This country snapshot provides an overview of national level data for the full scope of HIV and sexual & reproductive health and rights (SRHR) linkages/integration at three levels:

- enabling environment (policy and legal)
- health systems
- integrated service delivery

By highlighting results, areas that need strengthening, and data gaps, this snapshot can be used for determining priorities, programme planning, and resource mobilization.


Maternal health is an SRH service, which is often clustered with newborn and child health services.
Linkages versus integration

Linkages refer to bi-directional synergies in policy, systems, and services between SRH and HIV. It refers to a broader human rights-based approach, of which service integration is a subset.

Integration refers to the service delivery level and can be understood as joining operational programmes to ensure effective outcomes through many modalities (multi-tasked providers, referral, one-stop shop services under one roof, etc.).

Theory of change for SRHR and HIV linkages

Output

More enabling environment for a linked SRHR and HIV response

Stronger health systems that support SRHR and HIV integration

More integrated delivery of SRHR and HIV services

Outcome

Reduced HIV-related stigma and discrimination

Increased access to and utilization of quality integrated HIV and SRHR services

Reduced gender-based violence*

Improved programme efficiency and value for money

Impact

Improved health, human rights, and quality of life

Linking HIV and SRHR responses is critical for reaching human rights, gender equality, and health targets for the sustainable development goals.

* It is recognized that reducing stigma and discrimination and gender-based violence are also impact level measures and the outcome measures influence each other.


To find indicators and tools to measure progress
Visit http://bit.ly/1KVaET1

To find out more about linkages/integration
Visit http://srrhivlinkages.org - a collection of SRHR and HIV linkages resources.
**Key HIV and SRHR intersections: Tanzania data**

The intrinsic connections between HIV and SRHR are well-established, especially as HIV is predominantly sexually transmitted or associated with pregnancy, childbirth and breastfeeding.

### Population size 15 million

| Life expectancy at birth | 58 |

| Fertility rate | 5.2 |

### HIV is a leading cause of death in women of reproductive age (globally)

| New adult HIV infections | 31,000 | 23,000 |

| Women | Men |

### People living with HIV

| People living with HIV | 800,000 | 550,000 | 140,000 |

| Women | Men | Children |

### AIDS-related deaths among adults (ages 15+)

| 16,000 |

| Women | Men |

### People living with ART

| People living with ART | 52% |

| 15 years+ | 32% |

| 0-14 years | 29% |

### HIV testing in the general population

| HIV testing in the general population | 28.4% |

### Gender-based violence is a cause and consequence of HIV

| Prevalence of recent intimate partner violence | 34.7% |

### HIV-associated maternal death contributes to maternal mortality

| Maternal mortality ratio | 398 per 100,000 live births |

| Maternal deaths attributed to HIV | 2.40% |

### HIV transmission to infants can occur during pregnancy, childbirth, and breastfeeding. This is more likely where there is acute maternal HIV infection.

| Mother-to-child HIV transmission rate (after breastfeeding) | 8.6% |

| Pregnant women who know their HIV status | 69% |

### Demand for family planning satisfied with a modern method of contraception (15–49)

| Demand for family planning satisfied with a modern method of contraception | 51.3% |

### Certain sexually transmitted infections (STIs) significantly increase the risk of acquiring and transmitting HIV

| Male and female condoms provide triple protection from unintended pregnancies, HIV, and other STIs |

| Number of adults reported with syphilis | 23 |

| Condom use at last sex | 27.1% |

| Demand for family planning satisfied with a modern method of contraception for women living with HIV (15–49) | 21|

Where data is not available this is marked with ▲ also p.5 & 7
Enabling environment (policy and legal)

SRHR and HIV strategies and policies should be interconnected to increase service provision and uptake. Effective responses also must go beyond health services to address human rights and development.

Strategies and policies

Is there a national HIV strategy?\(^{25}\)

If yes, have the following SRHR components been included as a measurable target:\(^{25a}\)

- Condoms (with reference to STI prevention / contraceptive method)? No
- Prevention / elimination of mother-to-child transmission of HIV? Yes
- SRHR of people living with HIV? Mentioned
- Sexually transmitted infections? Yes
- Gender based violence? Yes

Is there a national SRHR strategy?\(^{26}\)

If yes, have the following HIV components been included as a measurable target:\(^{26a}\)

- Condoms (with reference to HIV prevention)? Mentioned
- Prevention / elimination of mother to child transmission of HIV? Yes
- SRHR of people living with HIV? No
- Sexually transmitted infections? Mentioned
- HIV counselling and testing? Mentioned

