of NGOs/CSOs.** A vibrant civil society sector is vital to successfully scaling up FP/RH, HIV, and GBV programs and services. Yet, this sector remains quite weak in Tanzania. The findings of HPI/Tanzania's capacity assessments underscore the need for substantial investment in capacity building of Tanzanian NGOs/CSOs, particularly in building their institutional capacity in areas such as management and finance.

6. **Expand efforts to mobilize religious leaders as a voice for change on GBV.** Religious leaders are trusted and influential voices in Tanzania. HPI/Tanzania reached out to religious leaders, raising their awareness on GBV and encouraging them to use their influence to speak out against it. The project laid the groundwork and achieved some initial successes, such as high profile speeches, and the airing of talk shows and sermons on national television and radio stations; however, this effort remains in its infancy. To capitalize on its potential will require additional investment and support. Given the high prevalence and acceptance of GBV and the tremendous potential impact of religious leaders' engagement, the project believes it is worth carrying forward and expanding this effort.
7. **Collaborate with the GOT to advance task shifting.** The project's work on task shifting revealed a lack of laws and policies (and a failure to use existing laws and policies) as a significant barrier to moving forward with task shifting. There is a need to begin working with the GOT to close the gaps identified by HPI/Tanzania's work on task shifting, including developing a standardized program for training and certification to guarantee essential standards of care, and to apply existing laws to greater effect.
8. **Provide timely support for high-level advocacy on the minimum age of marriage.** Support for continued high-level advocacy on the minimum age of marriage is needed immediately to capitalize on the momentum created by HPI/Tanzania. To ensure that the minimum age of marriage makes it onto the policy agenda through the constitutional review process, there is a need to act now to lay the groundwork for parliamentary support. There is also a need to engage religious leaders on the issue of early marriage, as their support may prove essential to raising the minimum age of marriage.
9. **Continue to build media capacity to provide accurate, evidence-based reporting on HIV, FP/RH, and GBV.** The role the media plays in shaping public opinion is clear. The project's efforts in this area have been fruitful, but relatively small in scope and scale. This is an area in need of continued support—particularly increasing media knowledge and understanding of GBV and enhancing journalists' capacity to gather, use, and verify evidence to ensure the accuracy of their reporting.

8 CONCLUSION

Over the past five years, HPI/Tanzania has sought to foster an enabling policy environment in Tanzania to support the scale-up of FP/RH and HIV programs and to combat the epidemic of GBV. Thanks to the project's work, Tanzania's policy and regulatory framework for HIV, FP/RH, and GBV is stronger than it was five years ago. New guidelines and policies are in place to address stigma and discrimination and gender-based violence. Leaders and champions from a variety of backgrounds have stepped forward to advance FP/RH, HIV, and GBV efforts. Parliamentarians, members of the media, religious leaders, women leaders, and PLHIV have all made their voices heard as a result of the project's support. The evidence-based information produced by HPI/Tanzania through *RAPIDWomen*, *FamPlan*, and other means, has provided a strong basis for successful advocacy and policy formulation. New mechanisms have been introduced to improve the tracking and allocation of FP resources, and FP has been incorporated into Tanzania's PRSP.

Nevertheless, significant challenges remain. Tanzania continues to rely almost entirely on donors for funding its FP/RH and HIV programs. CSOs continue to struggle with a lack of institutional and technical capacity. The minimum age of marriage remains unchanged. Levels of stigma and discrimination and gender-based violence remain unacceptably high.

There is a need for ongoing advocacy and policy work to address these challenges. As HPI/Tanzania draws to a close, its staff hope that its work will continue to be carried forward by USAID/Tanzania and by the many individuals and organizations the project has partnered with over the years.

9 REFERENCES

Hindin, M.S. et al. 2008 “Intimate Partner Violence Among Couples in 10 DHS Countries: Predictors and Health Outcomes.” *DHS Analytical Studies* No. 18. Calverton, MD: Macro International.

J. Flesichman. 2012. *Gender-based Violence and HIV: Emerging Lessons from the PEPFAR Initiative in Tanzania, A Report of the CSIS Global Health Policy Center*. Washington, DC: Center for Strategic and International Studies (CSIS).

