This summary highlights the experiences, results and actions from the implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages in Tanzania. The tool – developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives in 2009 – supports national assessments of the bi-directional linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and services levels. Each country that has rolled out the tool has gathered and generated information that will help to determine priorities and shape national plans and frameworks for scaling up and intensifying linkages. Country experiences and best practices will also inform regional and global agendas.

RECOMMENDATIONS

What recommendations did the assessment produce?

• Developing, disseminating and implementing a clear national SRH and HIV integration strategy, operational guidelines, supervision guidelines and yearly implementation plans, with targets and budget to support integration. At the moment, several policy documents call for integration, but are yet to be operationalized.

• For the Reproductive and Child Health Section (RCHS) and National AIDS Control Programme (NACP), jointly planning, coordinating and implementing integration activities at policy and service delivery levels.

• Increasing the number of service providers and sensitizing/building the capacity of new and existing staff, managers and other stakeholders on integration.

• Conducting and strengthening public education campaigns to inform communities on the availability of integrated services.

• Conducting research that will identify possible barriers to effective integration efforts, and informing policy and decision-makers accordingly.

1. Who managed and coordinated the assessment?

- The assessment was conducted by the National Institute for Medical Research (NIMR). It was led by two sections of the Ministry of Health and Social Welfare (MoHSW) – RHCS and NACP – under the guidance of the Family Planning and HIV/AIDS Technical Working Group.
- Financial and technical support was provided by WHO and Family Health International (FHI).
- Decisions were made by the members of the Family Planning and HIV/AIDS Technical Working Group. The overall budget was managed by FHI and the field budget by NIMR.

2. Who was in the team that implemented the assessment?

- The assessment was implemented by a group of 12 NIMR researchers and assistant researchers.

3. Did the desk review cover documents relating to both SRH and HIV?

- The desk review covered 41 strategies, policies, guidelines and legislation on SRH and HIV.

4. Was the assessment process gender-balanced?

- The assessment considered gender equity and was implemented by a team of six female and six male researchers.
- Of the 405 service users interviewed, 335 (82.7 per cent) were female, compared to 70 (17.3 per cent) male. The assessment found that more men were seeking HIV services than SRH services.
- The assessment did not document whether the service providers were male or female.

5. What parts of the Rapid Assessment Tool did the assessment use?

- Seven data collection instruments from the Rapid Assessment Tool were adapted for the assessment. The process involved adding and deleting some questions to suit the local context and specific issues of the NACP and RCHS.
- Changes were made to the tools, including dividing them into seven separate SRH and HIV tools for policymakers, service users and service delivery. Other changes included making some of the questions closed and/or adding further explanations.

6. What was the scope of the assessment?

- The assessment aimed to give a snapshot of the status of SRH and HIV integration in policies, systems and services. In line with government policy, it focused on family planning (FP) and HIV integration to inform a National Strategic Framework for FP and HIV Integration.
- The assessment took place in five regions selected on the basis of prevalence of HIV and contraceptives. From these regions, 15 districts were selected. Within these, all district hospitals [17], health centres [29] and dispensaries [42] providing SRH and HIV services were visited, totalling 88.

7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?

- Two interviews were carried out with policy-makers in the MoHSW’s Directorate of Preventive Services – one from the NACP, one from the RCHS.

8. Did the assessment involve interviews with service providers from both SRH and HIV services?

- 303 services providers were interviewed: 145 from SRH facilities and 158 from HIV. These were: nurses [191], clinical officers [95], laboratory technicians [7], physicians (6), counsellors (3) and a pharmacist (1).
9. Did the assessment involve interviews with clients from both SRH and HIV services?

- The assessment involved interviews with 405 service users.
- The service users were not categorized according to whether they had come for an SRH or HIV service.

10. Did the assessment involve people living with HIV and key populations?

- People living with HIV (PLHIV) were not involved in the assessment team.
- The service users interviewed at HIV services were PLHIV.
- The assessment did not directly address sex workers or people that use drugs.

FINDINGS

1. Policy level

National policies, laws, plans and guidelines:

- The policy documents for both SRH and HIV revealed a major shift towards linkages. But they also indicated significant differences in emphasis and degrees of implementation.
- In all key FP/reproductive health (RH) documents, HIV was mentioned at least once, but with inconsistent emphasis and recommendations. Examples of such documents included:
  - National Policy Guidelines for Reproductive and Child Health Services (2003): describing HIV as “a major reproductive health problem”, stating that “all reproductive and child health interventions in public, private NGOs and voluntary sector shall integrate STIs (sexually transmitted infections)/HIV/AIDS prevention and care” and emphasizing services such as condoms for dual protection.
  - Comprehensive Family Planning Procedure Manual (2007): advocating the provision of as many services as possible in one facility, calling on FP providers to respond to HIV and emphasizing particular HIV services, such as HIV counselling and testing.
  - National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths (2008–2015): emphasizing the integration of HIV, particularly prevention of mother to child transmission (PMTCT).
  - In all key HIV documents, FP was mentioned at least once, but, again, with inconsistent emphasis and recommendations. Key examples of such documents included:
    - National Guidelines for Management of HIV and AIDS (2008): citing FP as part of comprehensive prevention for PLHIV and stating that PMTCT should be integrated within all HIV, RH and child health services.
    - The HIV/AIDS Prevention and Control Act emphasizes the rights of PLHIV to basic health care and to marry and have a family. It provides against stigma and discrimination.
• In terms of wider rights and access: the legal age of marriage is 18 [male] and 15 [female]; there is no age restriction for SRH services; and parent/guardian consent is required for HIV testing for those under 16.
• Gender-based violence is addressed in the Sexual Offence Special Provision Act (although its enforcement has been varied).
• There is no national workplace policy for either FP or HIV.
• There is legislation that makes HIV transmission a criminal offence.