Is there a national SRHR and HIV integration policy or strategy?\(^{27}\)

Laws

People living with HIV

Are there laws that:\(^{27a}\)

- criminalise HIV transmission or exposure?\(^{27b}\) Yes \(^{30a}\)
- impose HIV specific restrictions on entry, stay or residence?\(^{27c}\) No \(^{30a}\)
- address HIV-related discrimination and protect people living with HIV?\(^{27d}\) Yes \(^{30a}\)

Key populations

Are there laws that:\(^{30b}\)

- criminalise same-sex sexual activities?\(^{31}\) Yes \(^{31a}\)
- deem sex work as illegal?\(^{32}\) Yes \(^{32a}\)
- mandate the death penalty for drug offences?\(^{33}\) No \(^{33a}\)
- demand compulsory detention for people who use drugs?\(^{34}\) No \(^{34a}\)
- recognise a third, neutral and non-specific gender besides male and female?\(^{35}\) No \(^{35a}\)

Gender-based violence

Are there laws that:

- address gender-based violence?\(^{36}\) Yes \(^{36a}\)
- penalise rape in marriage?\(^{37}\) No \(^{37a}\)
- allow free entry into marriage and divorce?\(^{38}\)
- allow the removal of violent spouses?\(^{39}\)

Other laws

Are there laws that:

- make sexuality education mandatory?\(^{40}\) No \(^{40a}\)
- allow legal abortion?\(^{41}\) Yes \(^{41a}\)
- prohibit female genital mutilation?\(^{42}\) Yes (limited enforcement)

Age of Consent

What is the minimum legal age for marriage without parental consent?\(^{43}\)
18 years

What is the legal age for HIV testing without parental consent?\(^{44}\)
16 years

What is the legal age for accessing contraceptives?\(^{45}\)
16 years

What is the legal age for consent to sexual intercourse?\(^{46}\)
16 years
Stigma faced by people living with HIV

People living with HIV often face stigma and discrimination. A non-supportive environment can drive people living with HIV away from SRHR and HIV prevention, treatment, care and support services, hindering the AIDS response.

Percentage of general population reporting discriminatory attitudes to HIV: 59.9%

Has the Stigma Index been conducted?

Sample of 2205 people living with HIV (56.8% female; 43.2% male)

Women’s empowerment

Achieving gender equality and empowering women (Sustainable Development Goal 5) is essential in its own right and also affects health status. It is a broad agenda that includes: ending stigma and discrimination, violence, and harmful practices; ensuring autonomy in health decisions; and accessing SRHR and equal rights to economic resources.

Ability to participate in decisions regarding their own health:
- Men: 96%
- Women: 60%

Women who believe wife is justified in refusing sex with husband:
- Men: 57%

Children and Social Protection

Orphanhood is frequently accompanied by prejudice and increased poverty, factors that can jeopardize children’s chances of completing school education and may lead to increased vulnerability to HIV and poor SRHR outcomes. As such, economic support (with a focus on social assistance and livelihoods assistance) to poor and HIV-affected households remains a high priority in many comprehensive care and support programmes.

Key findings from the Stigma Index

Denied sexual and reproductive health (SRH) services
- Dar es Salaam 2.4%, Other regions 1.7%

Denied family planning services
- Dar es Salaam 3.1%, Other regions 2.3%

Experienced forced or coerced sterilization by healthcare provider on the basis of HIV
- Female: Dar es Salaam 43.3%, Other regions 38.7% (n=440)

Ever counselled about reproductive options since being diagnosed HIV-positive
- Dar es Salaam 2.6% (n=14), Other regions 2% (n=28)

Could access ART (among people yet to commence)
- Dar es Salaam 41.7% (n=246), Other regions 38.8% (n=816)

Had a constructive discussion on HIV treatment options
- Dar es Salaam 8.7% (n=18), Other regions 2.7% (n=39)

Reported experience of stigma and discrimination that hinder access to HIV and SRH services
- Dar es Salaam 8.7% (n=14), Other regions 2% (n=28)

Sought redress if rights violated
- Dar es Salaam 13.6% (n=27)

Gender-based violence

Intimate partner violence has been shown to increase the risk of HIV infection by around 50%. Violence, and the fear of violence, may deter women and girls from seeking HIV testing, disclosing HIV-positive status, and seeking other services for their HIV and SRHR needs.


Prevalence of recent intimate partner violence
- 34.7%

In-school education on preventing dating violence
- Limited scale

Microfinance and gender equity training
- Limited scale

Changing social and cultural norms that support violence
- Larger scale

Children whose households received external support
- 7%

Ratio of school attendance of orphans to non-orphans (aged 10–14 years)
- 95

AIDS deaths in adults occur just at the time in their lives when they are forming families and bringing up children.

