



The United Republic of Tanzania
Ministry of Health and Social Welfare

Tanzania Mainland

NATIONAL GUIDELINE FOR COMPREHENSIVE PACKAGE OF HIV INTERVENTIONS FOR KEY POPULATIONS

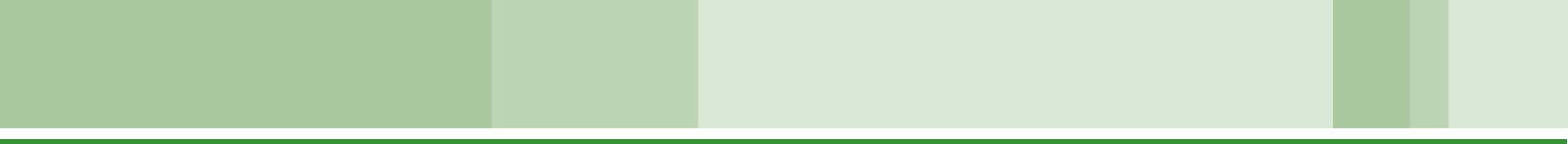
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Table of Contents

Executive Summary	11
Chapter 1	13
1.1 Background	13
1.2 Rationale for the National guideline for KP	13
1.3 Goal and objectives	14
1.4 General guiding principles of National guideline	14
1.5 Target audience for the national technical guide	17
1.6 Technical development process of the national guidelines for KP	17
CHAPTER 2	18
2. Setting the scene: Global, Sub-Saharan Africa and Tanzania	18
2.1 People Who Use /Inject Drugs (PWUD/PWID)	18
2.2 Men who have Sex with Men (MSM) and Transgender people	18
2.3 Sex Workers	20
2.4 Prisons	21
Chapter 3	21
3.0 Introduction	23
3.1 HIV Diagnosis, Prevention, Treatment, Care and Support	23
3.1 HIV testing and counseling	23
3.2 HIV, treatment, support and care	25
3.2.1 Antiretroviral therapy	25
3.2.2 Post-exposure prophylaxis for risky sexual and occupational exposure to HIV	26
3.2.3 Prevention of mother-to-child transmission of HIV	27
3.2.4 Other prevention and care interventions for KP living with HIV	27
3.3 Needle and syringe programmes	27
3.4 Medically assisted treatment, and other evidence –based drug dependence treatment	29
3.5 Managing common infections, co-infections and co-morbidities	29
3.5.1 Management of symptomatic STI/RTIs	29
3.5.2 Screening for asymptomatic STI	32
3.5.3 Prevention, diagnosis and treatment for viral Hepatitis	33
3.5.5 Prevention, Diagnosis and Treatment of Tuberculosis	34

3.6	Voluntary medical male circumcision	34
3.7	Social Behavioural Change Communication Interventions for HIV prevention	36
3.7.1	Information, education and communication/Social Behavior Change Communication	36
3.7.2	Comprehensive Condom Programming	36
3.8	Complimentary interventions	37
3.8.1	Outreach and Peer Education	37
3.8.2	Rehabilitation Services	37
3.8.3	Interventions for Women who use and inject drugs (WWUD/WWID)	38
3.8.4	Mental Health and Substance Use	38
3.8.5	Prevention of transmission through medical, dental, shaving, tattooing, piercing and other forms of penetration	39
3.8.6	Protecting prisoners and prison staff from occupational hazards	40
3.9	Community empowerment and Social Mobilization	40
3.10	Comprehensive Package of HIV Interventions for KP	41
3.10.1	People Who Use and Inject Drugs (PWUD/ PWID)	41
3.10.2	Men who have sex with men and transgender people	43
3.10.3	Sex workers	44
3.10.4	Prisoners	45

Chapter 4

48

4.1	Monitoring and Evaluation of KP Programmes	48
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Annex 1

Guides for KP or related publications

Annex 2

Summary WHO recommendations on the use of ART for treating and preventing HIV infection

Annex 3

Emerging issues for consideration

Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community-Based Organisation
DIC	Drop-In Centre
GBV	Gender-Based Violence
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IEC	Information, Education, Communication
MAT	Medically Assisted Treatment
MoHSW	Ministry of Health and Social Welfare
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
NSP	Needle and Syringe Programme
NS	Needle and syringe
PEP	Post Exposure Prophylaxis
PITC	Provider-Initiated Testing and Counseling
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RTIs	Reproductive Tract Infections
SSA	Sub Saharan Africa
STI	Sexually Transmitted Infections
SW	Sex Workers
TB	Tuberculosis
TG	Transgender people
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Foreword

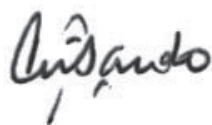
Tanzania has made substantial headway in the scale up of HIV interventions which have led to a significant reduction of the prevalence in the general population. Given the disproportionate burden of the HIV epidemic among the specific populations groups in the country, focus is now also very much needed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

The Government of the United Republic of Tanzania has endorsed several global commitments and the respective plans of actions, including MDGs; the UNGASS declaration; the Abuja High-Level Partner Forum on PMTCT (2005) among others. The commitments made by Tanzania aim to improve the quality of life and achieve elimination of new HIV infections in the general populations especially where new infections are concentrated. In line with this the Government of Tanzania has developed this National Guidelines which will guide and standardize the implementation of a comprehensive package of HIV and Health Interventions for the Key Populations who are at high risk for HIV.

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

The MoHSW is geared to ensure the implementation of these national guidelines by setting in place the systems and structures to support its implementation. These include provision of the training packages, provision of drugs, equipment and supplies that are necessary for provision of the quality prevention and treatment services to the KPs.

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



Dr. Donan W. Mmbando

CHIEF MEDICAL OFFICER

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Development and Implementation Partners (World Health Organization, UNAIDS, UNODC, UNICEF, USAID, Centers for Disease Control Population Services International, Engender Health, FHI360, and Prevention, MDH, PASADA,)

Academia (University of Dar es Salaam, Muhimbili University of Health and Allied Sciences, Kilimanjaro Medical College)

Civil society organizations (TANPUD, Mediciens Du Monde, Wake Up & Step Forward WASO Coalition of Key Populations, AMKA, Tanzania Network of Women Living with HIV, Sisi Kwa Sisi, Stay Awake Network Activities Organization (SANA), Community Peer Support Services for MSM, Kimara Peer Educators, AMKA LGBT AND SW Organization, Young Women Initiative Group, UNO-AG-CHA - Temeke)

We would like to thank all who were engaged in the comprehensive guide development especially the support of the Key Populations groups who made this possible.



Dr. Neema Rusibamayila

DIRECTOR OF PREVENTIVE SERVICES

Definitions of terms (Glossary)

Key Populations (KPs): KPs are defined within the World Health Organization (WHO) Global health sector strategy on HIV/AIDS 2011-2015 to include both vulnerable and populations who are higher for HIV. They often have legal and social issues related to their behaviours that increase their vulnerability to HIV.

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

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

People who use drugs (PWUD): PWUD are those that consume psychoactive drugs, and often, even more specifically, illicit drugs, or other drugs of which there is non-medical use.

People who Inject Drugs (PWID): Are those who have injected drugs at any time within the past 12 months. ¹

Prisoners: All those confined to prisons or confined settings, including adults and juveniles, during crime investigation, while awaiting trial, after conviction, before sentencing and after sentencing. ²¹

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

Sex Workers: Female, male and transgender adults and young people (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. ³

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

Men who have sex with men: Males who have sex with other males, regardless of the motivation for engaging in sex or identification with any or no particular 'community'. ⁴ It is important to ensure that the key focus of a definition of men who have sex with men remains those behaviours which are known to directly increase the risk of HIV infection— notably, unprotected anal sex.⁵

¹ S. 2 of the Prison Act .1967, A prison established or deemed to have been established under S.23 of the Prison Act. 1967, Any person whether convicted or not under detention in any prison.

Comprehensive Package of Services for KPs: This is the process of rendering services for KP in a full set of interventions recommended for example offering care and treatment services, counseling and testing, PMTCT, community based interventions as well as Information Change Communication at one setting.

Transgender people: Persons whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth.⁶ Transgender people may identify as transgender women (also male-to female or MTF) or transgender men (also female-to-male or FTM), who may engage in heterosexual or homosexual practices, or who may be polysexual or voluntarily asexual.⁷

Executive Summary

The HIV epidemic in Tanzania has existed for three decades and has claimed many lives. Over the year's collective efforts to control the epidemic has seen HIV prevalence decline progressively among adults aged 15-49 from 7% in 2003 to 5.1% in 2011. However several vulnerable groups such as street children, long distance truck drivers, miners and fishermen remain at high risk of HIV infection. Generally Key Populations are disproportionately affected by HIV. Key populations who are at higher risk of HIV include people who use and inject drugs (PWUD/PWID), men who have sex with men (MSM), transgender people, sex workers and prisoners.

In Dar es Salaam based on available evidence HIV prevalence among PWID, MSM and sex workers is 51%, 42% and 31% respectively. To ensure an effective and sustainable response to HIV there is a need to reach out to KPs with a comprehensive package of prevention, treatment, care, support interventions and other public health services. The interventions in the national guideline emerge and expand upon both from earlier and current key government policy documents to address HIV and AIDS, and also include evidence-based practices from World Health Organization and other United Nation agencies.

The goal of this guideline is to increase access to a comprehensive package of quality health and social services to KP in order to significantly minimize the transmission of HIV and to reduce HIV-related mortality, morbidity, stigma and discrimination. Implementation of the comprehensive package of interventions shall thereby contribute to the attainment of the three Zeroes: Zero new HIV infections, Zero discrimination, and Zero AIDS-related deaths.

The national guideline was developed through consultations involving the National AIDS Control Programme, Tanzanian Commission for AIDS, Drug Control Commission, Development Partners, HIV Implementing Partners, civil society groups and other relevant government departments. The following is a summary of good practice recommendations:

HIV diagnosis, Prevention, Treatment, Care and support

- HTC services should be offered to all KP voluntarily
- Linkage to care and treatment services should be provided for those infected with HIV and in need of care
- Linkage and referral mechanisms to community support programmes for KP should be established to ensure retention and follow up into care and treatment services.

Biomedical interventions for HIV prevention

- Medically Assisted Treatment should be provided as a high priority to all opioid dependent users and that this service should be expanded and implemented to scale to reach more PWID and non-injectors.
- Wide accessibility, availability and affordability of male and female condoms together with non-oil based lubricants should be ensured.

- Implement, expand and scale up of community-based needle and syringe programmes as a high priority to reduce HIV transmission among PWUD/PWID.
- Offer and encourage uptake of voluntary medical male circumcision by MSM as per the standard HIV intervention offered to other men in the wider community.

Social behavioural interventions for HIV prevention

- Provide community-based outreach and peer education incorporated into service delivery to improve Key Population engagement and connectivity to health and other social services
- Community empowerment interventions should be developed to empower Key Populations on their rights and access to health
- Messages promoting consistent and correct use of condoms for KPs and their sexual partners or clients are needed.

Managing common infections, co-infections and co-morbidities

- KPs with STIs should be offered syndromic management and treatment.
- Sensitization and awareness of hepatitis C and B prevention should be undertaken with all KP and health workers.
- Prisons need to intensify active case-finding, provide isoniazid prevention therapy and strengthen effective tuberculosis (TB) control measures.
- Prevention, screening, diagnosis and treatment of TB should be a high priority for all prisoners including PLHIVs.
- KPs that have harmful alcohol and substance use should have access to psychosocial interventions, including assessment, specific feedback and advice.

