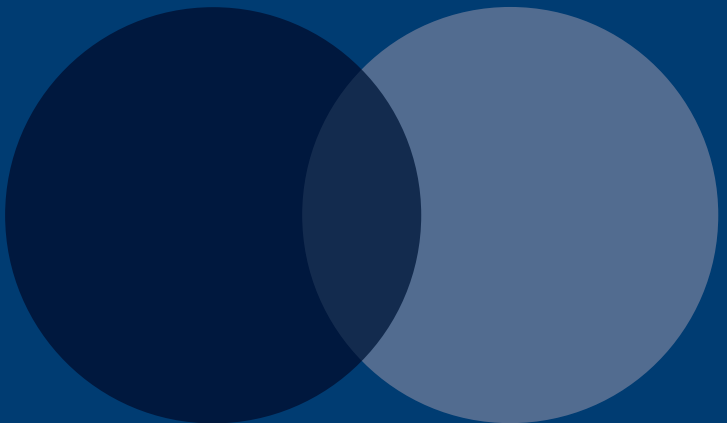




TUNISIA



RAPID ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES



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 Tunisia¹. 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?

Recommendations suggested by key informants, service providers and service users included:

- Improving access to sexual and reproductive health (SRH) and HIV services by developing and/or expanding: provision of services; tailored services for key populations and young people; in-service training for practitioners; and SRH and HIV outreach services. Training should cover stigma and discrimination, particularly in relation to key populations and people living with HIV (PLHIV).
- Delivering improved communication campaigns to increase demand for SRH and HIV services and primary prevention of sexually transmitted infections (STIs), HIV and other SRH areas. Developing functional networking between SRH and HIV practitioners and between governmental actors and non-governmental organizations (NGOs).
- Developing protocols, guidelines and training programmes that aim to enhance linkages between SRH and HIV services, including guaranteeing confidentiality.
- Disseminating and enacting legislation protecting the rights of PLHIV.
- Improving access to products and services (such as condoms, contraceptives and HIV testing).
- Enhancing gender awareness and sensitivity of services.
- Placing greater emphasis on preventing dangerous abortions and providing post-abortion care.
- Ensuring greater involvement of clients, in particular PLHIV, in defining and managing services.

The assessment report also recommended

strengthened integration of services in specific areas:

- Recommending an HIV test to patients attending antenatal care and STI treatment facilities. The provider-initiated HIV testing and counselling would involve routine HIV testing unless the patient did not agree to this.
- Providing HIV testing, emergency contraception and post-exposure prophylaxis to victims of sexual violence.
- Supporting sero-discordant couples, including a protocol to assist those wanting to have children.
- Strengthening the provision of SRH and HIV education in schools.
- Expanding the role of testing centres to ensure they systematically provide a wider range of SRH- and HIV-related services, including condoms and lubricants.

A number of broader, systemic recommendations were also made which will provide a framework for the above recommendations:

- Developing a national strategy to create and strengthen SRH and HIV integration.
- Strengthening networking and partnership between organizations involved in each area.
- Developing joint monitoring and evaluation (M&E) for HIV and SRH programmes and outcomes.
- Assessing and resolving remaining legal barriers to effective SRH and HIV programming.
- Developing an SRH and HIV coordination mechanism to coordinate and monitor integration.
- Developing national guidelines on an integrated approach to SRH and HIV.
- Conducting operational research aimed at identifying best practices in SRH and HIV integration.

1. This summary is based upon: *Évaluation des Liens entre la Santé Sexuelle et de la Reproduction et le VIH en Tunisie*, by Amel Ben Said and Senim Ben Abdallah, September 2010.

PROCESS

1. Who managed and coordinated the assessment?

- The assessment was organized by the National Family and Population Board (ONFP) and UNFPA. The Steering Committee included ONFP, UNFPA, UNDP, UNAIDS, UNICEF, WHO, Primary Health Care Directorate (DSSB), Tunisian Association for Reproductive Health (ATSR), Tunisian Association against STIs and AIDS and PLHIV representatives.
- The assessment formed part of the National Annual Action Plan 2009–10 of the UN Joint Team on AIDS.
- The study was conducted in July–August 2010 and the report published in September 2010.

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

- The six-person assessment team included people with different backgrounds, such as in medicine and sociology. In addition, a statistician was recruited to collect and compile data.
- This team was selected by a committee including representatives of UN agencies, NGOs and a national government partner (ONFP).

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

- The desk review covered documents related to four areas: international commitments of the government of Tunisia; laws and policies related to SRH and HIV, including gender equality and access to health care; policies and strategies on development, health, HIV, SRH and young people; and relevant project reports and evaluations.