Funding and budgetary support:
• Funding for SRH and HIV is vertical. It is from the government, donors and NGOs/faith-based organizations.
• The low allocation (10.1 per cent) of the national budget to health has affected the implementation of the Essential Reproductive and Child Health Package. The Guidelines for the Preparation of Medium-Term Expenditure Framework for 2007/08–2009/10 indicate no increase in funds to SRH or HIV.

2. Systems level

Partnerships:
• SRH and the medical response to HIV are both coordinated by the MoHSW, but in separate units – the RCHS and NACP. The Ministry has done much to foster coordination, including through the units' co-chairing of the FP/HIV Integration Technical Working Group. The overall response to HIV is coordinated by the Tanzania Commission for AIDS.
• Overall, the government has emphasized the integration of FP with HIV services, including hosting a meeting on the issue in 2008, with 60 multi-sectoral representatives.

Planning:
• The assessment will inform a National Strategic Framework for FP/HIV Integration. This will facilitate joint planning and strategizing on integration.

Human resources and capacity building:
• Limited human resources are a major challenge. For example, the assessment found that many of the regions lack physicians and pharmacists (for SRH) and physicians, counsellors or laboratory technicians (for HIV).

Logistics, supply and laboratory support:
• This area was not specifically addressed. But the PMTCT Guidelines recommend integrated logistics systems, and that orders for supplies include FP commodities.

Monitoring and evaluation:
• This area was not specifically addressed. But it was noted that recording systems, for example for PMTCT services, do not include sufficient indicators for FP.

3. Services level

A. SERVICE PROVIDER PERSPECTIVES

SRH and HIV service availability:
• The most commonly available SRH service was FP [92 per cent of 88 facilities], followed by maternal, newborn and child health (MNCH) [91 per cent]; prevention/management of STIs [87.5 per cent]; prevention of unsafe abortion/provision of post-abortion care [73 per cent]; and prevention/management of gender-based violence [47 per cent].
• The most common HIV services were PMTCT and HIV counselling and testing (both 92 per cent), followed by: condom provision [87 per cent]; HIV information/services for general population [82 per cent]; HIV prevention for PLHIV [72 per cent]; prophylaxis/treatment for PLHIV [71 per cent]; home-based care [68 per cent]; psychosocial support [63 per cent]; and specific HIV information/services for key populations [28 per cent].
• Hospitals provide the widest range of services, followed by health centres. Except for specific information/services for key populations, these provide over three-quarters of all services.

HIV integration into SRH services:
• The HIV services most commonly provided by FP facilities were condom provision, specific information/services for key populations, PMTCT, HIV counselling and testing, and HIV prevention (between 25.3 and 36.7 per cent). Almost none provided psychosocial support, home-based care, prophylaxis/treatment for PLHIV or prevention for PLHIV.

SRH integration into HIV services:
• The assessment gave a detailed analysis of SRH services provided by HIV facilities. The 80 services providing HIV counselling
and testing were most likely to also provide FP (26.3 per cent), followed by MNCH (16.3 per cent). The 60 providing prophylaxis/treatment for PLHIV were most likely to also provide prevention/management of STIs and prevention of unsafe abortion/provision of post-abortion care (both 6.7 per cent). The 56 providing HIV home-based care were most likely to also provide family planning and MNCH (both 3.6 per cent). The 53 providing HIV psychosocial support were most likely to also provide FP and MNCH (both 5.7 per cent). The 60 providing prevention for PLHIV were most likely to also provide prevention/management of gender-based violence (8.3 per cent), followed by family planning and MNCH (both 1.7 per cent). The 70 providing HIV prevention were most likely to also provide FP (27.1 per cent), followed by MNCH (17.1 per cent). The 77 providing HIV prevention were most likely to also provide prevention/management of gender-based violence (8.3 per cent), followed by family planning and MNCH (both 3.6 per cent). The 79 providing PMTCT were most likely to also provide FP (26.6 per cent), followed by MNCH (26.6 per cent). The 22 providing HIV information/services for key populations were most likely to also provide FP (54.5 per cent), followed by prevention of unsafe abortion/provision of post-abortion care (36.4 per cent).

Overall, facilities providing HIV services were least likely to also provide prevention of unsafe abortion/provision of post-abortion care, prevention/management of gender-based violence and prevention/management of STIs.