Chapter 1

1.1 Background

The HIV epidemic in Tanzania has existed for three decades and has claimed many lives. HIV prevalence has declined progressively among all adults aged 15-49 from 7% in 2003 to 5.1% in 2011. In Tanzania Mainland, HIV is a generalized epidemic affecting both urban and rural settings with approximately 80% of HIV infections a result of heterosexual transmission. Globally research shows that HIV disproportionately affects KPs particularly people who inject drugs (PWID), men who have sex with men (MSM), transgender, sex workers and prisoners. When compared to the general population, global data shows that on an average PWID are 22 times more likely to be HIV+; transgender 49 times; sex workers 14 times; MSM 13 times and prisoners 6-50 times depending on specific contexts.^{8 9 10 11 12} Despite the small number of studies done in Tanzania Mainland, evidence indicates HIV prevalence of 51% among PWIDS, 31.4% among female sex workers and 42% among MSM.¹³ HIV prevalence among transgender people is not known and official data from prisons is not available.

The National guideline on KP acknowledge there are other vulnerable population groups at risk of HIV in Tanzania Mainland notably the following: street living and working children; people on probation from prison; most at-risk adolescents; fishermen; long distance truck drivers; miners; construction workers; plantation workers; general labourers and females who engage in anal sex in heterosexual practices. However, in this National guideline for KP the focus is on PWUD/PWID, sex workers, MSM, transgender people and prisoners due to the strong international and national evidence of high risk behaviours, substantial vulnerability and marginalization, and that they are disproportionately affected by the HIV epidemic.

KPs are important to the dynamics of HIV transmission in a given setting and are essential partners in an effective response to the epidemic.¹⁴ There is evidence of overlapping sexual network between KP and general population indicating that HIV among key populations is not isolated and if not addressed accordingly risks the national responses. To ensure an overall effective and sustainable response to HIV there is a need for special interventions to reach out to KPs with comprehensive package of prevention, treatment, care and support interventions and services. This national guideline for KPs is intended to assist in this process. Importantly this National guideline for KPs emerges and expands upon, as well as compliments earlier and more current key government policy documents that include Third Health Sector HIV and AIDS Strategic Plan (HSHSP III), 2013 – 2017, Tanzania Third National Multi-sector Strategic Framework for HIV and AIDS 2013 – 2017, and Comprehensive National Multisectoral HIV and AIDS Stigma and Discrimination Reduction Strategy 2013 – 2017.

1.2 Rationale for the National guideline for KP

- To standardize the development and implementation of HIV interventions for PWUD/PWID, sex workers, MSM and TG people, and prisoners based on the best international evidence and good practice for what is effective.

- To promote a public health response to address the vulnerability, risk behaviours and associated adverse health consequences found among people who inject drugs, (including people that use drugs) , female, male and transgender sex workers, men who have sex with men (MSM) and transgender people (TG), and prisoners.

1.3 Goal and objectives

Goal

The goal of this document is to guide stakeholders in the delivery of cost-effective comprehensive package of quality health and social services to all KP in order to significantly minimize the transmission of HIV and to reduce HIV-related mortality, morbidity, stigma and discrimination. Implementation of the comprehensive package of interventions shall thereby contribute to the attainment of the three Zeroes: Zero new HIV infections, Zero discrimination, and Zero AIDS-related deaths.

Objectives

1. To develop, strengthen and scale up evidence-based comprehensive package of interventions and services for prevention, treatment and care of HIV and AIDS, other blood borne viruses (hepatitis B and C), reproductive health and other sexually transmitted infections among KPs
2. To create and maintain an enabling environment for HIV and AIDS and related interventions through multi-sectoral targeted dialogue for, targeted advocacy and community engagement to address the social, cultural, religious, political, structural legal and financial barriers that can impede upon a public health approach for KP.
3. To enhance and strengthen technical knowledge among the stakeholders to deliver the comprehensive package of evidence-based services in a more targeted, efficient, effective and cost-effective manner for KP.

1.4 General guiding principles of National guideline

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

Universal access, equity and the right to health

- Ensure services and programmes implemented are non-stigmatizing, non-discriminatory, accessible, acceptable, affordable and equitable for all. Universal health access aspires at providing package of health benefits to all that will lead to improved health outcomes.
- All services and programmes are gender-sensitive and address the special needs of men, women and transgender people from Key Populations Improve the legal, policy, and social environment to allow access by KP to available health services

Meaningful engagement of KP

- Foster active, meaningful and collaborative involvement of community members from key affected populations, including those that are HIV infected, in programmes and interventions to ensure recommendations outlined in this National Guideline have a greater opportunity of implementation and contribute to the national HIV response.

Multi-sectoral partnerships combined with political and institutional commitment and accountability

- Develop, build upon and sustain collaborative partnerships to support coordinated, comprehensive, transparent, accountable cost-effective public health approach responses to address the multiple health needs of Key Population.
- Strong political leadership and commitment at all levels are integral to an effective and sustained response to HIV and AIDS.

Advocacy

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

Gender sensitivity

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

Research and evidence-based planning

- Undertake adequate and appropriate research on KP to ensure responses to HIV and AIDS are informed by evidence. Research activities need to improve the amount and quality of strategic information for decision-making at all levels to ensure effective planning and allocation of resources where they are most needed.

Scaling up of sustainable, culturally relevant services, balancing the need for prevention, treatment and care

- Scaling up of services will need to ensure that resources (both human and financial) are available, that technical capacity of staff in the response will require development to implement the services, and that cost effectiveness of delivering services is an important consideration. Implementation of services must prioritize the sustainability of the intervention, results and the outcomes. Various factors need to be considered such as financial, material and human resources, and community ownership to ensure the efficiency, efficacy and effectiveness of the interventions

- Scale-up of appropriate, culturally relevant and sensitive, low threshold [ensures that implementation setting facilitates easier access to services through specific locations – such as drop-in centre- with appropriate opening hours suited to KPs and high impact services and programmes while maintaining quality and sustainability. The guideline advocates for a balanced approach to tackle HIV with focus on HIV prevention but ensuring that the needs of those HIV infected are catered for. Develop and maintain community ownership and organizational capacity to support scaling-up of services and programmes.
- Monitor and evaluate services and programmes that are scaled-up.

Decentralization, integration and public-private partnership

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

1.5 Target audience for the national technical guide

The Ministry of Health and Social Welfare and TACAIDS will ensure that this National guideline is implemented. This National guideline is intended to be used by all stakeholders in Tanzania that are involved in the implementation of HIV and AIDS programmes. As HIV and AIDS is a cross cutting issue it is important that other sectors are engaged to better understand the high vulnerability and marginalization of KP. This National guideline can act as reference and advocacy document and utilized by the following: relevant government ministries, development and donor partners, non-government organizations, community based organizations, faith based organizations, private sector, service providers, community members from KP as well as those from the wider community.

1.6 Technical development process of the national guidelines for KP

This document was developed through consultations involving National AIDS Control Programme, Tanzanian Commission for AIDS, and other relevant ministries and departments. Law enforcement agencies including those from the Ministry of Justice and Constitutional Affairs and Prisons also participated in the process. Other relevant key stakeholders' development partners and those from civil society organizations assisted in the development process.

CHAPTER 2

2. Setting the scene: Global, Sub-Saharan Africa and Tanzania

2.1 People Who Use /Inject Drugs (PWUD/PWID)

Global

For over three decades the main route of transmission of HIV has been sexual intercourse and to date it accounts for the overwhelming majority of the people who are newly HIV infected. However, one key population group highly vulnerable and extraordinarily burdened with HIV is that of PWID. Research identified an estimated 16 million PWID in 151 countries. Of these approximately 3 million PWID are HIV infected.^{15 16} Globally an estimated 10 per cent of all new HIV infections are attributed to the injecting of drugs, rising to 30 per cent when sub-Saharan Africa is excluded.¹⁷ With available data PWID have 22 times the rate of HIV infection as the general population in 49 countries and in 11 countries it is at least 50 times fold higher.¹⁸ PWID are also over burdened with Hepatitis C viral infection (HCV). On average, the prevalence of HCV infection among PWID is often greater than 50% in most countries¹⁹ compared to the global anti-HCV (exposure to HCV) prevalence among the general population at less than 3%.²⁰

Sub-Saharan Africa

The global twin epidemics of HIV and injecting drugs use are widely documented and well established. Only in more recent years has the situation of HIV infection among PWID in Sub-Saharan Africa (SSA) emerged as a growing concern. Research shows injecting drugs are becoming increasingly common with reports identifying PWID in 16 countries of Sub-Saharan Africa.^{21 22} Overall data is still lacking in the region yet research has found communities of PWID are well established in Kenya, Mauritius, South Africa, Nigeria and Tanzania.²³ HIV prevalence among PWID in some countries of SSA is high and of concern: Kenya (19%), Mauritius (45%) and South Africa (20%).^{24 25} Services to address the health and social needs of PWID throughout SSA are greatly lacking and what does exist remain small in scale.

Tanzania

Over the past decade Tanzania has seen an increase in the number of PWID.²⁶ The estimated number of PWID varies but the numbers are large enough to warrant attention. Nation-wide estimated numbers of PWID range from 25,000 – 50,000.^{27 28} The NACP in the year 2012 engaged over 11,800 Heroin users through outreach activities, of which 2,530 were injecting drug.²⁹ A pilot program working in one of the districts in Dar es Salaam reported engaging 2,933 PWID between August 2011 and March 2012.³⁰ The prevalence of HIV infection among PWID is significantly higher than in the general population. A study conducted in 2010-2011 in Dar es Salaam showed HIV prevalence of 51%³¹ and HCV positive antibody (indicating past exposure but not confirmed current infection) of 76% among PWID.³² The prevalence of HIV infection among women who inject drugs range from 55% to 68%^{33 34} while the prevalence rates among younger PWIDs (18-30 years) are reported to be approximately

31%.³⁵ Major health risks identified among PWID in Tanzania are unsafe injecting practices, reuse of contaminated injecting equipment and risky sexual behaviours.

2.2 Men who have Sex with Men (MSM) and Transgender people

Global

HIV/AIDS emerged among populations of self-identified gay and MSM in Western Europe, North America and Australia in the early 1980s.³⁶ Evidence has emerged in more recent years of HIV epidemics among MSM in a broad range of countries in Africa, Asia, the Caribbean and Latin America.^{37 38 39 40}

Studies among MSM show consistently higher HIV prevalence rates among MSM than non MSM practicing men.^{41 42 43} Globally HIV prevalence among MSM in various capital cities is 13 times higher when compared to the general population.⁴⁴ Among transgender people (specifically transgender women) studies show high risk behaviors, high prevalence of STIs and they are 49 times more likely to be living with HIV when compared to the general population.^{45 46 47 48 49}

Despite disproportionately being affected by HIV both MSM and transgender people are commonly underserved and under-resourced, and more so in low and middle income countries. Limited coverage and access to HIV prevention, treatment and care services was common whereby fewer than 1 in 10 MSM worldwide have access to the most basic package of HIV prevention interventions.⁵⁰ A combination of stigma, discrimination and criminalization limits MSM and transgender people to access available services^{51 52 53}. There has been a global failure to understand and respond adequately to their human rights and public health needs.⁵⁴

Sub-Saharan Africa

Notwithstanding the persistent denial of homosexuality in Africa, research points to the existence of this population.^{55 56 57 58 59 60 61} In recent years governments of several countries have strengthened laws against homosexuality and political and religious leaders have publically denounced male to male sex. According to Amnesty International as of 2011, there were 38 countries in Africa that criminalize same sex intercourse and in four of these countries same sex intercourse is punishable by law.⁶² MSM is rarely acknowledged and the HIV epidemic in SSA is primarily portrayed as heterosexual and mother to child transmitted.

