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Cover photo: Reproductive and child health clinic in Iringa, Tanzania, 2012. This health care worker provides integrated family planning services and HIV counseling and testing. Photo credit: Janet Fleischman.

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HIV AND FAMILY PLANNING INTEGRATION IN TANZANIA

BUILDING ON THE PEPFAR PLATFORM TO ADVANCE GLOBAL HEALTH

*Janet Fleischman*¹

Executive Summary

The President's Emergency Plan for AIDS Relief (PEPFAR) is well positioned to serve as a foundation for other global health programs, building on its health infrastructure, training, and systems. To fulfill that potential in the vital area of women's health will require integrating HIV/AIDS services with family planning and reproductive health services. The results from U.S. health investments in Tanzania indicate that this is a feasible and cost-effective strategy to combat the AIDS epidemic and promote the health of women and girls, and through them their families and communities. The lessons being learned in Tanzania should inform the scale up of strategic integration under PEPFAR for these critical interventions.

Support for using the PEPFAR platform to provide more comprehensive health services for women, and specifically for family planning, has gained momentum in recent years, based on growing evidence demonstrating the important program synergies and health benefits that flow from these linkages.² As more women living with HIV access antiretroviral (ARV) treatment, the HIV platform presents a critical opportunity to provide the information and services they need to decide the number and timing of their pregnancies. Importantly, this approach includes preventing new HIV infections by reducing unintended pregnancies, thereby preventing mother-to-child-transmission (PMTCT). Similarly, integrating HIV services into family planning,

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² See World Health Organization (WHO) and UN Population Fund (UNFPA), "Glion Consultation on Strengthening the Linkages between Reproductive Health and HIV/AIDS: Family Planning and HIV/AIDS in Women and Children," 2006, http://www.who.int/hiv/pub/advocacymaterials/glionconsultationsummary_DF.pdf; Rose Wilcher, Willard Cates Jr., and Simon Gregson, "Family Planning and HIV: Strange Bedfellows No Longer," *AIDS* 23, sup. 1 (November 2009): s1-s6, http://journals.lww.com/aidsonline/Fulltext/2009/11001/Family_planning_and_HIV__strange_bedfellows_no.1.aspx; Micah Gilmer and Brian Baughan, "Making the Case for Integration," Tides Foundation, May 2010, <http://www.tides.org/fileadmin/user/pdf/Tides-Africa-Fund-HIV-Making-the-Case-for-Integration-Report.pdf>.

reproductive health,³ and maternal and child health programs helps prevent HIV infection in women and girls, while increasing access for HIV-infected women to ARV treatment and to PMTCT programs to help ensure that their children remain uninfected.

This report examines the situation in Tanzania, where the United States has supported the national government in making notable progress toward integrating HIV services with family planning and reproductive health (RH), particularly through PMTCT programs. Integration in Tanzania has been driven by a number of factors, including political commitment from the national government, specified funding from the United States, and experience brought by some PEPFAR implementing partners in the area of family planning–HIV integration. Yet despite the improved policy environment, ongoing barriers remain in implementation, financing for integration, and integration of family planning as a core component of PEPFAR’s treatment programs.

In Tanzania, the United States has made important commitments to provide a more complete range of health services for women and girls, through PEPFAR, the Office of Population and Reproductive Health at the U.S. Agency for International Development (USAID), and U.S. bilateral program activities, all of which fall under the Global Health Initiative (GHI).⁴ Despite the politics that surround discussions of family planning in the United States and the challenges of integrating vertical programs, there is broad consensus among health experts that HIV and family planning services should be closely linked and that advancing integration is a smart and effective way to expand the impact of U.S. health investments.

However, many challenges remain in pursuing integration. In Tanzania, challenges include the large unmet need for family planning among HIV-positive and HIV-negative women; chronic stock-outs of family planning commodities; the need for training and ongoing support for both HIV and family planning providers to ensure quality integrated services; and the severe shortages of health workers. For the U.S. government, challenges revolve around galvanizing domestic bipartisan support for family planning–HIV integration in the current polarized environment,

³ Most public health experts include family planning within the broader context of reproductive health services, such as antenatal and postpartum maternal and newborn care, safe birthing services, prevention and treatment of sexually transmitted infections (STIs), postabortion care, obstetric fistula care, and cervical cancer screening. The WHO definition of reproductive health does not include abortion.