Overall perspectives on linkages in SRH and HIV services:

- SRH and HIV integrated services are most commonly provided at the same facility, on the same day and by the same provider. Next most commonly, they are provided at the same facility, on the same day, but with a different provider. There are few referrals.
- Service providers said that it is ‘normal routine’ that, for example, people coming for HIV services also get the SRH services they need. In practice, the needs are often undifferentiated because both the sites and the providers are the same.
- 75.3 per cent of providers experience constraints to integration. At both types of facilities, the largest were cited as low staff motivation, shortage of staff training and shortage of staff time.
- Service providers cite the likely impacts (positive and negative) of integration as: increased efficiency of services; increased need for equipment, supplies and drugs; decreased stigma of clients; and increased workload/time spent per client for providers.
- The majority of SRH and HIV services providers (62 per cent and 57 per cent respectively) felt that integration would increase the efficiency of services.

B. SERVICE USER PERSPECTIVES

- Of the 405 service users involved in the assessment, most of those at SRH services were primarily seeking MNCH and FP, while most at HIV services were seeking HIV counselling and testing, treatment and care.
- Many service users also had other needs. For example: those primarily seeking FP were most likely to also be seeking HIV counselling and testing. 81.7 per cent said they had received all the services that they sought at the facilities. For the 54 that had not, the reasons included: lack of service at the time (27.8 per cent), high cost of service (16.7 per cent) and providers not having time (22.2 per cent).
- Most service users (78.1 per cent) favoured receiving services at the same site. The largest benefit would be reduced number of trips to facilities (cited by 50 per cent), followed by reduced transport costs (32.6 per cent), reduced waiting time (25.7 per cent) and improved efficiency of services (25.2 per cent). The disadvantages would be: too much work for the provider (24.7 per cent), fear of stigma and discrimination (14.3 per cent), compromised quality of services (13.1 per cent), and lack of confidentiality (12.3 per cent).
- Over 43 per cent of clients felt that the same provider should address their various needs, while 32.1 per cent preferred a different provider for each service. The perceived advantages were reduced number of trips to facility (cited by 27.4 per cent), reduced waiting time (25.2 per cent) and improved efficiency (22.7 per cent). The disadvantages were too much work for the provider (31.1 per cent), decreased quality of services (17 per cent), increased waiting time (13.6 per cent), and lack of confidentiality (10.4 per cent).
LESSONS LEARNED AND NEXT STEPS

1. What lessons were learned about how the assessment could have been done differently or better?
• Although the assessment process involved representatives of PLHIV and exit interviews with clients, the report would benefit from more insight into the work and perspectives of civil society, particularly PLHIV and key populations.
• The assessment appears to have paid little attention to the system-level issues addressed in the Rapid Assessment Tool. The comprehensive analysis of policies and service availability could have been complemented by more information relating to issues such as partnerships, planning and human resources – which are critical to scaling up integrated approaches.
• The report was heavily dependent on analysing a large amount of quantitative data. The results give a complex picture, but do not necessarily ‘tell the story’ of the status/priorities.
• A series of focus group discussions at the policy, services and community levels could have been conducted to provide insights into the practical integration of SRH and HIV services.
• Additional time could have been spent adapting and focusing the data collection tools to the specific needs at country level.

2. What ‘next steps’ have been taken (or are planned) to follow up the assessment?
• The results of the assessment have been presented to various audiences, including members of the FP/HIV Technical Working Group, FP and HIV stakeholders and members of the Medical Research Coordinating Committee.
• The results will inform the development of a National Strategic Framework for FP and HIV Integration in Tanzania and efforts to link national SRH and HIV frameworks more broadly.
• Depending on the availability of the funds, follow-up will be conducted to assess levels of integration at the policy and services provision levels.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:
• policy level?
• systems level?
• services level?
Policy level:
• [None at the current time]
Systems level:
• Service delivery guidelines for FP and HIV services are being revised to include elements of integrated services.
Services level:
• Results from the assessment will complement other results from ongoing operations and research studies to inform the MoHSW on the optimal modalities for integrating services.

4. What are the funding opportunities for the follow-up and further linkages work?
• Efforts are being made to address integration within Tanzania’s application to Round 10 of the Global Fund to Fight AIDS, Tuberculosis and Malaria.
### Abbreviations

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<tr>
<th>Abbreviation</th>
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<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FP</td>
<td>family planning</td>
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<td>GNP+</td>
<td>Global Network of People Living with HIV</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>ICW</td>
<td>International Community of Women Living with HIV/AIDS</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>MNCH</td>
<td>maternal, newborn and child health</td>
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<td>MoHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<td>NIMR</td>
<td>National Institute for Medical Research</td>
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<td>PMTCT</td>
<td>prevention of mother to child transmission</td>
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<td>RCHS</td>
<td>Reproductive and Child Health Section</td>
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<td>RH</td>
<td>reproductive health</td>
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<td>SRH</td>
<td>sexual and reproductive health</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>WHO</td>
<td>World Health Organization</td>
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