Limited available literature of MSM report higher HIV infection rates and increased risk behaviours compared with non-MSM. HIV prevalence rates above 30% are reported in Zambia, Kenya and South Africa.^{63 64 65} Given the evidence of denial, stigma and discrimination towards MSM focused HIV interventions are mostly absent or rare in Africa. Research of transgender sex workers in Uganda, South Africa, Kenya and Zimbabwe highlight a range of problems with health care provision, poor treatment, discrimination, humiliation and breaching of confidentiality by health workers.^{66 67}

Policy makers in Africa mostly overlook MSM and transgender people as vulnerable groups and the role they play in HIV transmission.^{68 69} Policy and programmatic responses to HIV prevention in Africa predominately focus on interventions targeted to heterosexual and mother to child transmissions, despite evidence of some MSM reporting both male and female partners.^{70 71}

Tanzania

In Tanzania data on MSM and transgender people are limited yet various studies show their existence.^{72 73 74 75 76 77 78 79} MSM practice in Tanzania is stigmatized, criminalized and hence hidden. Public discussion of MSM elicits strong reactions of fear, hatred and disgust. Consensual “carnal knowledge against the order of nature” is punishable in Mainland Tanzania by a minimum of 30 years and a maximum of life imprisonment, while “gross indecency” between males is punishable by five years in prison.²

The contribution of MSM to the HIV epidemic in Tanzania has not been officially reported. However, preliminary results from a recent study in Dar es Salaam report HIV prevalence among MSM at 42%.³ In Zanzibar MSM are disproportionately affected by HIV: HIV prevalence among MSM was reported at 10.8% (ZNSP II) and 12.3%⁸⁰ compared to 0.6% among the general population. A recent study among PWID in Dar es Salaam found 6% of male respondents reported having ever engaged in same sex behaviours, of which 38% reported selling sex to males in the previous 12 months. It is believed these figures are under estimated due to widespread stigma associated with MSM practices in Tanzania.⁸¹

Tanzania’s Third National Multi-sectoral Strategic Framework on HIV and AIDS (2013-2017) acknowledge the vulnerability of MSM and advocate for the decriminalization of MSM practices. MSM continue to face many obstacles in accessing treatment, especially for STIs. HIV prevention interventions targeted towards MSM and transgender people are primarily limited to Dar es Salaam and conducted by Non-Governmental Organizations (NGOs) and Community Based Organizations (CBOs), and carried out on a small scale. MSM and transgender people have remained largely invisible to many of the ongoing interventions for HIV prevention, treatment and care.

2.3 Sex Workers

Global

Globally female sex workers (FSW) are on average 14 times more likely to be living with HIV than women in the general population.⁸² The potential for FSWs’ clients to serve as a “bridging population” by spreading HIV to the general population cannot be under estimated.⁸³ For example, in Asia there are an estimated 10 million women selling sex to an estimated 75 million men, who in turn have intimate relations with a further 50 million people.⁸⁴ A combination of multiple sexual partners, barriers to negotiate safer sexual practice (consistent and correct condom use) with many clients refusing to use condoms,

2 Tanzania Penal Code, Chapter 16 of the Law (revised) 1981

3 The study is been carried out by Nyoni and Ross in Dar es Salaam and Tanga. It includes testing for HIV and other STIs.

⁸⁵ ⁸⁶ lack of access to appropriate lubricants and violence against sex workers all have close links to higher prevalence of STIs. ⁸⁷ All these factors significantly contribute towards sex workers becoming HIV infected. ⁸⁸ ⁸⁹

A systematic evidence review of global prevalence of HIV infection among FSW found it at 11.8%. The highest prevalence of HIV was in Sub-Saharan Africa (36.9%), followed by Eastern Europe (10.9%), Latin America and the Caribbean (6.1%), Asia (5.2%) and lowest prevalence found in Middle East and North Africa (1.7%). ⁹⁰ Globally most sex workers are women yet a substantial number of male and transgender sex workers exist. The biological risks of anal intercourse and high prevalence of HIV identified among MSM and TG people have raised the profile of these issues. ⁹¹ ⁹² ⁹³

Sub-Saharan Africa

Sub-Saharan Africa has the highest prevalence of HIV among sex workers (36.9%) compared to other regions in the world. ⁹⁴ Transactional sex and sex work has been associated with high risk of HIV infection in a number of SSA studies. Numerous studies have documented significantly higher rates of HIV infection in women involved in sex work, when compared to women in the general population. ⁹⁵ ⁹⁶ SSA sex workers continue to be disproportionately affected with estimated prevalence ranging from 30% in Yaoundé, Cameroon to as high as 75% in Kisumu, Kenya. ⁹⁷ ⁹⁸

Tanzania

Tanzania law criminalizes sex work and loitering for the purpose of prostitution carries a three month prison penalty⁴. Studies have documented the existence of FSW in Tanzania and while estimated number of FSW nation-wide are not available, in Dar es Salaam a figure of 7,500 FSW has been suggested (range 5,000 to 10,000) with a median number of clients per FSW at three. ⁹⁹ As found globally, sex work in Tanzania mirrors similar risk behaviours that increase the vulnerability to HIV infection with the resultant prevalence being greater than in the general population. The first behavioral and biological surveillance survey (BBSS) among FSWs carried out by the Ministry of Health and Social Welfare (MoHSW) ¹⁰⁰ reported HIV prevalence of 31.4% among FSWs in Dar es Salaam compared to 6.2% among women aged 15 – 49 years in Tanzania. The same BBSS also identified Hepatitis B and C infection prevalence at 6.3% and 2.3% respectively. Risk behaviours include inconsistent condom use, alcohol and drug use, multiple sex partners, and widespread sexual and physical abuse by partners which limits protective choices among FSW.

With high prevalence of HIV infection inconsistent condom use and high number of sexual partners, the potential spread of HIV to the wider community is of concern. The NMSF III (2013-2017) and HSHSP III (2013 – 2017) clearly acknowledge sex worker vulnerability and advocates for their access to friendly HIV preventive, care, treatment and social support services

2.4 Prisons

Global

Over 30 million men and women spend time in prison each year and nearly all return to their community within a few months to a year.¹⁰¹ Prisoners have higher prevalence of HIV, Hepatitis B and C, STIs and Tuberculosis (TB) infections compared to the general population: HIV prevalence among prisoners was 6-50 times higher than in the general population.¹⁰² Poor health among prisoners was closely associated with various behaviours prior to and during incarceration including unsafe injecting of drugs and unsafe sex.

Overcrowding and poor ventilation in prisons contribute towards TB infection.¹⁰³ Scarcity and illegality of needles inside prisons leads to the sharing of contaminated injecting equipment among PWID and this accelerates the spread of blood borne infections.¹⁰⁴ Drug use inside prisons is common with a substantial number of them entering with established drug dependency and habits. Other prisoners can be initiated into drug use to cope with stress in prisons.^{105 106 107}

MSM practices occur in prisons but denial by authorities, fear of being exposed or the criminalization of homosexual acts results in under reporting.¹⁰⁸ Unsafe sex among MSM inside prisons facilitates the spread of HIV infection.¹⁰⁹ Women prisoners are often more vulnerable to HIV infection and more susceptible to sexual exploitation as they may engage in sex for exchange for food, drugs, and toiletries hence increasing their vulnerability to HIV infection.^{110 111} In prison health services are generally poor, ill equipped, understaffed, or non-existent. Most prisoners have poor or no access to HIV and STI prevention commodities, treatment, care and support services are inadequate.^{112 113}

Sub-Saharan Africa

In many countries available data on HIV prevalence have been collected erratically and often only among prisoners who have been diagnosed with HIV or AIDS. HIV prevalence among prisoners in South Africa is 44%, compared to 25% among adults in the general population.¹¹⁴ In Mauritius it is 5%, almost 50 times the prevalence among the general adult population.¹¹⁵

Same sex behaviours are not uncommon but as MSM is illegal and a taboo topic among prisoners, prison officers and authorities under report this activity.¹¹⁶ MSM in prison has been reported in Nigeria (5.2%) and in Zambia (4%).¹¹⁷ Available data show a rise of injecting drugs in Cape Verde, Côte d'Ivoire, Guinea, Kenya, Mauritius, Nigeria, Senegal and United Republic of Tanzania.¹¹⁸ Additional risks include the sharing of self-made sharp objects for shaving, as well as tattooing and rituals that involve blood mixing, thus seriously increasing the risk of HIV and Hepatitis C infections.¹¹⁹ HIV or other infectious diseases prevention treatment and care services are largely not provided.¹²⁰

Tanzania

In line with the global context most Tanzanian prisoners are not isolated from their communities for lengthy period of times. Higher rates of HIV infection among prisoners are likely as they are directly related to high rates of HIV infection in the wider population as a whole. The prevalence of HIV in prisons at 6.7% is relatively higher than the national population HIV prevalence estimated at 5.3% in the 2011-2012 Tanzania HIV /AIDS and Malaria Indicator Survey. HIV prevalence among female inmates is significantly higher than the HIV prevalence among male inmates (14.7% versus 5.2%). This gender difference in HIV prevalence is similar to the trend observed in the general population. Moreover, the HIV prevalence among female inmates is more than twice as high when compared to the female prevalence in the general population (14.7% versus 6.2%). These findings are consistent with similar studies done in Uganda and Kenya. The overall prevalence rate of 6.7% suggests that 2,546 prison inmates of the estimated 38,000 total populations of prisoners are living with HIV and AIDS. The majority of prisoners are unaware of their HIV status as only approximately 710 prisoners are currently enrolled in comprehensive ART care in the entire Prisons Service.

On the same vein, other sources report that approximately 9.2% of Tanzanian prisoners are HIV positive ¹²¹ with one prison reporting 53.2% of prisoners exposed to HIV risk practices.

¹²²

Despite inadequate data it is suggested that prisons in Tanzania are likely to be similar to many other prisons in Africa. Unsafe sex is likely to occur as is the sharing of sharp objects, blades and injecting of drugs among prisoners. A study conducted in Dar es Salam found that among all drug using respondents 58% reported a drug-related arrest in the past 12 months and more than a third reported ever being imprisoned: 31% reported drug use inside prisons and 5% reported injecting drugs. ¹²³ While HIV prevention interventions inside Tanzania prisons are limited the National Policy on HIV/AIDS (2001) does state prison inmates have the right to basic HIV/AIDS information, voluntary counselling and testing care and treatment of STIs.¹²⁴

Chapter 3

Introduction

This section gives detailed explanation on the comprehensive packages of HIV and health interventions targeting all KP. The recommended package of interventions includes: HIV diagnosis, treatment and care (ART, PMTCT, drug-drug interactions, nutrition, PEP), prevention of sexual transmission (which includes comprehensive condom and lubricant programming), interventions aimed at reducing harm due to substance abuse (NSP, OST, other drug dependence treatment, opioid overdose management), behavioural interventions, sexual and reproductive health (STI management, contraception, conception and pregnancy, cervical screening, voluntary medical male circumcision) and prevention and management of co-infections and co-morbidities like tuberculosis, viral hepatitis mental health etc.

3.1 HIV Diagnosis, Prevention. Treatment, Care and Support

3.1 HIV testing and counseling

HIV Testing and Counselling is a service that allows persons to learn their HIV status and make informed decisions about their health, based on their HIV status. It includes a confidential dialogue between an HTC provider and an individual, couple or family.. Furthermore serves as an entry point for clients and patients into care, treatment, support services and reinforce HIV prevention efforts by providing clients and patients with key messages on risk reduction and behaviour change. The key components of all HTC services are pre-test session, HIV test, post-test session, linkage to follow-up services and on-going support. For KP HTC is most important as it can inform them of their HIV status, and if they are found to be positive, they can be guided towards HIV treatment and care

The three primary approaches to HTC services in Tanzania include:

- **Client-Initiated HIV Testing and Counselling (CITC)** mean that the client or couples are the one that seeks out for HTC and is available to all. The knowledge of one's HIV status, and the counselling that accompanies it, can be a powerful catalyst for behaviour change, particularly for HIV-positive people and persons in HIV discordant relationships.
- **Provider-Initiated HIV Testing and Counselling (PITC)** mean that HIV testing is offered to all patients including key population attending all health facilities, as part of routine health care services. The provision of PITC in health facilities can improve diagnosis and may identify persons living with HIV earlier in their stage of disease, ultimately saving lives. The PITC services is used in generalized HIV epidemics
- **Home-Based HIV Testing and Counselling (HBTC)** bring HTC services into the home. Services are initiated by HTC providers who may go from house to house in a community, or who may target specific homes of clients or patients who voluntarily consent to have

the provider offer testing to their family members. By bringing HTC to communities and households, home-based HTC aims to increase uptake of this important intervention. The HBHTC compliments facility-based HTC. The community-based HTC is actively promoted in a community setting, and ensuring a fast linkage to care and treatment for those diagnosed as HIV infected.