4. Was the assessment process gender-balanced?

- Both men and women were involved in the assessment team.
- Among the service providers interviewed, 60 per cent were women.
- Among the clients interviewed, the majority (95 per cent) in SRH facilities were women, while the majority (63.3 per cent) in HIV facilities were men.

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

- The questionnaires and data collection tools were based on the Arabic translation of the *Rapid Assessment Tool*. They addressed all three levels (policy,

systems and services).

- The team lightly adapted the tool, modifying words to apply to the Tunisian context. The questionnaire for clients was made appropriate for the local dialect.
- A meeting was convened bringing together policy-level actors, development partners and service providers. Separate interviews were carried out with decision-makers to discuss the current state of SRH and HIV integration and the extent to which programmes are implemented as planned (and reasons why they are not), and to make recommendations for strengthening integration.

6. What was the scope of the assessment?

- The assessment involved service providers from 30 health facilities (15 SRH and 15 HIV) in eight of the 24 governorates of Tunisia.
- The facilities included hospitals, health centres, school/university health services and NGOs dealing with SRH and HIV testing services.

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

- Key informants interviewed included SRH and HIV decision-makers and managers from Ministry of Health (MOH) departments and other ministries, NGOs, private sector organizations and a Country Coordinating Mechanism (CCM) representative.

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

- 60 service providers were interviewed – two each from the 15 SRH and 15 HIV facilities.
- Those at the SRH services included doctors, nurses, midwives, managers of centres and psychologists. Those at the HIV services included doctors, nurses, managers of centres and programme managers.

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

- Exit interviews were conducted with 120 clients (four from each of the 30 SRH and HIV facilities).
- The majority (65.8 per cent) of the clients were female.

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

- During the field work, men who have sex with men (MSM) were involved in

conducting the assessment. They also participated in workshops to validate the assessment's findings.

- The assessment included interviews with PLHIV and MSM.

FINDINGS

1. Policy level

National policies, laws, plans and guidelines:

- Tunisia has made a number of international commitments. The International Conference on Population and Development (ICPD) recommendations were ratified and enacted by the 1997 National Reproductive Health Programme, covering antenatal care, STIs, HIV, reproductive health (RH) for young people, cancer, menopause and infertility. Tunisia reports regularly against the HIV indicators for the United Nations General Assembly Special Session on AIDS. Progress has been made towards the Millennium Development Goals, particularly in the area of equality for women.
- Legal reform has addressed gender, for example through women's right to vote, equal rights in marriage and removing polygamy.
- Relevant legal provisions include:
 - The right to treatment without discrimination and confidentiality in medical settings.
 - Abortion is legal in authorized premises in the first three months of pregnancy and later if there is a threat to the mother's health. Access is unconditional and spousal consent is not required.
 - Treatment for communicable diseases, including HIV, is free.
 - Premeditated HIV transmission is punishable by three years in prison. No case of wilful transmission has come to court.
 - HIV testing is not obligatory for those wishing to get married. HIV counselling and testing is available on the basis of voluntary counselling and testing (VCT) or provider-initiated testing and counselling.
 - Although there is no specific legislation, gender-based violence (GBV) can be challenged under existing penal code provisions.
- There are strict laws against drug use. Homosexuality and 'clandestine' sex work are illegal and punishable by custodial sentences.
- A number of programmes and initiatives have a direct bearing on SRH and HIV, such as:
 - The national directorate – focusing on poverty reduction, improving gender equality, promoting maternal and child health (MCH) and health systems strengthening.
 - National SRH policies address emergency contraception, abortion, improvement of SRH service quality, family health and GBV.
 - The national MCH programme includes some integration of HIV services, in particular VCT for pregnant women and referrals for HIV-positive mothers and babies. This also enables some aspects to be implemented by the same health care workers.
 - The strategic plan of the National AIDS Programme (NAP) focuses on treatment, most-at-risk populations and the rights of PLHIV, but does not address SRH.
 - The National STI Strategy addresses syndromic management combined with HIV testing. While good progress has been achieved, it is recognized that men are not well reached.
 - The prevention of mother to child transmission (PMTCT) strategy includes HIV prevention with women of childbearing age, contraception and PMTCT for HIV-positive pregnant women. There is little provision to support sero-discordant couples who wish to have children.
 - The National Programme on Health of Adolescents in School (2007) promotes counselling facilities (in place since the 1990s) and youth-friendly services.
 - The National Strategy against Violence (2008) includes monitoring, care and support, referrals, awareness-raising, rehabilitation support, legal education and implementation.