⁴ On July 3, 2012, the GHI principals—Administrator Rajiv Shah of USAID, Ambassador Eric Goosby of PEPFAR, Director Thomas Frieden of CDC, and Executive Director of GHI Lois Quam—published a joint message stating the office of the Global Health Initiative will be closed and that an office of Global Health Diplomacy will be set up at the State Department. This office will have the mandate to ensure that GHI principles are implemented in the field. GHI country teams will continue to work to implement GHI strategies under the leadership of the U.S. ambassador. See “Global Health Initiative Next Steps—A Joint Message,” U.S. Global Health Initiative, <http://www.ghi.gov/newsroom/blogs/2012/194472.htm>. At this writing, it is unclear what these changes will mean for the direction of GHI in Washington, and the implementation at the country level.

and ensuring that such integration is prioritized and measured. Underlying all these challenges is the need to ensure that the rights of women and girls in Tanzania are respected.

In Tanzania, HIV prevalence is 7 percent for females and 5 percent for males; young women aged 15 to 24 are infected at rates four times higher than men their age, and most of these women were infected through sexual transmission. Under the U.S. Global Health Initiative (GHI), the interagency GHI country team in Tanzania has made women's and girls' health a priority area, with a special focus on aligning U.S. health programs across delivery platforms and linking HIV with family planning, reproductive health, and maternal, newborn, and child health (MNCH) programs. In a move toward greater effectiveness in the health sector, the Tanzanian government is also bringing these services together under the auspices of the Ministry of Health and Social Welfare's Reproductive and Child Health Services.

Policy Options

PEPFAR's support for expanding linkages between HIV and family planning in Tanzania demonstrates how that platform can be used to improve the health of women and girls and to meet Tanzania's HIV and PMTCT goals. This process is increasingly being recognized as a critical aspect of HIV programs; the Centers for Disease Control and Prevention (CDC) recently stated that contraception is "critically important to prevent unintended pregnancy among women at risk for HIV infection or infected with HIV,"⁵ just as HIV-infected women who want to become pregnant need access to PMTCT services. To build momentum and sustainability for integration in Tanzania, PEPFAR should consider the following steps:

- Support the strategic integration of HIV and family planning by national governments and encourage high-level political support at the national and donor level for increasing access to family planning in general and to integrated family planning-HIV programs in particular.
 - Ensure that partners in both PEPFAR and family planning programs are invested in and implementing family planning-HIV integration.
 - Focus particular support on the needs of HIV-infected women related to voluntary family planning, reproductive health, and maternal child health, in the

⁵ Naomi K. Tepper et al., "Update to CDC's *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: Revised Recommendations for the Use of Hormonal Contraception Among Women at High Risk for HIV Infection or Infected with HIV*," *Morbidity and Mortality Weekly Report (MMWR)*, June 22, 2012, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6124a4.htm?s_cid=mm6124a4_w.

context of their HIV care and treatment needs. This includes counseling to provide information on a range of contraceptive methods.

- Support country-level stakeholders and civil society organizations to advocate for greater family planning–HIV integration. Promote integration champions at all levels—in all government ministries, not just the Ministry of Health, and in civil society.
- Provide clear guidance to PEPFAR and GHI country teams about best practices on family planning–HIV integration. This should emphasize the priority placed on integration and the expectations for implementation, as well as how PEPFAR funds can be used for integrated programs.
- Expand on the early progress of GHI’s gender focus in Tanzania to ensure greater interagency efficiencies and collaboration and to further promote family planning–HIV integration. This means ensuring appropriate budgets, plans, and targets that reflect these priorities; developing indicators on family planning–HIV integration to ensure accountability; and holding each U.S. agency accountable for carrying forward GHI principles on strategic integration and women’s health.
- Continue high-level, bipartisan leadership in the United States on the importance of investing in comprehensive health services for women and girls, and institutionalize these approaches in U.S. policy to ensure sustainability.

Family Planning–HIV Integration in Tanzania

Integration of HIV and family planning, as well as with other maternal and child health programs, has been underway in Tanzania since 2008. This program direction was included in the Obama administration’s strategy under PEPFAR, and the more integrated GHI approach also facilitated U.S. engagement in this area. According to one U.S. official in Tanzania, “PEPFAR II opened the window and made integration more explicit.”⁶ Integration in Tanzania has also been supported by PEPFAR’s PMTCT Acceleration Plan,⁷ which expanded integration of services provided by key PEPFAR treatment partners to include HIV care and treatment, family planning, emergency obstetric care, and cervical cancer screening. The aim is to move from stand-alone HIV/AIDS sites to more integrated sites, in line with the Tanzanian government’s framework (see below).

Integration of family planning and HIV services has been promoted by groups already working in Tanzania, including by U.S. implementing partners and Tanzanian civil society organizations. In particular, the Family Planning/HIV Integration Technical Working Group (see below), with the

⁶ Interview in Dar es Salaam, April 16, 2012.