For reasons that include stigma, discrimination and illegal behaviours many KP can be reluctant to utilize facility-based services. Studies conducted to compare community-based HTC with facility-based in generalized epidemics found that overall community-based HTC increased rates of people testing for the first time but the frequency of positive tests were higher in facility-based health settings. ¹²⁵

In line with national and international standards for health care service delivery and human rights principles, HIV testing and counselling (HTC) services shall be conducted with the best interests of clients and patients in mind, and shall respond to the needs and risks of clients and patients. In view of that, all HTC services must adhere to the following five core principles of HTC: **Confidential**, meaning that anything discussed between the client(s) or patient(s) and the HTC provider may not be shared with another person, unless the client(s) or patient(s) explicitly give consent to share this information. Exceptions to these terms of confidentiality are described in the Comprehensive guidelines for HTC; HTC services must include accurate and sufficient Pre and Post-test **Counselling**: may give their explicit and voluntary informed **Consent** to receive services; ensure provision of **Correct HIV test results** to clients and patients; Clients and patients are **Connected** with appropriate follow-up services following HTC, including prevention, care, treatment, support and other clinical services, as well as non-clinical services within the community.

Despite high risk behaviours and increased vulnerabilities KP test may be irregularly or not at all. A study among drug users in Dar es Salaam showed 70% of females and 43% of males had ever been previously tested for HIV, and among these only half reported that their last test was in the past two years. ¹²⁶

Whether HTC is facility-based or community-based the risk of stigma towards KP can increase. The ability of HTC providers to manage specific issues that concern KP always need to be carefully considered and appropriately managed.¹²⁷ The HTC service provider needs to ensure quality services, be inclusive and non-discriminatory and then acceptability and feasibility for all KP.

Role of health care workers in reducing stigma

It is the responsibility of all health care workers to abide by policies and procedures that protect clients from discrimination in healthcare facilities. Client's confidentiality should be maintained at all times. Facilities should have procedures in place for reporting discrimination. Healthcare workers should familiarize themselves with the relevant sections of the *National HIV and AIDS (Control and Prevention) Act of 2008*. See Part VII of the Act (Include appendix for this Act)

Healthcare workers and stigma

When HCWs deliver services to KP, they need to be aware of the scope and intensity of stigma suffered by KPs. More importantly, they should be acutely aware of their own stigmatizing attitudes and behaviours towards KPs. Healthcare workers, family members and community members may simultaneously express both sympathetic and stigmatizing attitudes towards KPs. Frequently, it is the fear of acquiring HIV through occupational exposure or of being stigmatized because of their risk behaviours which associated with HIV risks that causes an HCW to have negative attitudes towards KPs.

Key messages: All KP

- Provide community-based HIV testing and counseling (HTC) to improve access of testing to KPs
- Refer KP who has accessed HTC to programs offering HIV prevention, care, treatment and support services.
- Encourage KP to retest for HIV every 6 months.
- Train HTC service providers on how to provide HTC to KP without stigma and discrimination.
- Offer HTC for intimate partners of those associated with KP.
- HTC Counsellors shall assess high risk behaviours and if they are engaged in high risk behaviours, conduct appropriate risk reduction counselling and refer for follow-up services.
- HTC providers shall provide high-quality, confidential, non-judgemental, and non-coercive services that are friendly to KP at higher risk of HIV exposure.
- Prisoners shall be offered voluntary HTC as part of all regular medical care, and specifically when they are showing signs or symptoms of underlying HIV infection.
- HTC provider shall conduct HTC when person makes an informed decision and explicitly agrees to be tested.
- Community home based care providers shall engage with KP and alert them of mobile HTC services in their community.

Recommended guides on HIV testing and counseling see Annex 1

3.2 HIV, treatment, support and care

3.2.1 Antiretroviral therapy

Antiretroviral therapy (ART) is the key management of HIV infection. ART is highly effective in delaying the onset of AIDS and shown to decrease morbidity and mortality among HIV infected population ART is a biomedical intervention and consequently sexual orientation or identity play minimal or no role at all on expected effects and thus appropriate for all KP. KPs can successfully receive antiretroviral treatment and get the same benefits as other persons on ART.^{128 129} Many believe HIV infected PWID will be poor candidates for ART due to a perception they will not be adherent to the medicines but with tailored HIV care for PWID the provision of ART can be successful.¹³⁰ Survival among PLHIV initiating ART with and without history of drug injecting does not differ.¹³¹ For PWID receiving Opioid Substitution Therapy (OST), treatment outcomes improve as does adherence.¹³²

Providing ART to sex workers is as feasible and effective as with the general population and their treatment outcomes are generally good. Increasing CD4 counts can be maintained in sex workers,¹³³ and available evidence does not show increased in high-risk sexual behaviour.

134

According to the National Guidelines on Management the use of ART for treating and preventing HIV infection has been more simplified.¹³⁵ The guidelines provide a recommended framework when to start ART in PLHIV, what first line ART regimens to start, issues of co-infection, monitoring ART response and diagnosis of treatment failure, and second line ART. KP should be given ART as per the national guidelines.

KEY MESSAGES: All KP

- Healthcare providers **should** initiate ART to all KPs as per National Guidelines.
- As a priority, healthcare providers shall give or refer Opioid Dependent PWID to MAT when/where accessible and available
 - Opioid Dependent PWID (and non-injecting Opioid users) living with HIV, and in need of ART have better outcomes and improved adherence to ART when on Medically Assisted Treatment (MAT).
- Healthcare providers shall closely monitor Opioid Dependent PWIDS (and non-injecting Opioid users) on ART accessing MAT due to drug interactions.
- Healthcare providers serving KP should observe and adhere to ethical conduct and confidentiality in line with their professions.
- Healthcare providers serving KP shall support equitable access to ART for KP and their treatment as part of the comprehensive care treatment and support approach.
- Healthcare providers within prison settings shall develop a discharge plan that links community care for prisoners living with HIV upon release or important gains in health status could be lost.
- Healthcare providers shall link HIV infected KPs with home based care providers.
- Healthcare providers shall initiate ART to KP with HIV and HBV co-infection regardless of CD4 counts.
- Healthcare providers shall provide ART among people co-infected with HCV as in HIV mono-infection.
- Healthcare providers shall provide ART using current regimes in those co-infected with HIV and HCV or HBV, with the exception that nevirapine and efavirenz be avoided if possible and liver function test monitored closely.
- ART can be used safely and effectively using current regimes in those co-infected with HIV and HCV, with the exception that nevirapine be avoided if possible and liver function test are monitored closely.
- Optimized ART regimen (Tenofovir/Lamivudine/Efavirenz) should be initiated in all individuals with HIV and HBV co-infection regardless of WHO HIV clinical stage or CD4 cell count if there is evidence of severe chronic liver disease.

Recommended guides on antiretroviral therapy see Annex 1.

3.2.2. Post-exposure prophylaxis for risky sexual and occupational exposure to HIV

Post-exposure prophylaxis (PEP) is a short term ART regime of 28 days for KP with possible risk of HIV infection. Taking PEP reduces the likelihood of acquiring HIV infection following potential exposure as a result of occupation (such as needle stick injury) or through sexual intercourse. The first dose should be taken as soon as possible and at least 72 hours after exposure. PEP has been recommended to be used in cases of sexual assault.¹³⁶ Sexual violence is not commonly just confined to those involved in sex work but also among female injecting drug users and prisoners. Sexual violence inside prisons or closed settings is a reality and involves a range of sexually coercive (non-consensual) behaviours that can include sexual assault and rape.¹³⁷ ¹³⁸ Overtly violent rapes are the most visible and dramatic but many sexually violent episodes involve prisoners that have engaged in sexual acts against their will, and commonly report they had no choice.¹³⁹

KEY MESSAGES: Sex workers, female drug users, prisoners.

- Healthcare providers shall provide women, men and transgender people presenting within 72 hours of an episode of HIV exposure with HIV PEP as per the National guideline.
- Healthcare providers will initiate shared consenting and decision-making with KP survivor of sexual violence or staff member in prison health facility to determine whether HIV post-exposure prophylaxis is appropriate
- Healthcare providers shall be train/retrained and sensitized about HIV PEP
- Healthcare providers shall be made aware on stigma so as to offer services free of stigma and prejudice for all KP survivors of sexual violence or staff member in prison health facility coming forward for HIV PEP.

Recommended guides on sexual violence and post-exposure prophylaxis see Annex 1. (include Tanzania SV management guidance document)

3.2.3 Prevention of mother-to-child transmission of HIV

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

KEY MESSAGE: Female prisoners, sex workers and drug users

1. Health care providers shall implement the full range of PMTCT interventions for female KPs as per national guidelines for comprehensive care services for prevention of mother to child transmission of HIV and keeping mothers healthy.
2. Prison health care providers shall offer any child born to a mother living with HIV in prison appropriate PMTCT follow up services.

Recommended guides on prevention of mother-to-child transmission of HIV see Annex 1

3.2.4 Other prevention and care interventions for KP living with HIV

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

1) Psychosocial counseling and support	2) Vaccination for selected vaccine-preventable diseases (Hepatitis B, pneumococcal, Influenza and Yellow Fever Vaccines)
3) Disclosure, partner notification, and testing and counseling	4) Nutrition
5) Co-trimoxazole prophylaxis for opportunistic infections	6) Family planning
7) Tuberculosis prophylaxis	8) Preventing mother-to-child transmission of HIV
9) Prevention of fungal infections	10) NSPs and OST
11) Prevention of sexually transmitted and other reproductive tract infections	12) Water, sanitation and hygiene
13) Prevention of malaria	
KEY MESSAGES: All KP	
<ul style="list-style-type: none"> • KP living with HIV should have access to HIV prevention, care, treatment, and support services as it is to the general population. 	
Recommended guides on HIV prevention, treatment care and support interventions see Annex 1	

3.3. Needle and syringe programmes

Needle and syringe programmes (NSPs) distribute free sterile injecting equipment to PWID which facilitate the use of clean needles and syringes (N/S) and reduces the risk of blood borne infection. There is compelling evidence that implementing NSPs contributes substantially to reductions in HIV prevalence and incidence. NSPs have shown to be an important contact point with other health services, which can then facilitate access to drug dependence treatment, HIV treatment care and support, tuberculosis treatment, primary health care and other welfare services. NSPs also offer other injecting paraphernalia such as alcohol swabs, vials of sterile water, filters, and tourniquets. NSPs encourage safe disposal of used injecting equipment by providing puncture proof containers.¹⁴⁰ NSPs provide condoms, information and education on safer sex practices as well as safer injecting. Some of the other health services and linkages include: guidance towards Opioid Substitution Therapy (OST); HIV testing and counseling (HTC) and testing for viral hepatitis; antiretroviral therapy (ART) treatment and care; prevention and treatment of sexually transmitted infections (STI) services.