Funding and budgetary support:

- SRH is primarily funded by the government, with support from UNFPA, the European Union, and the development assistance programmes of Japan (JICA) and Spain. MCH is primarily funded by the government. Additional funding comes from IPPF – channelled through ATSR.
 - The NSP is primarily funded by the government and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The government funds the drugs budget and the GFATM the other programme costs. GFATM grants also cover HIV funding for NGOs.
 - Most funding sources do not have requirements for or make provisions for SRH and HIV integration. None of the government funding is targeted at creating integration.
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2. Systems level

- Tunisia has a well established health system, with 95 per cent of the population being a maximum of four kilometres from a public-sector health facility.
- HIV services are more specialized than SRH services. For example, the 340 PLHIV currently on antiretroviral therapy (ART) are treated through four specialized centres (third-line level), whereas ONFP and DSSB have regional centres and first-line facilities in each of the 24 governorates.
- In general, the capacity of the health sector to provide tailored services to marginalized groups and young people is perceived as being limited.

Partnerships:

- Programmes and services are implemented by a number of ministries, as well as NGOs.
- The primary international partner for SRH is UNFPA. The primary international funder for HIV programming is the GFATM.
- Other international partners – such as WHO, JICA, European Commission, League of Arab States and the Spanish government – provide support on health systems more generally.
- The principal organization involved in RH is ONFP. It also now plays a major role in HIV as the principal recipient of a GFATM grant.
- The health system includes private sector providers, but there is no defined plan for private sector involvement in SRH and HIV. Their involvement is determined by the capacities of each

provider. It is rare for the private sector to provide SRH services.

- The CCM is the major partnership forum related to HIV, bringing together ministries, NGOs and development partners. There is no equivalent for SRH.
- Many partners support both SRH and HIV, affording opportunities for better integration.

Planning:

- There is no joint planning mechanism for SRH and HIV. The national SRH plan and national STI/HIV programme are implemented by different entities.
- Since 2005, the CCM has played a major role in implementation of the 2006–2010 National Strategic Plan (NSP), as it coordinates the multi-stakeholder process of GFATM request development and management for NSP funding.

Human resources and capacity building:

- Training on SRH and HIV has reached hundreds of health care workers and NGOs, covering a range of topics. However, it is not systematically designed with an integration approach. Also, the content of the training does not always match up with service protocols in use.
- Burn-out of health care workers, non-specialization and lack of systematic training, integrated protocols and referral systems all hamper the integration of SRH and HIV services.

Logistics, supply and laboratory support:

- Condoms are no longer classified as pharmaceutical products, facilitating their procurement and sale in a variety of settings.
- In a 2008 study on adherence to ART, 64 per cent of those reporting adherence problems said the problem related to drug stock-outs.

Monitoring and evaluation:

- There is no M&E framework that is common to SRH and HIV.
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3. Services level

A. SERVICE PROVIDER PERSPECTIVES

HIV integration into SRH services:

- A large proportion of SRH providers provided some HIV-related services. For example, 73 per cent provided HIV testing, 77 per cent general information on HIV and 93 per cent condoms, while fewer provided HIV clinical or care services. Among the providers, 77 per cent said they provided information to most-at-risk populations. Psychosocial support was provided by 77 per cent and positive prevention by around 40 per cent.

- The assessment also gauged the level of provision of HIV-related services within specific types of SRH services. The most common entry point was family planning (FP) and STI prevention and treatment. In both of these, 96 per cent provided condoms, over 80 per cent general information and 64 per cent and 75 per cent respectively HIV testing. In both cases, 32 per cent provided PMTCT services (although often limited to contraception and HIV prevention advice).
- A high proportion of SRH providers (80–90 per cent depending on the specific service in question) stated that they could provide clients with access to HIV services either by direct provision or referral to other providers within the same facility on the same day. Referrals were more frequent for highly specialized SRH services such as MCH, GBV and post-abortion care.
- Two-thirds of SRH providers stated that they provided ongoing follow-up after referring clients to other services. Follow-up was conducted mainly by telephone with the referral facility and with the client, or directly during the next client appointment.
- Overall, there is provision of HIV services by SRH providers, particularly those specializing in FP and STI treatment and prevention. Services related to abortion and GBV are less commonly provided and are less likely to integrate HIV components. But, in general, complementary HIV services can be received the same day, if not always from same practitioner.