S. Maman, J. Mbwambo, N. Hogan, G. Kilonzo et al. 2002. “HIV-positive women report increased partner violence in Tanzania” *American Journal of Public Health* 92(8): 1331–1337

International Center for Research on Women (ICRW). 2005. *Too Young to Wed: Education and Action toward Ending Child Marriage*. Washington, DC: ICRW.

Law Reform Commission of Tanzania (LRCT). 1994. *Inquiry and Report on the Law of Marriage Act, 1971*. Dar es Salaam: United Republic of Tanzania.

M. Betron. 2008. *Gender-based Violence in Tanzania: An Assessment of Policies, Services, and Promising Interventions*. Washington, DC: USAID | Health Policy Initiative Task Order 1, Futures Group.

McIntyre, P. 2006. *Married Adolescents: No Place of Safety*. Geneva: WHO.

MOHSW. 2011. *National Management Guidelines for the Health Sector Prevention and Response to Gender-based Violence*. Dar es Salaam: Government of Tanzania.

MOHSW. 2010. *National Family Planning Costed Implementation Program 2010–2015*. Dar es Salaam: Government of Tanzania.

National Bureau of Statistics. 2010. *Tanzania Demographic and Health Survey*, Dar es Salaam: Government of Tanzania.

United Nations Development Programme (UNDP). 2013. *Human Development Report 2013*. Geneva: UNDP.

TACAIDS. *Tanzania HIV/AIDS and Malaria Indicator Survey 2011–2012*. Dar es Salaam: Government of Tanzania.

TACAIDS. 2010. *UNGASS Country Progress Report 2010, Tanzania Mainland and Zanzibar*. Dar es Salaam: Government of Tanzania.

World Bank. 2011. *World Development Indicators: Adolescent fertility rate (births per 1,000 of women ages 15–19)*. <http://data.worldbank.org/indicator/SP.ADO.TFRT/countries?display=default> [Last accessed 4 June 2013].

World Health Organization (WHO). 2005. *WHO Multi-Country Study on Women’s Health and Domestic Violence Against Women: Initial Results on Prevalence, Health Outcomes, and Women’s Responses*. Geneva: WHO.

ANNEX I: LIST OF REPORTS/BRIEFS PRODUCED

Government Documents

- National Policy Guideline for the Health Sector Prevention and Response to Gender-Based Violence (English, 2011; Kiswahili, 2013)
 - Summary of National Policy Guideline for Health Sector Prevention and Response to Gender-Based Violence (2011)
- National Management Guidelines for the Health Sector Prevention and Response to Gender Based Violence (English, 2011; Kiswahili, 2013)
 - Summary of the National Management Guidelines for Health Sector Prevention and Response to Gender Based Violence (2011)
- National Multi-Sectoral HIV and AIDS Stigma and Discrimination Reduction Strategy (2013-2017)
 - Summary of Tanzania's National Multi-Sectoral HIV and AIDS Stigma and Discrimination Reduction Strategy (2013-2017) (English, 2013; Kiswahili, 2013)
- Public Servants' Rights and Responsibilities related to HIV and AIDS (English, 2013; Kiswahili, 2013)
- The National Family Planning Costed Implementation Program (2010)

HPI/Tanzania Reports/Publications

- Analysis of Policy, Legal, and Regulatory Frameworks for Task Shifting in Tanzania (November, 2012)
- Influencing Government Health Budgets in Tanzania: A Guide for Civil Society (July, 2013)
- Advocating for a Change to Tanzania's Legal Age of Marriage: Efforts under the Health Policy Initiative (July, 2013)
- Measuring Progress on Repositioning Family Planning in Tanzania (June, 2013)

HPI/Tanzania Media Publications/Recordings

- HIV and AIDS Reporting Guidelines for Journalists
- "Zungumza" Television Programs on Gender Based Violence (GBV)
- Arrisalah Da'wah
- Mahubiri Kupinga Unyanyapaa na Ubaguzi kwa Watu Waishio na Virusi Vya UKIMWI-CCT