KEY MESSAGES: PWUD/PWID

- Conduct advocacy with various sectors and local community to ensure a supportive and enabling environment to allow full functioning of NSPs.
- Distribute N/S which suit the local context.
- NSP services shall be linked with health service and serve as an important point of entry to receive other services including MAT, HTC, ART, STI, TB and psychosocial services.
- Provide condom and information, education and communication materials.
- Provided puncture-proof safe disposal containers to encourage and facilitate safe disposal by receiving used syringes.
- Provide clean syringes irrespective of if PWID has returned used syringes.
- N/S distribution should be included in all hot spots and outreach programs

Recommended guides on NSPs see Annex 1

3.4 Medically assisted treatment, and other evidence –based drug dependence treatment

For PWUD/PWID who are Opioid Dependent, Medically Assisted Treatment, (MAT) as maintenance, is highly effective in the reduction of opiate use, injecting behaviours, risks of HIV and HCV and improved retention in treatment.^{141 142 143} Methadone is a synthetic Opioid used to treat heroin and other Opioid dependence. It reduces Opioid withdrawal symptoms and the euphoric effect when Opioids are used. Methadone is taken orally on a daily basis and is most effective when it is provided at adequate dose and for sufficient duration. For those that are HIV infected and/or have tuberculosis access and adherence to ART and TB treatment improves and there is also a reduction in mortality.¹⁴⁴ For those with opportunistic infections as a result of HIV infection MAT can also assist them to adhere to other specific medicines to keep people healthy. MAT has also shown to reduce criminality¹⁴⁵, improve psychosocial outcomes¹⁴⁶ as well as decreased risk to pregnant women dependent upon drugs.¹⁴⁷ Methadone and buprenorphine, both listed as essential medicines by WHO are the most commonly used Opioid agonists.¹⁴⁸

MAT should be available and accessible for the prisoners. Whilst the smoking of opiates has far less HIV risk factors, the transition to injecting has considerable risk of HIV infection when PWID do not use clean N/S and the potential for sharing injecting equipment increases. A recent study in Dar es Salaam found that the transition to injection is an ongoing process among heroin smokers and increasingly users are compelled to adopt injection as primary route of administration. Most drug users are initiated to heroin through smoking but it has been noted younger heroin users are appearing to be more frequently being initiated to heroin directly through injection.¹⁴⁹ MAT for opiate smokers has merit to halt this transition to injecting.

Behavioural interventions such as psychosocial therapy are commonly provided and can be useful.

KEY MESSAGES: PWUD/PWID and all other KP that are Opioid Dependent.

- Provide MAT to all Opioid Dependent users at risk of HIV Healthcare providerHealthcare providers shall support voluntary cessation of MAT only after stabilization of client Healthcare providers shall prescribe methadone for pregnant women who are Opioid Dependent
- MAT should be free of charge in line with National Mental Health Act (2008)
- Health care providers shall monitor closely PWUD/PWID on methadone who are also on medications for HIV and tuberculosis as they can interact with MAT as a result dose adjustments are accordingly recommended
- Prisoners who were enrolled on MAT prior to their incarceration shall continue receiving MAT and a coordinating system should be established to allow this to happen.
- Upon release from prison, prison healthcare providers shall refer prisoners to existing MAT services in their communities

Recommended guides on drug dependence treatment see Annex 1.

3.5 Managing common infections, co-infections and co-morbidities

3.5.1 Management of symptomatic STI/RTIs

Sexually Transmitted Infections (STIs) continue to remain a major public health concern: STIs comprise of a range of infections (viruses, bacteria, fungi) predominantly transmitted through unprotected sexual contact with an infected person. Failure to treat STIs can lead to various health complications and they have also been found to increase the sexual transmission and acquisition of HIV infection. ¹⁵⁰IBBSS Studies done in Tanzania among FSWs has showing high prevalence of STIs which is estimated to an average of 26% in 2010 and an average of 38% for Herpes Simplex in 2013.

Syndromic approach is a cost effective intervention for management of STI/RTIs focuses on identification of symptoms and signs. Majority of STIs present with symptoms that include urethral discharge, dysuria, genital ulcer/s, vaginal discharge and lower abdominal pain. Among Key population the management of STI/RTIs will focus on all STIs syndromes including anorectal-related syndromes.

Common STI/RTIs syndrome

STI SYNDROME	SEX	AETIOLOGIC AGENTS
Urethral Discharge Syndrome (UDS)	Male	<i>Chlamydia trachomatis</i> <i>Neisseria gonorrhoea</i>
Painful Scrotal Swelling (PSS) (acute epididymoorchitis)	Male	<i>Chlamydia trachomatis</i> <i>Neisseria gonorrhoea</i>
Vaginal Discharge Syndrome (VDS)	Female	<i>Candida albicans</i> <i>Chlamydia trachomatis</i> <i>Gardnerella vaginalis</i> <i>Neisseria gonorrhoea</i> <i>Trichomonas vaginalis</i>
Pelvic Inflammatory Disease (PID) (Lower Abdominal Pain)	Female	<i>Anaerobic bacteria</i> <i>Chlamydia trachomatis</i> <i>Neisseria gonorrhoea</i>
Genital Ulcer Disease (GUD)	Male and Female	<i>Chlamydia trachomatis</i> <i>Haemophilus ducreyi</i> Herpes simplex virus type-2 <i>Treponema pallidum</i> <i>Klebsiella granulomatis</i>
Inguinal Bubos	Male and Female	<i>Chlamydia trachomatis</i> <i>Haemophilus ducreyi</i>
Neo-natal Conjunctivitis (Ophthalmia neonatorum)	Newborns Males and Females	<i>Neisseria gonorrhoea</i> <i>Chlamydia trachomatis</i>

KEY MESSAGES: All KP

1. KPs with symptomatic STI/RTIs should be properly examined including anal and oral examination for those practicing anal and/or oral sex and treatment provided according to national guidance for the syndromic management approach. Examination of KPs will not be complete without anorectal examinations
2. Community-based interventions help to ensure that the benefits of interventions for STI/RTIs management are sustained and risk of reinfection is minimized.
3. Training is required for health-care workers to deal with STI/RTIs among KPs
4. KP related health care issues should be integrated in pre-service training curricula for various cadres of service providers
5. KP friendly services should be provided for successful management of STI/RTIs.
6. Healthcare providers should be respectful and sensitized to the need of patients and to be non-judgmental.
7. Health care providers should provide active referral and linkages and integrate services to facilitate access to comprehensive health care for KP who have STI/RTIs.
8. Healthcare providers should need to counsel KPs with STI/RTIs and their clients on compliance with treatment, risk reduction, and condom use.
9. Healthcare providers should give follow-up appointments for re-assessment for all STI/RTI syndromes.
10. KP women with lower abdominal pain, who have fever, missed period, abnormal vaginal bleeding, recent delivery, miscarriage or abortion should be referred to in-patient department.
11. Neonates with ophthalmia neonatorum should be re-examined 3 days after starting treatment and their parents should be treated for discharge syndrome
12. Healthcare providers should offer KPs with STI/RTIs and their clients counseling and testing for HIV infection

Flow charts for STI management see Annex 1

3.5.2 Screening for asymptomatic STI

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

151.

A systematic evidence review was conducted to assess if screening of female sex workers using laboratory tests is effective to reduce incidence and prevalence of STIs. The results overall were positive with a rapid decline and consistent reductions in the prevalence of syphilis, gonorrhoea and chlamydia infections.

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

High prevalence of syphilis has been identified among MSM and transgender people and the rates among MSM have been increasing in several countries, particularly among HIV infected MSM. ¹⁵²

KEY MESSAGES: All KPs

1. Provide periodic screening for asymptomatic STIs, particularly Syphilis, *T. vaginalis*, *N. gonorrhoea* and *C. trachomatis*, among KP
2. STI screening should not be coercive or mandatory.
3. Presumptive treatment *should be offered to survivors of sexual violence*.
4. Community-based interventions should be developed to ensure that the benefits of interventions for STI/RTIs management are sustained and risk of reinfection is minimized.
5. Training is required for health-care workers to deal with STI/RTIs among KPs
6. KP related health care issues should be integrated in pre-service training curricula for various cadres of service providers
7. KP friendly services shall be provided for successful management of STI/RTIs.
8. Healthcare providers shall be respectful and sensitized to the need of patients and to be non-judgmental.
9. Healthcare providers shall provide active referral and linkages and integrate services to facilitate access to comprehensive health care for KP who have STI/RTIs.
10. Healthcare providers shall counsel KPs with STI/RTIs and their clients on compliance with treatment, risk reduction, and condom use.
11. Healthcare providers shall give follow-up appointments for re-assessment for all STI/RTI syndromes.
12. Women with lower abdominal pain, who have fever, missed period, abnormal vaginal bleeding, recent delivery, miscarriage or abortion should be referred to in-patient department.
13. Neonates with ophthalmia neonatorum should be re-examined 3 days after starting treatment and their parents should be treated for discharge syndrome
14. Healthcare providers shall offer KPs with STI/RTIs and their clients counseling and testing for HIV infection

Flow charts for STI management see Annex 1

3.5.3 Prevention, diagnosis and treatment for viral Hepatitis

While the primary focus is on HIV, it is important to include other major blood borne viruses such as Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) in comprehensive prevention HIV care and treatment. It is estimated that globally 10 million PWID have been exposed to HCV as per presence of HCV antibody and 8 million have chronic infection. ¹⁵³ This is far greater than those PWID infected with HIV which is estimated to be 3 million. Globally an estimated up to 90% of new HCV infections were linked to injecting drug use and majority were found in low and middle income countries. ^{154 155} HCV co-infection is common among PWID who are also infected with HIV. ¹⁵⁶ In Dar es Salaam a recent study among PWID show that HCV antibody positive (indicating past exposure but not confirmed current infection) at 28% prevalence, and that co-infection (HIV and HCV) was 17% overall. ¹⁵⁷ Co infection of

HIV and HCV is of concern due the fact that HIV accelerates HCV-related disease progression and mortality.

An estimated 1.2 million PWID live with chronic HBV as shown by hepatitis B surface antigen (HBsAg). A further 6.4 million PWID that have been exposed to the HBV: positive to hepatitis B core antibody (HBcAb).¹⁵⁸ Globally among MSM and transgender people there is higher risk of HBV: reports of HBV prevalence of 8%¹⁵⁹ and 13.3%¹⁶⁰ have been found. Sex work and risky sexual practices are also associated with HBV infection in different regions of the world.^{161 162} High HBV positive tests are found among male, transgender people and female sex workers at rates of 22%, 40% and 52% respectively.^{163 164} Among female sex workers in Dar es Salaam, Tanzania HBV positive tests were 6.3%.¹⁶⁵

Among those chronically infected with HBV and/or HCV there is risk of various illnesses and for some death which is primarily due to liver cirrhosis and hepatocellular cancer.¹⁶⁶ Hepatitis B vaccine is 95% effective in preventing HBV infection and medical consequences. There is no vaccine for HCV and while there is treatment it is mostly prohibitively expensive for most people to afford in low and middle income countries.

Key messages: All KP

1. Community program as well as health facility staff should create awareness of HVB and HVC prevention with all KP.
2. Key population with active HBV or HCV infection should receive treatment according to available and affordable treatment regimens.
3. Rapid HBV vaccination shall be offered to KP at risk of HBV infection.
4. HBV vaccine should be offered to any KP who has experienced sexual violence within 14 days of event.

Recommended guides on prevention, diagnosis & treatment of viral hepatitis see Annex 1.

3.5.5 Prevention, Diagnosis and Treatment of Tuberculosis

Tuberculosis (TB) remains a leading killer of people with HIV. People living with HIV and infected with TB are 20 to 40 times more likely to develop active TB compared to people not infected with HIV living in the same country.¹⁶⁷ PWUD/PWID and prisoners are highly vulnerable to TB. Tuberculosis (TB) is reported to be up to 30-100 times more common in prison than in the wider community. Of increasing concern is that the prevalence of multidrug-resistant TB can be up to 10 times higher inside prisons. A combination of late diagnosis and treatment of infectious cases as well as overcrowding and poor ventilation has resulted in TB as a major cause of sickness and death in prisons.^{168 169}

Key Messages: All KP

1. Prisons health facilities shall intensify active case-finding, provide isoniazid prevention therapy and provide effective tuberculosis (TB) prevention and control measures in line with national guidelines.
2. Community programme and health facility staff should be sensitized PWID and prisoners on their risk to TB and of the importance to have regular screenings.
3. Facilities providing services to PWID, as well as in institutions such as closed settings and prisons should implement a National TB control strategy
4. Facilities providing services to PWID, as well as in institutions such as closed settings and prisons should implement case-finding for both TB and HIV. ¹⁷⁰ .
5. KP living with HIV should be screened for TB and KP with TB should be encouraged and advised to have HIV test.
6. KP living with HIV but without symptoms of active TB (no current cough, fever, weight loss or night sweats) should be offered isoniazid prevention therapy.
7. In all KPs with HIV and active TB regardless of CD4 count should start anti-TB treatment immediately and then ART within the first 2 weeks.
8. Prisoners should be screened for TB symptoms using standard TB screening questions upon entry into prisons, and every 6 – 12 months thereafter.
9. Prisoners with active pulmonary TB should be segregated until they are no longer infectious.
10. TB patients should be made to avoid overcrowding to be and ensure spaces are well ventilated and have natural light.
11. PWUD/PWIDs should have equitable non-stigmatizing and non-discriminatory access to the full range of TB services through a well-integrated and coordinated means that links them to HIV prevention, care and treatment as well as drug dependence treatment.
12. Specific adherence support measures for PWID on TB medicines should include drug observed therapy; linkage to MAT, adherence counselling; and adherence reminders by service providers and by peers and outreach workers.

