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 Zanzibar. 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?**

**Policy level:**
- Revising current SRH and HIV policies to strengthen support, the mandate and guidance for linked services.
- Operationalizing policy and guideline support through the dissemination, mobilization and implementation at the programme and service delivery levels.
- Devising a comprehensive action plan using the reproductive and child health (RCH) and HIV technical working groups (TWGs) to address: policies; capacity and training; changes to facilities; information, education and communication (IEC); record-keeping and monitoring and evaluation (M&E); logistics; referrals and community engagement.
- Operationalizing SRH and HIV integration: starting with a pilot project in Pemba and Unguja Districts before linking and integrating SRH and HIV services countrywide. An evaluation should precede the involvement of all facilities in the country.

**Systems level:**
- Promoting efforts to ensure that development partner support is effectively coordinated for the implementation of SRH- and HIV-related activities and to reduce duplication.
- Supporting health provider training and refresher courses on SRH- and HIV-related issues through technical and financial support.
- Developing cross-cutting M&E tools and determining the need for SRH- and HIV-related services.
- Continuing to collect and assess global and local research on the most effective models for the delivery of integrated services to inform their design and scale-up.
- Seeking funding from key donors and government agencies.

**Zonal officials**
- Prevention: coordinators of parent-to-child transmission (PPTCT) and RCH should work, plan and budget together at zonal level to support the sustainable implementation of integrated SRH and HIV services.

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1. This summary is based upon: *Rapid Assessment of Linkages between HIV and Sexual and Reproductive Health Services in Zanzibar*, Ministry of Health, Zanzibar, June 2011.
• Support for training: zonal officials should provide technical and financial support for training and refresher courses on SRH- and HIV-related issues to health providers.

District officials
• Ensuring the provision of integrated, joint, sustainable and supportive supervision of SRH and HIV services.
• Strengthening the capacity of Council Health Management Teams to effectively coordinate SRH and HIV services provided by different development partners.
• Planning, budgeting for and organizing training and refresher courses on SRH- and HIV-related issues for district-level health providers.

Service delivery level:
• Carrying out need assessments of human resources, equipment and supplies for integrated SRH and HIV services.
• Submitting recommendations to the district level on how to address deficiencies in human resources, equipment and supplies.
• Encouraging in-house knowledge and information sharing among staff through monthly or quarterly seminars or clinical meetings overseen by staff-in-charge.
• Making efforts to publicize available services that can meet unmet needs (as identified by client interviewees) and which can also address client misunderstandings regarding services on offer.
1. Who managed and coordinated the assessment?
The Zanzibar AIDS Commission (ZAC), under the auspices of the Ministry of Health (MoH) and with technical and financial support from UNFPA, coordinated the rapid assessment (RA).

2. Who was in the team that implemented the assessment?
The RA was undertaken by the National Institute for Medical Research (NIMR), Muhimbili Medical Research Centre and its research team. The team comprised a Principal Investigator, responsible for overall implementation and data quality assurance; a field coordinator, who assisted in implementation, including developing the research tools, hiring the research assistants and provision of logistics; and 14 research team members involved in data collection (10 from NIMR and four from Zanzibar), including two team leaders, a data manager, and administrative assistance.

3. Did the desk review cover documents relating to both SRH and HIV?
Yes. A total of 12 documents were reviewed, including policy documents and guidelines on SRH (1) and HIV (8), as well as HIV-related laws (1) and sector-wide policies and strategies (2).

4. Was the assessment process gender-balanced?
It is not possible to make an overall assessment of the gender balance of the process. In terms of:
- The research team (14): there were 8 men and 6 women.
- The policy-makers (33): the majority were women.
- The service providers (66): the majority were men.
- The clients (244): males constituted 7 per cent of the sample (n=17), while female clients were 93 per cent (n=227), with the majority of the women aged between 35 and 39.