Children who have lost one or both parents due to AIDS
- 810,000

Achieving gender equality and empowering women (Sustainable Development Goal 5) is essential in its own right and also affects health status. It is a broad agenda that includes: ending stigma and discrimination, violence, and harmful practices; ensuring autonomy in health decisions; and accessing SRHR and equal rights to economic resources.

Intimate partner violence is a cause and consequence of HIV
Health systems

Integrating SRHR and HIV services requires addressing components of health systems. These include coordination, joint partnerships, planning and budgeting, human resources, procurement and supply chain management, and monitoring and evaluation.

Human resources

- **Doctors per 1,000**
  - 0.031

- **Nurses and midwives per 1,000**
  - 0.436

- **Community and traditional health workers per 1,000**
  - 0.031

Training and supervision

- Are there SRHR training materials and curricula that include HIV?
  - Yes
- Are there HIV training materials and curricula that include SRHR?
  - Yes
- To what extent is supportive supervision for SRHR and HIV integrated at the health service-delivery level?
  - Data not available
- Is there a tool for integrated supervision available?
  - Yes

Logistics and supplies

**HIV and SRHR commodities**

- Are there integrated supply systems?
  - Yes
- Are there integrated ordering systems?
  - Yes
- Are there integrated monitoring systems?
  - Yes

**Commodity stockouts**

- Contraceptives
- Antiretrovirals for HIV
- STI drugs

Coordination, planning and budgeting

- Is there joint planning of HIV and SRHR programmes?
  - No
- Is there any collaboration between SRHR and HIV for programme management/implementation?
  - No

Health information systems

**Health system statistical capacity**

- National surveys: 2/2
- Facility-based data collection: 1.7/3

SRHR and HIV service coverage

- **HIV testing and counselling facilities per 100,000 adult population**
  - 16
- **Primary level service delivery points offering at least three modern methods of contraception**
  - Data not available

Rapid Assessment of SRH and HIV linkages

- Has the Rapid Assessment for Sexual and Reproductive Health and HIV Linkages been conducted?
  - Yes

A rapid assessment of SRH and HIV linkages is a useful tool for countries to assess existing bi-directional linkages at the policy, systems and service-delivery levels.
Integrated service delivery

Providing integrated services enables clients to receive as many quality services as possible at the same time and in the same place, especially at the primary healthcare level. This can happen through government, civil society, and private providers.

Integrated service provision

Health facilities provide HIV services integrated with other health services

- HIV counselling and testing with SRH
  - Many

- EMTCT with antenatal care/maternal and child health

Elimination of mother-to-child transmission of HIV (EMTCT)

Eliminating new HIV infections among children and keeping their mothers alive is based on a four-pronged strategy.\(^{81}\)

Women living with HIV delivering\(^{82}\)

- 84,000

New child HIV infections\(^{83}\)

- 7,200

Indicators for elimination of mother-to-child transmission of HIV

<table>
<thead>
<tr>
<th>Prong</th>
<th>Description</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prong 1:</td>
<td>new HIV infections among women 15-49(^{87})</td>
<td>29,000</td>
</tr>
<tr>
<td>Prong 2:</td>
<td>unmet need for family planning for women of reproductive age(^{88})</td>
<td>25%</td>
</tr>
<tr>
<td>Prong 3:</td>
<td>final mother-to-child HIV transmission rate(^{89})</td>
<td>8.6%</td>
</tr>
<tr>
<td>Prong 3:</td>
<td>women receiving antiretrovirals (ARVs – excluding single dose nevirapine) to prevent new infections among children(^{90})</td>
<td>89.8%</td>
</tr>
<tr>
<td>Prong 3:</td>
<td>women or infants receiving ARVs during breastfeeding(^{91})</td>
<td>&gt;95%</td>
</tr>
<tr>
<td>Prong 4:</td>
<td>ART coverage among children under 15 years(^{92})</td>
<td>29%</td>
</tr>
</tbody>
</table>

Demand for family planning satisfied with a modern method of contraception for women living with HIV (15-49)\(^{95}\)

83% Urban
40% Rural

Dual elimination of mother-to-child transmission of HIV and syphilis

In 2007 WHO launched an initiative for the global elimination of congenital syphilis, outlined in the global elimination of congenital syphilis: rationale and strategy for action.\(^{96}\) Initiatives are now ongoing for dual elimination of mother-to-child transmission of HIV and syphilis as an integrated process, including data validation.\(^{97}\)