SRH integration into HIV services:

- All of the HIV facilities also provided STI treatment and prevention services. However, levels of integration of other SRH services were much lower: 36.7 per cent provided services related to FP, 26.7 per cent MCH, 23 per cent GBV and 20 per cent post-abortion care.
 - The HIV facilities most likely to be able to provide a related SRH service were HIV testing facilities. Providers focused on home-based care or psychosocial support were least likely to provide additional SRH services.
 - Where HIV practitioners stated they were not able to provide SRH services, the majority said they were able to refer clients within the same establishment on the same day.
 - 63 per cent of HIV service providers stated that they monitored clients who had been referred to other providers for other services.
- The assessment indicated that HIV practitioners are more specialized and less likely to provide SRH-related services when compared with SRH practitioners providing HIV services. However, under the broad headings of SRH and HIV, there is a mix of highly specialized services (such as HIV treatment or post-abortion care) and services that are easier to integrate with others and for which integration would be more appropriate.

B. SERVICE USER PERSPECTIVES

- Those attending SRH facilities were primarily attending for MCH services. Those attending HIV facilities were primarily attending for HIV testing.
- According to clients, the subjects most often raised by providers (of all types) were: sexuality, HIV prevention, condoms and HIV testing (all raised by more than 25 per cent of providers). PMTCT, male health, cancer and antenatal care were rarely raised by providers.
- 75 per cent of those receiving SRH services stated that they were either satisfied or very satisfied with the service they had just received. 93 per cent of those receiving HIV services had high levels of satisfaction.
- Of those clients referred for other services, the majority had received the secondary service on the same day in the same establishment.
- Where clients did not receive a service that they had requested, it was due to lack of time on the part of the provider.
- To improve service provision, respondents suggested: personalization of services and care; increased staffing/duration of consultations; and improved confidentiality.
- Most clients preferred to receive SRH and HIV services in the same facility (to save time and costs), although a sizeable minority (29 per cent) preferred services to be provided separately to better preserve confidentiality.
- Opinions on whether individual providers should provide both SRH and HIV services were also divided. Among the clients, 62 per cent preferred to have different providers for different types of services based on concern that providers would be unlikely to be able to dedicate sufficient time if they had to provide a wider range of services.

LESSONS LEARNED AND NEXT STEPS

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

- The assessment benefited from collaboration among the relevant UN agencies. Its process created national interest and interaction about SRH and HIV integration among and between government structures and NGOs – in turn building better ownership of the results.
- The assessment could have benefited from more in-depth analysis of how laws repressing sex work, sex between men and drug use – which are globally recognized as a barrier to universal access – impact on SRH and HIV responses in Tunisia.
- Although the assessment contacted facilities that were ‘primarily’ SRH- or HIV-focused, there appears to be considerable overlap – with many providers having the capacity to provide services in both areas. This is particularly the case for less complex services such as information provision, condom distribution and HIV testing. Inter-service referrals were also in effect in a large number of facilities. As a result, a certain level of appropriate integration has taken place despite the absence of strategies or plans for integration. This is an opportunity which can be built on to make integration and referrals more systematic.

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

- A national action plan has been developed. A Steering Committee – involving ONFP, the NAP, the Tunis section of the Tunisian Association to Fight against STIs and AIDS (ATL), ATSR (an IPPF Member Association) and UN agencies – has responsibility for finalizing the plan.
- The report was disseminated to national governmental structures involved in the process (including the MOH and through relevant departments, such as those for RH, HIV and Health), as well as NGOs and the Joint Team on AIDS.

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:

- The results of the assessment will be incorporated into the development of the new National AIDS Programme for 2011–15.

Systems level:

- The results of the assessment will inform the new strategy on condom promotion led by UNFPA and supported by the GFATM.

Services level:

- The recommendations of the study will help managers and decision-makers to expand the package of SRH and HIV services within both HIV and SRH centres targeting different population profiles, including key populations.

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

- The first step involves finalizing the national action plan and its budget. The Steering Committee will then be responsible for follow-up to identify roles and responsibilities and the contribution of each partner.
- The GFATM principal recipient requested support from UNFPA for a condom promotion strategy at the national level. The National Strategic Plan will integrate the results of the report within its next cycle in 2011–2015.
- UNFPA’s Country Office will ensure follow-up to this programme and contribute to its implementation at the national level.

Abbreviations

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ATSR	Association tunisienne de la santé de la reproduction (Tunisian Association for Reproductive Health)
CCM	Country Coordinating Mechanism
DSSB	Direction des soins de santé de base [Department for Primary Health Care]
FP	family planning
GBV	gender-based violence
GFATM	Global Fund to Fight against AIDS, Tuberculosis and Malaria
GNP+	Global Network of People Living with HIV
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
JICA	Japan International Cooperation Agency
M&E	monitoring and evaluation
MCH	maternal and child health
MOH	Ministry of Health
MSM	men who have sex with men
NAP	National AIDS Programme
NGO	non-governmental organization
NSP	National Strategic Plan
ONFP	Office national de la famille et de la population (National Family and Population Board)
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission
RH	reproductive health
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing
WHO	World Health Organization

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