5. What parts of the Rapid Assessment Tool did the assessment use?
The Rapid Assessment Tool was adapted to the local context through a review and revision process which resulted in the following instruments being developed and used:
- Client exit interview guide.
- Provider tool (HIV).
- Provider tool (SRH).
- Health systems-level tool (SRH).
- Health systems-level tool (HIV).
- Policy-level tool (HIV).
- Policy-level tool (SRH).

6. What was the scope of the assessment?
To conduct an RA on linkages and integration between SRH and HIV programmes in order to inform the process of strengthening bi-directional linkages and to improve service coverage and quality to underserved and/or vulnerable populations. The specific objectives were to:
- Assess SRH and HIV bi-directional linkages at the policy, systems, and service delivery levels.
- Identify factors that facilitate or hinder the integration of the two programmes.
- Identify current critical gaps in policies and programmes, including systems and human resources (quantity and quality).
- Recommend measures for strengthening linkages and integration of SRH and HIV services at all levels (including M&E).
7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?

Yes. In total, 33 interviews were conducted.

- National level: nine interviews were conducted with HIV and SRH programme managers, PPTCT national coordinators and representatives from donor agencies and/or development partners. These included Danish International Development Agency (DANIDA), Clinton Health Access Initiative (CHAI), United Nations Children’s Fund (UNICEF), ZAC, people living with HIV, and the MoH Planning Unit and Directorate for Preventive Services.

- Zonal level: four interviews were conducted with the Pemba and Unguja Zonal Medical Officers and PPTCT Coordinators.

- During the assessment period, Zanzibar had no District HIV/AIDS Coordinators. Twenty interviews were therefore undertaken with 10 District Medical Officers and 10 District SRH/RCH Coordinators (i.e. one of each from the 10 districts).

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

Yes. Interviews were conducted with 66 facility heads, including those in charge of facilities (30), heads of RCH units (30) and heads of HIV/AIDS units at the hospital level (6). These came from a total of 30 health facilities (4 government, 1 private and 1 public–private hospitals, 4 PHCCs and 20 PHCUs). Interviews were conducted with 244 clients from both SRH and HIV services, covering all 10 districts and the five regions of Zanzibar.

In addition, a total of 79 health service providers of mixed cadres from the 30 facilities were interviewed.

9. Did the assessment involve interviews with clients from both SRH and HIV services?

Yes. The study assessed a total of 244 clients from both SRH and HIV services, including 90 exiting six large hospitals, 40 exiting PHCCs and 114 exiting PHCUs.

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

Yes, at the second meeting during the policy-level process one representative from the national network of people living with HIV participated. There is no information on whether clients interviewed included PLHIV or key populations.
FINDINGS

1. Policy level

Strengths:
• The main linkages in the operational guidelines for both the HIV and RCH strategies are PPTCT and condom use for dual protection.
• Integrated services were included in almost all of the HIV-related documents. Among these were the provider-initiated testing and counselling (PITC) guidelines, which mandate the provision of HIV counselling and testing (HCT) in PPTCT clinics.

Challenges:
• Conceptually, there is a general recognition of bi-directional linkages; operationally this is not the case.
• Linkages between SRH and HIV are still weak; however, efforts have started to address this.
• Other challenges and gaps include:
  • Vertical programmes from the national to lower levels; and
  • A lack of adequate emphasis on SRH and HIV service linkages in most policy documents.

Policies:
• In both of these, key populations (including female sex workers, men who have sex with men and people who use drugs) were identified as populations for whom strategies aim to reduce HIV transmission.
• The absence of gender parity in various forms and at different socioeconomic levels is recognized as one of the factors exacerbating the risk of acquiring HIV among women. To address this requires collaborative efforts to empower women to undertake informed sex negotiations. However, as ZNSP I and II concentrate more on ABC – abstain, be faithful, use condoms – and PPTCT, with an emphasis on the use of available guidelines to prevent new infections, they overlook the obvious linkages between HIV and SRH.

When the Zanzibar Reproductive and Child Health Strategy [ZRCHS] (2007–2012) was developed, HCT had not yet been integrated into antenatal care, as PPTCT services had not yet commenced in Zanzibar. However, the ZRCHS refers to the provision of integrated RCH services as one of its guiding principles.