Recommended guides on prevention, diagnosis and treatment of tuberculosis see Annex 1

3.6 Voluntary medical male circumcision

Research has found male circumcision when conducted by well-trained medical professionals does reduce the risk of female to male HIV transmission by half. ^{171 172 173} It is acknowledged that additional studies are required to measure and compare the effectiveness of adult male circumcision to prevent HIV and STI among MSM that practice insertive and receptive anal sex. Circumcision should be provided to MSM who request for it, unless there are contraindications, as part of comprehensive package for HIV prevention.

KEY MESSAGES: All male KPs

- Healthcare providers should offer voluntary medical male circumcision to MSM as per the standard HIV intervention offered to other men.
- Healthcare providers should offer circumcision as a complimentary HIV preventative measure.

3.7 Social Behavioural Change Communication Interventions for HIV prevention

3.7.1 Information, education and communication/Social Behavior Change Communication

Information, Education and Communication (IEC) and Social Behavior Change Communication (SBCC) is an important component of the package and when combined with other interventions, such as condom promotion or the provision of sterile needle and syringe for PWID, can successfully assist and sustain positive change in the reduction of HIV risk behaviours.¹⁷⁴ Among drug users, IEC/SBCC on overdose prevention is particularly important as it has become a major cause of death and this is more so with PWID/PWUD. It is not only how to prevent an overdose but how to respond in a situation where drug overdoses occur. In this situation, training on resuscitation can be expanded beyond drug users and can include family members, partners and peers. IEC/SBCC needs to be developed to suit the local context and be appropriate to match the needs of KP. Raising awareness about HIV, STI, and other key health issues need to be routinely provided and repeated to maintain the benefits of conveyed messages. IEC/SBCC should be effective when presented as factual, non-judgmental and accessible in various formats. Worldwide more people are increasingly accessing Information and Communication Technology (ICT) for health information. ICT includes internet, mobile phones, and other social media tools such as tweeter and Facebook. ICT has made it easier for KP with ICT access, to receive HIV prevention interventions, anonymously, in private and at a time convenient for them. Despite the need for more rigorous evidence, ICT accessibility is likely to increase and becomes a major source of information. Targeted ICT based strategies increase validity for KP. Research shows social marketing does change or promote health behaviours on a wide variety of health issues, with different populations and in diverse settings.^{175 176 177} There is support that social marketing strategies, framed within a comprehensive package of interventions, used to increase the uptake of HIV and STI testing and counseling, HIV services among MSM and TG people also may be possible for other KP.

Key Messages: All KP

- IEC for KP shall be framed within a comprehensive package of interventions for prevention and treatment of HIV and STI
- Individual and community-level behavioural interventions, social marketing and innovations should be linked to information and communication technology and can be included as part of the comprehensive package.
- Involve KP groups in message design, piloting as well as using peer educators and outreach to assist in disseminating messages.
- Key Population IEC shall be integrated into the overall HIV and AIDS prevention, treatment and care programmes

3.7.2 Comprehensive Condom Programming

Consistent and correct use of a male or female condom during vaginal and anal sex reduces sexual transmission of HIV and STIs. Increasing the availability, accessibility, affordability and use of male and female condoms and condom-compatible lubricants among people from key populations through targeted distribution programmes is an essential component of the HIV response.

Key Messages: All KPs

- Advocate for wide accessibility, availability and affordability of male and female condoms
- Promote messages on consistent and correct use of condoms lubricants for all KP and their sexual partners or clients
- Healthcare providers should inform all KP of the correct and consistent use of condoms with water –based lubricants for safer sex
- Healthcare providers should conduct condom demonstrations with all KPs accessing any HIV and STI services.
- Peer educators should promote and distribute condoms, and report on the progress and challenges.
- Health care providers should advocate for correct and consistent use of condoms with condom-compatible lubricants to all key populations to prevent sexual transmission of HIV and STIs

Recommended guides on condom programming see Annex 1.

3.8 Complimentary interventions

3.8.1 Outreach and Peer Education

Community based outreach and peer education are viewed as a modality for delivering specific services and recommended as components of HIV prevention, treatment and care programmes. Outreach and peer education are effective when KPs are involved in the planning. Community outreach and peer education can be an opportunity for KP to access health services. Outreach workers and peer educators should facilitate the process to guide and link KP to drop-in-centres and other services that have been sensitized to their needs.

Key Message: All KP

- Provide and link KPs into community based outreach services and peer education Outreach workers and peer educators should deliver a set of comprehensive and integrated services including distribution of needles, syringes, condoms, water-based lubricants and IEC materials.

Outreach workers and peer educators should work closely with home-based care service providers **Recommended guides on outreach work and peer education see Annex 1.**

3.8.2 Rehabilitation Services

Stigma and discrimination towards PWUD/PWID is high and society can often be unforgiving towards former PWUD/PWID that have abstained from using drugs making reintegration back to society a challenge Offering employment and vocational educational opportunities to PWUD/PWID is associated with improved treatment outcomes.¹⁷⁸ Adequate family support and absence of other mental illness are also associated with good outcomes. The rehabilitation needs of those struggling with drug dependence and undergoing recovery are unique. Innovation and a tailor-made approach result in successful outcomes.^{179 180} Being a KP is commonly associated with socially and economically disadvantaged backgrounds, in which education and employment opportunities may have been hampered.

Key message: All KP

- Ensure linkage to other multi-sectoral engagement for Income Generating Activities (IGA), livelihoods options, occupational therapy and rehabilitation services to assist socially and economically disadvantaged KP to become meaningfully employed
- Provide linkage and assist KPs with their re-integration back to the family and wider community.
- Provide referral to active drug users for rehabilitation services if they show interest and commitment
- Provide KPs linkage to organizations working on microcredit programmes and small business ventures so as to provide appropriate capabilities and support their needs

Recommended guides on vocational education see Annex 1.

3.8.3 Interventions for Women who use and inject drugs (WWUD/WWID)

The Comprehensive Package for PWUD/PWID does address key HIV prevention interventions including for Women Who Use and Inject Drugs (WWUD/WWID). Yet as a result of the extreme vulnerability to HIV among women drug users, special attention and additional assistance is required. In Dar es Salaam HIV prevalence among WWID reached is 68%, the highest of any key population.¹⁸¹ WWUD/WWID face more stigma, discrimination, marginalization, and are more hidden compared to their male counter- parts largely on the basis of drug use and gender.¹⁸² For WWUD/WWID it is common for them to be viewed as 'bad' women and if they have children, unfit to be mothers.¹⁸³ Women are more likely than men to finance their drug use, including their steady sexual partners, through selling sex. Some engage in transactional sex for protection, housing, food, and other support.¹⁸⁴ High rates of gender based violence; harassment and exploitation of women who use drugs and engage in survival sex work have been extensively documented.¹⁸⁵ Women, more so than

men, are commonly initiated into drug use by a sexual partner, and in this context can impact upon a women's autonomy in modifying drug using behaviour.¹⁸⁶ As services for PWID are largely male centric (majority of drug users are male) most women drug users are reluctant to access services including drug treatment in part because of shame and embarrassment, but also services do not address their gender-specific and broad ranging needs.¹⁸⁷

Key message: All women KP

- Provide access to range of gender-specific harm reduction interventions for WWID/WWUD
- WWID/WWUD should be provided with linkage to: gynecology and reproductive care; pregnancy care; cervical screening; prevention of mother-to-child transmission of HIV; motherhood and childcare support and; gender based violence support in line with the National guidance documents.
- Provide linkage to either harm reduction interventions or by offering on-site services through referral service.

Recommended guides on women who inject drugs see Annex 1.

3.8.4 Mental Health and Substance Use

Research has found that many of those from KP experience problems with alcohol and substance use or dependence.¹⁸⁸ The harmful use of alcohol and various substances is closely associated with decreased ability to keep HIV/STI prevention practices and measures in mind due to sexual disinhibition.¹⁸⁹ The risk of HIV infection can also arise due to the selling of sex to ensure supply of drugs.¹⁹⁰ Some recommendations outlined by World Health Organization Mental Health Gap Action Programme for specific interventions for prevention and management of harmful and dependent substance use includes:

- Trained primary health care workers screen and offer brief interventions including psychosocial support for those with harmful substance use
- Medically assisted treatment for those that are Opioid Dependent
- Needle and syringe programmes
- Detoxification and assistance to prevent relapse
- Referral and guided support to a specialist in substance dependence

Key Messages: All KPs

1. Community programme and health facility staff should refer to primary health mental services all KP that have harmful alcohol and substance use for evidence based psychosocial interventions, including assessment, specific feedback and advice.
2. Community programme and health facility staff jointly offer all KP that inject drugs needle and syringes or link them with needle syringe programmes in the community.
3. Healthcare providers should offer all Opioid dependant KPs treatment with MAT where available.
4. Healthcare providers should identify and manage dual diagnosis of depression and substance use irrespective of KPs HIV status.
5. Healthcare providers enrolling opioid users into MAT programme should appropriately screen them for other mental health conditions.
6. Healthcare providers offering MAT need to evaluate KPs concurrent treatment in relation to adherence to ART as well as for drug interactions.

Recommended guides on mental health and substance use see Annex 1

3.8.5 Prevention of transmission through medical, dental, shaving, tattooing, piercing and other forms of penetration

Prisoners do have higher prevalence of HIV and other blood borne infections compared to the wider community. As a result it is critically important to ensure caution is taken during medical and dental procedures to minimize the risk of blood borne infections by following standards. Tattooing and body piercing are often prohibited inside prisons although commonly practiced. Tattooing, body piercing and sharing of shaving blades is associated with the risk of acquiring HIV, hepatitis B and C virus and Tetanus infections.

Key Message: Prisoners and staff responsible for prisoners

- IPC should be incorporated into prison health facilities appropriately and adequately
Prison authorities should promote awareness among prisoners to reduce the sharing and reuse of equipment used for shaving, tattooing, piercing and other forms of skin penetration.

Recommended guide to prevention of transmission through medical, dental, tattooing and body piercing see Annex 1

3.8.6 Protecting prisoners and prison staff from occupational hazards

Prisoners and prison staff shall receive HIV prevention, Care, treatment and support services. Apart from information and education sessions prison staff will require training on how to conduct their work in a safe and healthy manner to minimize occupational hazards.

Key message: Prison staff responsible for prisoners

- 1) Prison health staff should be provided with free Hepatitis B vaccinations. ???
- 2) Prison health staff should have access to appropriate post-exposure prophylaxis and counseling if and when required.