Elimination of mother-to-child transmission of syphilis

<table>
<thead>
<tr>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital syphilis rate (per 100,000 live births)(^{98})</td>
<td>44.9%</td>
</tr>
<tr>
<td>Antenatal care attendees tested for syphilis at first antenatal care visit(^{99})</td>
<td>44.9%</td>
</tr>
<tr>
<td>Antenatal care attendees who test positive for syphilis(^{100})</td>
<td>DATA NOT AVAILABLE</td>
</tr>
<tr>
<td>Antenatal care attendees positive for syphilis who are treated appropriately(^{101})</td>
<td>DATA NOT AVAILABLE</td>
</tr>
</tbody>
</table>

http://bit.ly/1jCx7sf
Focus on adolescents and youth

Young people need access to a range of SRHR and HIV information and services on a broad range of topics related to their physical, social, emotional, and sexual development.

**Sexual behaviour**

Median age at first sex among young people aged 20-24

<table>
<thead>
<tr>
<th>Gender</th>
<th>Median Age at First Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>17.4</td>
</tr>
<tr>
<td>Male</td>
<td>18.8</td>
</tr>
</tbody>
</table>

Adolescents aged 15-19 who had:

<table>
<thead>
<tr>
<th>Description</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple sexual partners</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Multiple partners and used a condom at last sex</td>
<td>38%</td>
<td>45%</td>
</tr>
<tr>
<td>Had sex before age 15</td>
<td>9%</td>
<td>12%</td>
</tr>
</tbody>
</table>

**Youth unemployment**

6.5%

**HIV**

Estimated number of adolescents living with HIV aged 10-19

- Young people living with HIV aged 15-24: 98,000 - 65,000

- New HIV infections among adolescents aged 15-19: 6,000

- AIDS deaths among adolescents aged 10-19: 3,800

**Knowledge and comprehensive sexuality education**

- Young people aged 15-19 who have heard of family planning on any of the three sources (radio, TV or newspapers): 50%

- Adolescents aged 15-19 who have comprehensive knowledge of HIV: 37%

- Schools that provided skills-based HIV and sexuality education in the previous academic year: 42%
Focus on key populations

Key populations, including men who have sex with men, people who use drugs, sex workers and transgender people typically have higher HIV prevalence than the general population.

The criminalization of key populations drives people away from health services, increasing vulnerability to negative SRHR and HIV outcomes, as well as to stigma, discrimination, and violence.

Key populations are often not reached with health services, including for SRHR and HIV, and frequently experience violation of their human rights.

<table>
<thead>
<tr>
<th>Men who have sex with men</th>
<th>People who inject drugs</th>
<th>Sex workers</th>
<th>Transgender people</th>
</tr>
</thead>
</table>
| Population size estimate  | 49,700  
118                | 30,000  
119                | 155,450  
120             |
| HIV prevalence            | 17.6%  
122                | 15.5%  
123                | 28%  
124              |
| HIV testing               | 62.8%  
126                | 21.9%  
127                | 43.1%  
128             |
| Condom use                | 13.9%  
130                | 29.4%  
131                | 70%  
132             |

Useful programme implementation tools* and guidelines

http://bit.ly/1ISZWVz

http://bit.ly/1HlTgZ

UNFPA et al. (2015) Implementing comprehensive HIV and STI programmes with men who have sex with men.
http://bit.ly/1LWyIQ6

*Similar implementation tools for HIV/STI programming with other key populations are currently under development.
Additional regional and national data

This infographic snapshot builds on an overarching framework defining HIV and SRHR linkages/integration and provides related national data. Specific aspects of HIV and SRHR linkages/integration vary by region and country due to different types of HIV epidemics and structural drivers of HIV and SRHR. Therefore, a differentiated approach to investment and programming is required.

The suggested way forward

1. **Disseminate the snapshot broadly** to key decision-makers in the government (e.g. Ministry of Health and National AIDS Commission), programme managers, donors, UN agencies, civil society organisations and community-based organisations, and use for advocacy at key events.

2. **Review the data** presented in the snapshot with key HIV and SRHR stakeholders to identify and discuss areas where further work is particularly needed.

3. **Convene a technical working group** with HIV and SRHR stakeholders to jointly plan, coordinate activities and monitor progress on HIV and SRHR linkages/integration.

4. **Work with the Ministries of Justice, Education and Health, and other appropriate sectors** to eliminate human rights violations, such as gender-based violence, early and forced marriage and stigma and discrimination.

5. **Use the snapshot** when developing and evaluating strategies, operational plans and funding proposals.