⁷ The PMTCT Acceleration Plans, announced as a \$100 million program in 2010, focused on six countries—Malawi, Mozambique, Nigeria, South Africa, Tanzania, and Zambia—with high rates of maternal-to-child transmission of HIV. See PEPFAR, “For Women, Children, and Families: PEPFAR and Prevention of Mother-to-Child-Transmission of HIV (PMTCT),” <http://www.pepfar.gov/documents/organization/156903.pdf>.

involvement of the Tanzanian government as well as with nongovernmental organizations (NGOs) with experience in implementing integrated services, represented an important element in advancing this agenda in Tanzania. The advocacy generated by this working group process has helped encourage the governments of Tanzania and the United States to make program integration an area of greater focus and priority.

Despite a 30 percent increase in contraceptive prevalence rate (CPR) from 2004/2005 to 2010, unmet need for family planning remains high in Tanzania at 25 percent. According to the 2010 Tanzania Demographic and Health Survey (DHS), 27 percent of currently married women and 51 percent of sexually active unmarried women are using modern contraception.⁸ The contraceptive prevalence rates have been increasing since 1991, rising in married women from 10 to 27 percent. However, over 40 percent of women seek but cannot access family planning services, which may be related in part to the problems of recurring stock-outs and insufficient numbers of health care workers to deliver services. This gap is of particular concern because, after a period of progress in the 1990s that lifted the contraceptive prevalence rate and made Tanzania a regional success story, the national program began to stagnate, leading to stock-outs of key family planning commodities and constraining ongoing efforts to address misconceptions about family planning.⁹

The high unmet need for modern family planning in Tanzania, including for women living with HIV, and the comparatively modest resources required to address this unmet need, makes integration especially important. According to a study by Columbia University's International Center for AIDS Care and Treatment Programs (ICAP), only 38 percent of HIV-infected women getting treatment in Tanzania reported that a health care provider at the antiretroviral therapy (ART) clinic discussed family planning with them, despite the fact that 70 percent did not intend to become pregnant within the next six months.¹⁰ The implications of this deficit are important, both for providing women and couples (given the importance of involving men) with information and services to determine the number and timing of their children and for preventing unintended pregnancies among HIV-infected women as part of PMTCT.

⁸ National Bureau of Statistics and ICF Macro, *Tanzania Demographic and Health Survey 2010* (Dar es Salaam: National Bureau of Statistics, April 2011), [http://www.measuredhs.com/pubs/pdf/FR243/FR243\[24June2011\].pdf](http://www.measuredhs.com/pubs/pdf/FR243/FR243[24June2011].pdf).

⁹ USAID, "Tanzania BEST Action Plan 2010–2015: Best Practices at Scale in the Home, Community, and Facilities," March 25, 2011.

¹⁰ R. Mbatia et al., "Unmet need for family planning among PLHIV attending HIV care and treatment services in Kenya, Namibia, and Tanzania," International Center for AIDS Care and Treatment Programs (ICAP), Columbia University, n.d., http://www.aidstar-one.com/sites/default/files/technical_consultations/fp_hiv_mnch_integration/day_2/3_Redempta_Mbatia.pdf.

Information from health clinics in Tanzania indicates that HIV-infected women are accessing PMTCT through reproductive and child health services (usually during antenatal care) at considerably higher rates than they are accessing HIV care and treatment. This discrepancy relates to the fact that care and treatment clinics are physically separate from reproductive and child health (RCH) clinics, that linkages between treatment and family planning services are frequently poor, and that stock-outs of family planning commodities are a chronic problem. The result is an insufficient link between PMTCT and treatment services, leading to women being HIV tested in antenatal clinics, but not being referred successfully to care and treatment programs for themselves if they test positive.

These gaps are compounded by the “desperate” shortages of human resources, which present challenges to all service delivery. “They [health care providers] are spread thin, and there is no magic bullet,” one PMTCT implementer commented.¹¹ The insufficient resources for family planning for many years also contribute to the challenges of effective family planning–HIV integration. A USAID representative cast the problem in stark terms: “There’s a generation of women who are 3 to 4 children into their reproductive lives, who have never heard public family planning messages.”¹² With the advent of GHI, family planning objectives are now part of PMTCT. Since 9.8 million pregnant women, including 660,000 HIV-infected women, accessed PEPFAR-supported PMTCT services globally in 2011, this provides an important opportunity to give them and their partners information about family planning and access to services.