Legal framework:
The draft Zanzibar HIV and AIDS Prevention and Management Bill (2011) aims to provide for the prevention and management of HIV, and to protect and promote the human rights of persons living with or affected by HIV, and related matters. It does not contain any clauses relating to criminalization. Tanzania does not have a national HIV/AIDS workplace policy, though efforts are under way to ensure that such a policy is in place.

2. Systems level

Strengths:
• There is a willingness among health workers, district and national-level officials to support SRH and HIV integration.

Challenges:
• Due to the ZNSP II and ZRCHS, SRH and HIV integration implementation is a problem, with a lack of operationalization at lower levels.
• Vertical programmes.
• Shortage of human resources and retention, due to low salaries and transfers to other health facilities, especially of trained health workers.
• Shortage of human resources trained in both HIV and RCH service delivery.
• Lack of SRH and HIV training curricula, with the exception of PPTCT.
• Lack of some services (e.g. PPTCT) in some facilities.

Partnerships:
• There is little evidence of partnerships on SRH and HIV linkages. Eight respondents (5 in Pemba and 3 in Unguja) reported having worked with people living with HIV and youth to deliver HIV and SRH messages on prevention and unwanted pregnancies to their communities.
Planning, management and administration:

- The Zanzibar AIDS Control Programme (ZACP), which is responsible for PPTCT, and the RCH Unit, which is responsible for SRH, are both within the MoH; nevertheless, they have different coordination mechanisms, operations, mandates, and sources of funding. Furthermore, almost all facilities have RCH services, but few offer PPTCT services.
- There is no evidence of joint planning of HIV and SRH programmes or integrated supervision of SRH and HIV activities.
- There is no multi-sectoral TWG on SRH and HIV linkages.

Staffing, human resources and capacity development:

- According to the 30 people in charge of health facilities (19 from Unguja and 11 from Pemba), out of 415 service providers from Unguja District, 245 (59 per cent) had attended SRH and HIV training; out of 304 service providers from Pemba District, 256 (84 per cent) had attended such training.
- Training for health care workers on different aspects of SRH and HIV is needed, but most important is sensitization on the necessity of SRH and HIV integration.

Logistics:

- A lack of laboratory services was reported in one health facility.

Monitoring and evaluation:

- Both SRH and HIV programmes have separate M&E systems, with different information captured by SRH and HIV programmes.

3. Services level

Strengths:

There are several facilitating factors for integration, as both HIV and SRH services are widely available across Tanzania/Zanzibar, i.e.:

- There are favourable models of service delivery, and both providers and clients seem receptive to linkages.
- The majority of the respondents are in favour of SRH and HIV service integration, albeit with some reservations, including the need for training, the need for integration from higher to lower levels, and an overall reduction in budgets when integrating services.

Challenges:

- Lack of staff training, workload, lack of incentives for service providers, structural problems leading to lack of space, and inadequate confidentiality inhibiting SRH and HIV service linkages and integration.
A. SERVICE PROVIDER PERSPECTIVES:

- With the expectation of the prevention and management of gender-based violence services, almost all other HIV- and SRH-related services are provided by the majority of facilities.
- Co-existence of family planning (FP) and HIV services is more prevalent in hospitals than in lower-level facilities. HIV services most often provided in FP services at this level are HIV information for key populations, PPTCT, condom provision, HIV prevention and HCT.
- More than half of SRH service providers (52.8 per cent) reported that services for HIV and sexually transmitted infections (STIs) were provided on the same day and by the same service provider at both the hospital and primary health care levels. A few providers cited referral of clients to another unit within the same facility or to another facility.
- At lower-level facilities (PHCCs and PHCUs), there were only RCH units, leading to service integration by default – i.e. clients seeking either HIV or SRH services are attended to by the same service provider in the same service unit.
- Most health service providers reported that they experienced some constraints in integrating services, including low staff motivation and a shortage of staff training, as well as shortage of space for private and confidential services, shortage of equipment, limited staff time, and inappropriate and/or insufficient staff supervision.
- The likely benefits of linked SRH and HIV services cited by those interviewed included decreased stigma of clients and service costs; however, likely disadvantages included increased need for equipment, supplies and drugs, as well as increased workload.