6. **Collaborate with relevant data collection entities** to fill gaps where data are not available.
4. Data used in the HIV and SRHR Linkages Infographic Snapshot is the most recent data available.
9. 2012. Tanzania HIV and malaria indicator survey (THMIS 2011/12); UNAIDS GARPR
14. UN Commission on Status of Women (2013). Agreed conclusions on the elimination and prevention of all forms of violence against women and girls. New York, UN CSW.
15. 2014. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months. UNAIDS GARPR
16. 2014. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months. UNAIDS GARPR
18. 2014. UNAIDS 2014 estimates
19. 2014. WHO Universal Access Indicator 3.4
21. Indicator: Percentage of total demand for family planning among married or in-union women living with HIV aged 15 to 49 that is satisfied with modern methods (modern contraceptive prevalence divided by total demand for family planning)
23. Indicator: Number of adults reported with syphilis in the past 12 months. WHO Universal Access Indicator 1.17.6
24. 2014. UNAIDS GARPR
30. 2015. GNP+ Global Criminalisation Scan: http://criminalisation.gnpplus.net/alphabetical


36. 2015. There are laws that address GBV but there is contradiction. For example, the Marriage Act, Cap. 29: still sanctions marriage of girls below 18 years contrary to a number of international human rights instruments. Review of the laws and policies related to gender-based violence of Tanzania, Tanzania Women Lawyers Association 2014. http://tawa.or.tz/doc4tawlawe/GBV%20report%202014%20by%20TAWLA%20TAMWA%20%20CRC%20%20TGNP%20%20ZAFELA.pdf


50a. 2014. UNAIDS GARPR


57. 2014. UNAIDS 2014 estimates

58. 2012. WHO Global Health Observatory Data Repository. Density per 1000 Data by country http://apps.who.int/gho/data/node.main.A1444

59. 2012. WHO Global Health Observatory Data Repository. Density per 1000 Data by country http://apps.who.int/gho/data/node.main.A1444

60. Indicator: Community and traditional health workers density (per 1000 population). WHO Global Health Observatory Data Repository. Density per 1000 Data by country http://apps.who.int/gho/data/node.main.A1444

61. 2015. Correspondence with UNFPA Country Office Tanzania, November 2015

62. 2015. Correspondence with UNFPA Country Office Tanzania, November 2015

63. 2015. Correspondence with UNFPA Country Office Tanzania, November 2015

64. Indicator: To what extent is supportive supervision for SRH and HIV integrated at the health service-delivery level? 2015. Correspondence with UNFPA Country Office Tanzania, November 2015

65. 2015. Correspondence with UNFPA Country Office Tanzania, November 2015

66. 2015. Correspondence with UNFPA Country Office Tanzania, November 2015

67. Indicator: Percentage of facilities stocked-out of contraceptives

68. Indicator: Percentage of health facilities dispensing ARVs that experienced stock-out of at least one required ARV in the last 12 months. WHO Universal Access

69. Data not available


73. 2014. WHO Global Health Observatory Data Repository. Testing and counselling facilities Data by country http://apps.who.int/gho/data/node.main.6257C7&lang=en

74. Indicator: Primary level service delivery points offering at least three modern methods of contraception


77. 2014. UNAIDS GARPR

78. Indicator: Are health facilities providing HIV services integrated with other health services: EMTCT/PMTCT with antenatal care/maternal and child health? UNAIDS GARPR
Inter-Agency Working Group on SRH and HIV Linkages

The Inter-agency Working Group on Sexual and Reproductive Health (SRH) and HIV Linkages is convened by UNFPA, WHO, and IPPF and works with more than 20 organizations to:

- advocate for political commitment to a linked SRH and HIV agenda;
- support national action to strengthen SRH and HIV linkages at the policy, systems, and service delivery levels; and
- create a shared understanding of SRH and HIV linkages by building the evidence base and sharing research, good practice, and lessons learnt.

Key achievements since 2004

- 2004: The Glasgow Call to Action and the New York Call to Commitment
- 2005: A Framework for Priority Linkages
- 2008 onwards: Gateways to Integration Case Studies
- 2008 onwards: Rapid Assessment Tool for SRH and HIV Linkages
- 2010: SRH and HIV linkages resource pack
- 2009: Advocating the Sexual and Reproductive Health and Human Rights of People Living with HIV
- 2011: SRH Services and HIV Interventions in Practice
- 2012: What Works? SRH and HIV Linkages for Key Populations
- 2013: EMTCT Job Aid
- 2014: SRH and HIV Linkages Compendium: Indicators and Tools
- 2014: Navigating the Work in Progress

To find out more

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