HPI/Tanzania Program Briefs

- Achieving the MDGs – the contribution of Family Planning [Tanzania] (updated June 2013)
- Engaging Religious Leaders in the Response to HIV and AIDS in Tanzania (July, 2013)
- Legal Redress for HIV-related Discrimination in Tanzania: Barriers and Recommendations (June, 2013)
- Reducing HIV-related Stigma and Discrimination in Tanzania (June, 2013)
- Repositioning Family Planning in Tanzania (June, 2013)
- Stories from the Field: Women leaders join in Mara, Strengthening Tanzania's Policy Framework to Respond to GBV (May, 2013)
- Strengthening Tanzania's Policy Framework to Respond to GBV (July, 2013)
- TARWOC's Drop-in Centre: GBV Prevention and Response in Tanzania (July, 2013)

ANNEX II: AGENDA FROM END OF PROJECT MEETING, JULY 24, 2013

8:30 AM	Arrival	
9:00 AM	Welcome <i>Nancy J. McGirr, Deputy Director, Center for Policy and Advocacy, Futures Group</i>	
9:15 AM	Opening Remarks <i>Andrew Rebold, Acting Director, Health Office, USAID/Tanzania</i>	
9:30 AM	Opening Remarks <i>Regina Kikuli, Permanent Secretary, MOHSW (delivered by Dr Donan Mmbando, Chief Medical Officer)</i>	
9:45 AM	Keynote Presentation <i>Policy and Advocacy – Critical to Health Systems, Health Outcomes, and Country Ownership Ron MacInnis, Deputy Director – HIV, Health Policy Project, Futures Group</i>	
10:00AM	Concurrent Sessions	
	Moving HIV Policy into Practice <i>Moderator: Gene Peuse, Senior Advisor, Public-Private Partnerships, USAID/Tanzania</i> <ul style="list-style-type: none"> • PPSM Commitments in Implementing HIV/AIDS Policies: <i>Anne Mazalla, Director of Social Diversity, PPSM</i> • District-level policy implementation: <i>Dr. Mbonea Yonaza, District AIDS Control Coordinator, Handeni District/Tanga Region</i> • PLHIV engagement in policy implementation: <i>Deogratius Peter Rutatwa, Chief Executive Officer, NACOPHA</i> 	Family Planning Policy and Advocacy <i>Moderator: Karen Hardee, Deputy Director – FP, Health Policy Project, Futures Group</i> <ul style="list-style-type: none"> • National achievements in family planning: <i>Maurice Hiza, National Family Planning Coordinator, RCHS-MOHSW</i> • Family planning advocacy – efforts, achievements, challenges: <i>Gregory Kamugisha, Senior Technical Advisor, Futures Group/HPI</i> • District-level advocacy for family planning: <i>Peter Bujari, Executive Director, HDT</i>
11:15 AM	Break	
11:45AM	Concurrent Sessions	
	Policy and Advocacy Efforts to Reduce HIV-related Stigma & Discrimination <i>Moderator: Charles Kayoka, Program Manager, AJAAT</i> <ul style="list-style-type: none"> • <i>Dr. Hafidh Ameir, Regional Coordinator, Coast Region, TACAIDS</i> • <i>Deogratius Peter Rutatwa, CEO, NACOPHA</i> • <i>Rev. Lewis Hiza, Chaplain, University of Dar es Salaam/CCT</i> • <i>Hasina Shemduli, Director HIV/AIDS, BAKWATA</i> • <i>Grace Mkinga, Head of Legal Aid Department, TAWLA</i> 	Advancing GBV Policy and Programming <i>Moderator: Meshack Ndaskoi, Director for Gender Development, MCDGC</i> <ul style="list-style-type: none"> • Policy achievements and current efforts to address GBV: <i>Dr. Samuel Likindikoki, Lecturer at MUHAS & Head of Psychiatric Department</i> • GBV issues in Tanzania: <i>Hon. Lediana Mafuru Mng'ong'o, Member of Parliament</i> • Addressing GBV at the community level: <i>Pendo Luoga, Centre Manager, TARWOC Iringa Drop-In Centre</i>
1:00PM	Closing Remarks <i>Dr. Fatma Mrisho, Executive Chairman, TACAIDS (delivered by Dr. Hafidh Ameir, Coast Regional Coordinator for TACAIDS)</i>	
1:15 PM	Acknowledgements & Appreciation <i>Erin McGinn, Acting Chief of Party, Futures Group</i>	