Recommended guide to protecting staff from occupational hazards see Annex 1

3.9 Community empowerment and Social Mobilization

Community empowerment and social mobilization evolves as a collective, social action process and is critically important for KP. An important part of the process of community mobilization is helping community members overcome their sense of isolation, identify with one another, and build social ties based on their shared experiences and progress towards empowerment.¹⁹¹ Sex workers have commonly used this intervention with good effect to tackle the structural constraints of health, human rights and well being. Community empowerment is more likely to produce better outcomes compared to programmes that exclusively target individual risk of KPs. The overall aim is to create social and behavioural changes to improve access to health services, reduce the risk of becoming HIV infected and overall improve quality of life. The advantages of community empowerment may reduce the underlying conditions of vulnerability faced by KPs, and lessen the risks of becoming HIV infected.^{192 193 194 195}

A range of interventions delivered as a result of community mobilization and empowerment can include: raised awareness of KPs right to health through the process of ongoing engagement with KPs; drop-in centres established specifically for KPs and an opportunity to determine the types of services required to match their needs and in the local context. Community empowerment and mobilization allows for the establishment of a safer environment, increased solidarity and a strengthening of advocacy efforts. Improving living conditions of KP, strengthening strategies for the right to health and redressing violations of human rights are regarded as critically important.

Community empowerment and mobilization provides the opportunity that can encourage and support behaviour change, such as the community norms around safer sex behaviours which in turn ensures their contribution in the response to HIV in their community.¹⁹⁶ To drug users, community mobilization and empowerment has globally grown in strength despite the many challenges. Previously drug user organizations were rare, but currently their networks and communities are found in all regions of the world including sub-Saharan Africa.^{197 198} Community mobilization and empowerment led to the emergence of drug user networks which have significantly contributed to the development of a comprehensive package that is widely understood as the harm reduction approach.

Key Messages: All KP

1. Develop and implement a context specific KP package of interventions to enhance community empowerment for KP needs.
2. Ensure ongoing engagement to raise awareness of public health rights, creating community led drop-in centres, establishing collectives that determine the types of services needed, conducting outreach and advocacy.
3. Community empowerment should need to utilize peer networks
4. Community empowerment should be provided with available resources in the community

3.10 Comprehensive Package of HIV Interventions for KP

Globally there has been increasing advocacy for the inclusion of good practice recommendations in response to health and social needs of KP at high risk and vulnerable to HIV infection. Good practice is not derived from scientific evidence but from a range of international agreements on human rights, ethics, common sense and the right to health.¹⁹⁹ Good practice recommendations are of high importance due to the widespread hostility, stigma, discrimination, and criminalized behaviour that adversely impact upon KP.

3.10.1 People Who Use and Inject Drugs (PWUD/ PWID)

Stigma, discrimination and open hostility towards PWID (including people who use drugs) is a significant problem globally. It is important to emphasize that human rights law apply to everyone including PWID.²⁰⁰ Protecting the rights of PWID is an essential precondition to improving their health. Generally PWID are in poor health, commonly have multiple co-morbidities, and often lack adequate shelter and nutrition. In this era of the right to health, access to health care requires greater emphasis. Against this background good practice recommendations become critically important.

Key messages

1. PWUD/PWID should have access to appropriate health care without discrimination and based on the medical ethics and the right to health.
2. Health services need to be acceptable and appropriate to PWUD/PWID to ensure effectiveness, better utilization and retention in care. Consultations with those working with drug users or drug users themselves can assist to achieve this goal.
3. Health services should regularly provide evidence-based health and treatment information to PWUD /PWID to improve their understanding of health issues
4. Integrated health service provision for PWUD/PWID is needed as a result of common multiple co-morbidities and poor social situations. We recommend strong links among health service providers working with PWUD/PWID to be established and maintained.

Comprehensive Services For PWUD/PWID

The HIV prevention, care, treatment, and support services outlined below should be made available to people who inject drugs using available national guidelines.

Prevention	Treatment, Care & Support	Psycho-Social Support
<ul style="list-style-type: none"> • Sterile needles/syringes (NSP) and associated injected equipment, e.g. alcohol swabs, sterile water, tourniquet, etc. • Medication Assisted Therapy (MAT) • Condoms & water-based lubricants • HIV testing & counseling (HTC) • Presumptive STI screening • Targeted IEC • Sexual & reproductive health (SRH) • Basic health care: TB, viral hepatitis, injection site care 	<ul style="list-style-type: none"> • Prevention, diagnosis and treatment of OIs/TB • Vaccination, diagnosis and treatment of viral hepatitis • Antiretroviral Therapy • STI treatment • Palliative care including symptomatic management • Home-based care (HBC) • Nutrition 	<ul style="list-style-type: none"> • Mental health services, counseling & care • Legal advice & support • Rehabilitation (Occupational therapy, vocational training, Income generation, and employment) • Personal development and empowerment • Establishment of peer support groups

To consider if sufficient numbers of PWID identified/high drug dependency identified:

- Medication Assisted Therapy (MAT)
- Overdose management
- Drug detoxification
- Drug dependence treatment
- Relapse prevention
- Socio-economic and related reintegration services

3.10.2 Men who have sex with men and transgender people

MSM and transgender people are disproportionately burdened by HIV in Tanzania, and are likely to experience social and health disadvantages that may include depression, substance misuse, social isolation and disconnection as found in many other countries. ^{201 202}.

Recommendations

1. Regardless of sexual orientation or gender identity, MSM and transgender people should be able to access health services and the service is provided free of discrimination.
2. Health services should be made inclusive of MSM and transgender people, based on the principles of medical ethics and the right to health.
3. Healthcare providers should be respectful of diversity, aware of their professional obligations, and informed of the specific health and social needs of MSM and transgender people.

Comprehensive Services For Men Who Have Sex With Men (MSM And Transgender People (TG)

The HIV prevention, care, treatment, and support services outlined below should be made available to men who have sex with men and with transgender people using the guidelines published separately. Activities related to the following services can be found under Objective 2 of this implementation plan.

Prevention	Treatment, Care & Support	Psycho-Social Support
<ul style="list-style-type: none"> • Condoms & water-based lubricants • HIV testing & counseling (HTC) and linkage to care • Presumptive STI screening & treatment • Targeted IEC (through peers, mobile phones, internet, etc) • Male sexual health • Post exposure prophylaxis (PEP) in cases of rape and sexual assault 	<ul style="list-style-type: none"> • Prevention, diagnosis and treatment of OIs/TB • Vaccination, diagnosis and treatment of viral hepatitis • Antiretroviral Therapy (ART) • STI treatment • Palliative care including symptomatic management • Home-based care (HBC) • Nutrition 	<ul style="list-style-type: none"> • Mental health services, counseling & care • Legal advice & support • Income generation & employment • Personal development and empowerment • Establishment of peer support groups and networks

If required:

- Harm reduction services, including sterile needles/syringes (NSP)
- Overdose management
- Medically Assisted Treatment (MAT)
- Drug detoxification
- Drug dependence treatment
- Relapse prevention
- Socio-economic and related reintegration services
- Services for the sexual partners of MSM (female, transgender, male) including family planning

Cross Cutting Elements:

- | | |
|--|--|
| <ul style="list-style-type: none">➤ Key population-friendly outreach and drop-in centres and clinics➤ Case management➤ Peer Education➤ Prevention of violence➤ Building strategic partnerships through linking community-based with health care services | <ul style="list-style-type: none">➤ Life skills training➤ Service referrals➤ IEC➤ Crisis response and management➤ Peer counseling and individual and small group interventions |
|--|--|

3.10.3 Sex workers

For effective HIV and sexual health programmes it is important to include sex workers as partners as they can develop solutions that will more accurately respond to the environment where they live and work. The following factors can contribute towards further adverse social, health and economic consequences among sex workers: physical and sexual violence directed towards sex workers; widespread insensitivities, stigma and discrimination towards sex workers by health workers that can deny health services and: repressive police practices against sex workers that can include harassment, extortion and arbitrary arrest.

Recommendations

1. Health services should be made available, accessible and acceptable to sex workers based on the principles of the right to health and free of stigma and discrimination.
2. Law enforcement agencies should be sensitized on the vulnerabilities of sex workers to HIV, including the right to health.
3. Advocacy efforts with the police should be undertaken to ensure that sex workers are protected against violence as this increases behavioural risks of HIV.
4. Multi-sector dialogue should be encouraged to control stigma, discrimination and violence against sex workers.
5. Education and sensitization programmes designed for health-care staff to be non-discriminatory and to ensure quality of comprehensive health care for sex workers need to be implemented.
6. Violence against sex workers must be prevented as it is a risk factor for HIV, and is best addressed as a combined effort between law enforcement agencies and the wider community (including clients and partners) with sex workers and sex worker organizations.
7. Violence against sex workers need to be monitored, reported and support services for sex workers experiencing violence need to be provided.

Comprehensive Services For Sex Workers

The HIV prevention, care, treatment, and support services outlined below should be made available to sex workers using the guidelines published separately. Activities related to the following services can be found under Objective 2 of the implementation plan.

Prevention	Treatment, Care & Support	Psycho-Social Support
<ul style="list-style-type: none"> • Condoms & water-based lubricants • HIV testing & counseling (HTC) • Presumptive STI screening & treatment • Targeted IEC • Sexual & reproductive health (SRH), including PMTCT • Post exposure prophylaxis (PEP) in cases of rape and sexual assault 	<ul style="list-style-type: none"> • Prevention, diagnosis and treatment of OI/ TB • STI treatment • Antiretroviral Therapy (ART) • Palliative care including symptom management • Home based care • Nutrition support 	<ul style="list-style-type: none"> • Mental health services, counseling & care • Legal advice & support • Income generation & alternative livelihood access • Child care and support • Personal development and empowerment • Establishment of peer support groups and networks • Training and involvement of non-paying partners

If required:

- Harm reduction services, including sterile needles/syringes (NSP)
- Overdose management
- Medically Assisted Treatment (MAT)
- Drug detoxification
- Drug dependence treatment
- Relapse prevention
- Socio-economic and related reintegration services

Cross-Cutting Elements:

- | | |
|---|--|
| <ul style="list-style-type: none">➤ Key population-friendly outreach and drop-in centres and clinics➤ Case management➤ Peer Education | <ul style="list-style-type: none">➤ Life skills training➤ Referrals to services➤ IEC |
|---|--|

3.10.4 Prisoners

Prison authorities are obligated to protect the health and life of prisoners which need to include adequate access to HIV prevention and health services. Being imprisoned does not mean that humane treatment and dignity are to be removed or that the standard of health services offered inside prison are sub-standard and not the same to those offered outside in the community.²⁰³ To ensure that recommendations for prisons are able to be introduced and implemented, it is important to have an enabling and non-discriminatory environment. A series of good practice recommendations targeted towards prisons are recommended to improve the health and life of prisoners.²⁰⁴

Recommendations

1. Prisons should be closely included in national HIV and tuberculosis and drug dependent treatment programming, and linkages should be strengthened with outside health and social services in delivering health care in prisons.
2. Mobilize additional financial resources for prisons to ensure that reform in health care can take place. Activities are not just focused on medical care but also on issues of preventative health measures and health promotion. Further public health authority engagement with health issues inside prisons will have a positive impact on prison and public health in general.
3. Gender-responsive interventions need to be given more emphasis to address the complex needs of women who are imprisoned. While most of the comprehensive package can accommodate their needs more attention will be required to address their sexual and reproductive health needs.
4. Issues of stigma and discrimination need to be more pronounced in prisons against specific vulnerable KP – PWUD/PWID, MSM, transgender people, and sex workers – consequently some additional effort will likely be required to address their HIV prevention, treatment, care and support needs.
5. HIV, other blood borne viruses and TB control will require broader prison and criminal justice reforms. Multiple challenges and financial constraints exist but the importance of improving the conditions for prisoners remains critically important to improve control of infectious diseases such as HIV and TB
6. Further reform can be considered to reduce the excessive use of pre-trial detention which is often having a detrimental health impact upon prisoners: many prisoners are held in sub-standard conditions and often without medical treatment or infectious control.
7. Alternative measures need to be explored to reduce the incarceration of PWID who are drug dependant or those with mental health problems and move such vulnerable people towards evidence based and more appropriate services in the community.

Comprehensive Services For Prisoners & Prison Staff

The HIV prevention, care, treatment, and support services outlined below should be made available to prisoners and prison staff using available guidelines published. Activities related to the following services can be found under Objective 2 of the national implementation plan.