B. SERVICE USER PERSPECTIVES:

- For female clients, HCT was the most cited reason for visiting a HIV clinic; for male clients, maternal and child health (MCH) services was the main reason for visiting SRH facilities.
- In the case of SRH services:
  - The majority of the female clients who visited an SRH facility said that they had received MCH and FP services.
  - Considerably fewer male clients had sought SRH services, and among those who did, many were interested in MCH services. Male involvement in RCH, including FP, has been reported in other studies and needs to be further emphasized.
  - The majority of male clients said that they had received both STI and MCH services.
- In the case of HIV services, most of the attendees, regardless of their gender, indicated that they had received HCT services.
  - The majority of clients (89.8%) received all the services they had sought, though 10.3% indicated that they were unable to receive the desired services, with HCT (19.33%) and routine gynaecological examinations (19.2%) being most often cited. The reasons included non-availability (55%), nurses not having time (7%), clients not having time (7%), and not being comfortable during the visit (4%).
  - The majority of clients (82.6%) preferred receiving both SRH and HIV services at the same health facility. The reasons advanced were: reduction in the number of visits (57.2%), reduction in transport costs (43.8%) and reduction in waiting time (22.6%).
  - The disadvantages of receiving both SRH and HIV services in the same facility were: provider would be too busy (11.5%), fear of stigma and discrimination (8.23%), and compromised confidentiality (7.8%).
- Nearly half (48.2%) of respondents preferred not to receive health services from the same provider, compared to 46.1% who did.
  - Advantages of having the same provider included reduction in the number of visits (27.6%), reduction in waiting time (22.2%), and increased efficiency in service provision (18.9%).
  - Disadvantages cited included: overloading service providers (32.1%) and increased waiting time (23.9%).
## Lessons Learned & Next Steps

### 1. What lessons were learned about how the assessment could have been done differently or better?

**Desk review:**
The assessment could have included other relevant documents that may mention SRH and HIV linkages, but that were not reviewed as they are yet to be finalized.

**Client sampling:**
- The data collected were drawn from a sample of clients attending health facilities during the assessment period. An ideal representative sample would have been drawn from the community, but this option was not used due to logistical difficulties associated with the enrolment of ‘healthy study subjects’ who might not even have used – let alone been conversant with – SRH and HIV services. Nevertheless, clients’ views were triangulated with those of key informants.
- If resources were available, interviews could be extended to include more people within communities who did not attend HIV or SRH facilities.

### 2. What ‘next steps’ have been taken (or are planned) to follow up the assessment?

- Some protocols, guidelines and manuals are in the process of being developed.
- Other HIV services such as HIV prevention messages and HCT have been included within SRH services.
- Other SRH services such as FP are being provided in a few HIV care and treatment clinics.

### 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?**
  - Governments and civil society organizations are working hard to enhance SRH and HIV linkages.
  - Service providers have started to offer comprehensive services.

### 4. What are the funding opportunities for the follow-up and further linkages work?

- Sources of funds for SRH and HIV services are mainly from donors (with differing needs and priorities) and the government, though these sources are not integrated.
- Major development partners for the SRH and HIV programmes include Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO, UNFPA, United States Agency for International Development (USAID), Family Health International (FHI), UNICEF, CHAI, Jhpiego, EngenderHealth, DANIDA and International Center for AIDS Care and Treatment Programs (ICAP).
- Whereas HIV and RCH programmes have comparatively larger budgets, implementation is highly vertical and does not facilitate integration – i.e. apart from PPTCT, donors have not funded SRH and HIV integration.
- The major champions of SRH and HIV linkages are United Nations agencies such as UNFPA; however, there is an overall lack of champions, thus hindering linkages. This underlines the need for inclusion of donors and other development partners to support this constructive, yet neglected, agenda.
- Efforts to mobilize resources for SRH and HIV linkages implementation are needed.