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

Prevention	Treatment, Care & Support	Psycho-Social Support
<ul style="list-style-type: none"> • Bleach/decontamination for safer injection, tattooing • Personal hygiene kits to prevent disease transmission • Targeted IEC • Presumptive STI screening and treatment • Voluntary HIV testing and counseling • Basic prison health care: prevention and management of TB, viral hepatitis prevention interventions, hepatitis B vaccination, etc. • Post exposure prophylaxis in the event of rape/sexual assault 	<ul style="list-style-type: none"> • Prevention, diagnosis and treatment of OI/TB • Vaccination, diagnosis and treatment of viral hepatitis • Antiretroviral Therapy • STI treatment • Palliative care • Nutrition support 	<ul style="list-style-type: none"> • Mental Health services, counseling & care • Legal advice & support • Education programmes • Personal development and empowerment • Establishment of peer support groups • Post release support and community reintegration • Linkages with livelihoods support and other social welfare service post release

Essential but requiring advocacy:

- Condoms and water-based lubricants

To consider if sufficient numbers of PWID/high drug dependency identified:

- Safe injection kits
- Medication Assisted Therapy (MAT)
- Drug detoxification
- Drug dependence treatment
- Relapse prevention

Cross Cutting Elements:

- | | |
|--|--|
| <ul style="list-style-type: none"> ➤ Key population-friendly drop-in centres and clinics ➤ Case management ➤ Peer education | <ul style="list-style-type: none"> ➤ Life skills training ➤ Service referrals ➤ IEC |
|--|--|

Chapter 4

4.1 Monitoring and Evaluation of KP Programmes

Monitoring and Evaluation (M & E) is a crucial component to the success of any programme. M& E provides information about how the programme is progressing and highlights what is working, what is not and shows progress towards the objectives of the program. M & E is to be incorporated at the design stage of any programme. Analysis of the information and data gathered during the M & E process allows for guidance on ongoing KP interventions, and importantly will ensure accountability to relevant key stakeholders.^{205 206 207} Effective and efficient monitoring keeps track of program inputs, process and outputs. Equally important evaluation assesses whether the targets of the program are being achieved.

Indicators and data collection tools need to be in place, and capacity of staff built on M&E. To assess the degree to which services meet the actual needs of those whom it is to serve, the active involvement of KPs will prove invaluable. KPs need to be encouraged to participate in programme design implementation and evaluation.²⁰⁸

For M & E to be effective it is important that the process is clear and based on a logical pathway. The major levels of M & E are: inputs, processes, outputs, outcomes and impacts. During the systematic M & E of various aspects of a programme or a service it is important that standards of quality are able to be met. For detailed information about M & E and the critically important linkages of standardizing indicators, target-setting processes, and measuring population size, refer to recommended guides in Annex 1.

Key Messages

1. Develop Unique Identifier Code for ease of tracking KP throughout the HIV prevention, Treatment and care continuum from community into health care
2. The M&E for KPs shall be integrated into existing National HIV and AIDS monitoring and evaluation system.
3. Harmonize and coordinate various stakeholders to collect appropriate and meaningful data which allows useful data management

Recommended guides on monitoring and evaluation see Annex 1

Annex 1

Guides / related publications for KP.

Recommended guides on needle and syringe programmes:

- Guide to starting and managing needle and syringe programmes. Geneva, World Health Organization, Department of HIV/AIDS, 2007. <http://www.who.int/hiv/pub/idu/needleprogram/en/index.html>
- Evidence for action: Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Geneva, World Health Organization, 2004. <http://www.who.int/hiv/pub/idu/e4a-needle/en/index.html>

Recommended guides on drug dependence treatment:

- Guideline For Medically Assisted Treatment for Opioid Dependence in Tanzania. <http://www.pmo.go.tz>
- Medically Assisted Treatment For Opioid Dependence: Clinical Guide for Zonal And Regional Referral Hospitals.
- Minimum Standards For Health Facilities Providing Medically Assisted Treatment of Drug Dependence in Tanzania. <http://www.pmo.go.tz>
- Guidelines for psychosocially assisted pharmacotherapy for the management of Opioid dependence. Geneva, World Health Organization, 2009. <http://www.who.int/hiv/pub/idu/Opioid/en/index.html>
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- The Health Sector HIV and AIDS Communication Strategy 2008-2015. URT/MOHSW
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Recommended guides on prevention, diagnosis and treatment of viral hepatitis:

- Guidance on prevention of viral hepatitis B and C among people who inject drugs. Geneva, World Health Organization, 2012.
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Chapter 8. Prevention of hepatitis A, B and C and other hepatotoxic factors in people living with HIV

<http://www.euro.who.int/en/what-we-publish/abstracts/hivaids-treatment-and-care-clinical-protocols-for-the-who-european-region>

Recommended guides on prevention, diagnosis and treatment of tuberculosis:

- National Policy Guidelines for Collaborative TB/HIV Activities (2009). URT/MOHSW <http://www.ntlp.go.tz>
- WHO, UNODC, UNAIDS. Policy guidelines for collaborative TB and HIV services for injecting and other drug users: an integrated approach. Evidence for Action Technical Papers. Geneva, WHO, 2008. http://www.who.int/hiv/pub/idu/tb_hiv/en/index.html
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- Treatment of tuberculosis guidelines, fourth edition. Geneva, World Health Organization, 2010. <http://www.who.int/tb/publications/2010/9789241547833/en/index.html>
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- Staying Safe: A manual to train peer educators in IDU interventions. UNODC, New Delhi. India. 2013
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Evidence for Action Series. Geneva, World Health Organization, 2004.
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<http://www.fhi360.org/sites/default/files/media/documents/Program%20Brief%20on%20Vocational%20Training%20and%20Job%20Placement%20Program.pdf>
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- Moving on: education, training and employment for recovering drug users. Scottish Government, 2001
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- Pinkham S and Malinowska-Sempruch K. Women, Harm Reduction, and HIV. New York: International Harm Reduction Development Program of the Open Society Institute. 2007.
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Recommended guides on community based HIV testing and counseling (HTC) and provider initiated HTC:

- Service delivery approaches to HIV testing and counselling (HTC): a strategic HTC programme framework. Geneva, World Health Organization, 2012 http://apps.who.int/iris/bitstream/10665/75206/1/9789241593877_eng.pdf
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- WHO. Mental Health Gap Action Programme (mhGAP) intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Geneva, WHO, 2010.
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Recommended guides on HIV prevention based on antiretroviral drugs: oral pre-exposure prophylaxis and serodiscordant couples

- Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV: recommendations for use in the context of demonstration projects. Geneva, World Health Organization, 2012 http://apps.who.int/iris/bitstream/10665/75188/1/9789241503884_eng.pdf
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Recommended guides to manage some common co-infections and comorbidities (not previously listed):

- Guidelines on co-trimoxazole prophylaxis for HIV-related infection among children, adolescents and adults: recommendations for a public health approach. Geneva, World Health Organization, 2006. www.who.int/hiv/pub/plhiv/ctx/en
- Rapid advice: diagnosis, prevention and management of cryptococcal disease in HIV-infected adults, adolescents and children. Geneva, World Health Organization, 2011. www.who.int/hiv/pub/cryptococcal_disease2011
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- For complete vaccination schedules and detailed guidance: WHO recommendations for routine immunization – summary tables [web site]. Geneva, World Health Organization, 2012 www.who.int/immunization/policy/immunization_tables/en/index.html

Recommended guides on sexual violence and post-exposure prophylaxis:

- Responding to intimate partner violence and sexual violence against women: clinical and policy guidelines. Geneva, World Health Organization, 2013. http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf
- Interventions to address HIV in prisons: prevention of sexual transmission. Evidence for Action Technical Papers: WHO, UNODC, UNAIDS 2007. https://www.unodc.org/documents/hiv/aids/EVIDENCE%20FOR%20ACTION%202007%20sexual_transmission.pdf

Recommended guides on prevention of mother-to-child transmission of HIV:

- Prevention of Mother to Child Transmission of HIV. National Guidelines (2007) URT/ MOHSW <http://www.nacp.go.tz>
- Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Geneva, World Health Organization, 2013. [Chapter 7: 7.1.2]

<http://www.who.int/hiv/pub/guidelines/arv2013/download/en/>

Recommended guide to prevention of HIV and HCV transmission through medical, dental, tattooing and body piecing

- Minimum standards for HIV and AIDS, TB, Hepatitis B and C and sexually transmitted infections prevention, care and support in prisons in the Southern African Development Community (SADC). Communicable Diseases Project, Directorate for Social and Human Development and Special Programmes SADC Secretariat. 2011.
- Health in prisons: A WHO guide to the essentials in prison health. WHO 2007
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- Prevention of communicable disease and infection control in prisons and places of detention: A manual for healthcare workers and other staff, Department of Health, UK, 2011.

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Recommended guides on monitoring and evaluation

- UNAIDS et al. A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations. Joint United Nations Programme on HIV/AIDS (UNAIDS). 2007.
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Annex 2:

Summary WHO recommendations on the use of ART for treating and preventing HIV infection

When to start ART for people living with HIV (Adults and adolescents)	What ART regimens to start for adults
<ul style="list-style-type: none"> • As a priority, ART should be initiated in all individuals with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and individuals with CD4 count ≤ 350 cells/mm³ • ART should be initiated in all individuals with HIV with CD4 count >350 cells/mm³ and ≤ 500 cells/mm³ regardless of WHO clinical stage • ART should be initiated in all individuals with HIV regardless of WHO clinical stage or CD4 cell count in the following situations: <ul style="list-style-type: none"> ➤ Individuals with HIV and active TB disease ➤ Individuals co-infected with HIV and HBV with evidence of severe chronic liver disease ➤ Partners with HIV in serodiscordant couples should be offered ART to reduce HIV transmission to uninfected partners 	<ul style="list-style-type: none"> • First-line ART should consist of two nucleoside reverse-transcriptase inhibitors (NRTIs) plus a non-nucleoside reverse-transcriptase inhibitor (NNRTI). • TDF + 3TC (or FTC) + EFV as a fixed-dose combination is recommended as the preferred option to initiate ART • If TDF + 3TC (or FTC) + EFV is contraindicated or not available, one of the following options is recommended: <ul style="list-style-type: none"> ➤ AZT + 3TC + EFV ➤ AZT + 3TC + NVP ➤ TDF + 3TC (or FTC) + NVP <p>Countries should discontinue d4T use in first-line regimens because of its well-recognized metabolic toxicities</p>

<p>Monitoring ART response and diagnosis of treatment failure (All populations)</p>	<p>Second-line ART: what ARV regime to switch to (Adults, adolescents, pregnant & breastfeeding women)</p>
<ul style="list-style-type: none"> • Viral load is recommended as the preferred monitoring approach to diagnose and confirm ARV treatment failure • If viral load is not routinely available, CD4 count and clinical monitoring should be used to diagnose treatment failure 	<ul style="list-style-type: none"> • Second-line ART for adults should consist of two nucleoside reverse-transcriptase inhibitors (NRTIs) + a ritonavir-boosted protease inhibitor (PI). The following sequence of second-line NRTI options is recommended: • After failure on a TDF + 3TC (or FTC)-based first-line regimen, use AZT + 3TC as the NRTI backbone in second-line regimens. • After failure on an AZT or d4T + 3TC-based first-line regimen, use TDF + 3TC (or FTC) as the NRTI backbone in second-line regimens. • Use of NRTI backbones as a fixed-dose combination is recommended as the preferred approach • Heat-stable fixed-dose combinations ATV/r and LPV/r are the preferred boosted PI options for second-line ART
<p>Third-line ART</p>	
<ul style="list-style-type: none"> • National programmes should develop policies for third-line ART • Third-line regimens should include new drugs with minimal risk of cross-resistance to previously used regimens, such as integrase inhibitors and second-generation NNRTIs and PIs • Patients on a failing second-line regimen with no new ARV options should continue with a tolerated regimen 	

Source: WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Geneva. 2013

Annex 3:

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