An additional complication in promoting family planning–HIV integration involves differences in U.S. agencies’ focus and experience in this area. This is especially evident in the provision of all four elements (or “prongs”) of comprehensive PMTCT services, which includes integration of family planning services to prevent unintended pregnancy in women with HIV, known as “prong 2.” In addition to preventing HIV transmission from mother to child (prong 3), comprehensive PMTCT includes preventing HIV in women of reproductive age (prong 1), and preventing unintended pregnancy in women with HIV (prong 2). As one implementing partner explained, program implementation involving women and adolescent girls can be more complicated when the funding is coming from CDC, as opposed to USAID, which has more experience in family planning programming. In PMTCT programs, for example, a representative of one NGO stated, “CDC goes right to prong 3”—preventing HIV transmission from mother to child and skipping over the first 2 prongs that involve preventing HIV in women of reproductive age and preventing unintended pregnancies in HIV-infected women.¹³ This underscores the need to make sure that U.S. agencies and implementing partners are focusing on comprehensive PMTCT.

¹¹ Interview in Dar es Salaam, April 16, 2012.

¹² Interview in Dar es Salaam, April 17, 2012.

¹³ The four-prong approach to PMTCT was developed by the United Nations in 2001 and is now recognized as the most comprehensive way to address PMTCT. Each “prong” represents a stage at which program services work to (1) prevent HIV in women of reproductive age, (2) prevent unintended pregnancy in women with HIV, (3) prevent HIV transmission from mother to child, and (4) provide

The Government of Tanzania's Response

Since 2008, the government of Tanzania has made progress in establishing a policy environment that supports greater program integration.¹⁴ National policies for HIV/AIDS care and treatment have been revised to include integration as a core component, including screening for unintended pregnancies, and family planning counseling and referral for services.¹⁵ The Reproductive and Child Health Section of the Ministry of Health and Social Welfare has updated its protocols and training curriculum to include family planning for HIV-infected women. In addition, the government established a national Family Planning/HIV Integration Technical Working Group in 2009, cochaired by representatives of the National AIDS Control Program and the Reproductive and Child Health Section, that brings together family planning and HIV implementers—local and international—to exchange information and provide technical assistance for greater integration.¹⁶

As part of this process, the government added a family planning target to the National Strategy for the Prevention of Mother-to-Child Transmission 2008–2015; by 2015, at least 80 percent of women living with HIV and attending PMTCT services should receive family planning messages. In addition, service protocols and training for family planning providers now include contraception for people living with HIV.¹⁷ In its 2012 PMTCT guidelines, the government has moved to integrate family planning into PMTCT, through the reproductive and child health platform and its antenatal clinics (ANCs). The government is also moving toward integrating ART into maternal and child health services to facilitate HIV treatment for women, and it is operationalizing guidelines to integrate family planning into ART programs.¹⁸ Working with the Technical Working Group, the government is developing a national strategic framework for the integration of maternal, newborn, and child health, including family planning, into HIV and other health services.

ongoing postpartum care and support to mothers, their children, and families. See USAID AIDSTAR-One, “Prevention of Mother-to-Child-Transmission (PMTCT) of HIV,” http://www.aidstar-one.com/focus_areas/pmtct.

¹⁴ Dr. Deborah Kajoka, MOHSW, “Integrating Family Planning and HIV Services: Tanzania’s experience” (presentation at a meeting on integration of FP/HIV/MNCH in Washington, DC, March 2011), http://www.aidstar-one.com/sites/default/files/technical_consultations/fp_hiv_mnch_integration/day_1/Tanzania.pdf.

¹⁵ Gilmer and Baughan, “Making the Case for Integration,” p. 26.

¹⁶ FHI360, “Integrating Family Planning with HIV in Tanzania,” May 2011, http://www.fhi360.org/en/CountryProfiles/Tanzania/res_TanzaniaFPHIV.htm.

¹⁷ FHI360, “Integration of family planning and HIV care and treatment in Tanzania: FHI360’s past and future role,” internal document.

¹⁸ United Republic of Tanzania, “Country Progress Reporting,” March 2012, p. 17, [http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2012countries/ce_TZ_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2012countries/ce_TZ_Narrative_Report[1].pdf).

However, reports from some of those attending the Family Planning/HIV Integration Technical Working Group meetings indicate that government departments and NGOs focused on HIV/AIDS participate far less often in the working group than those government departments and NGOs working on family planning, indicating that the siloed approach remains difficult to break down and that the family planning community is more motivated to find ways to leverage the PEPFAR platform to provide integrated services. In addition, a significant barrier to integration is the lack of integrated funding streams, especially given the vast discrepancy in funding for family planning versus HIV in Tanzania.

To further promote the process of family planning–HIV program integration, the Tanzanian government will have to develop a clear integration strategy with accompanying guidelines and budgets, and ensure joint planning and coordination between the Reproductive and Child Health Section and the National AIDS Control Program.¹⁹ At the service delivery level, this integration has already been happening; the national government now has to move ahead with operational guidance and standardization.

According to the Reproductive and Child Health Section of the Ministry of Health and Social Welfare, significant progress has been made in improving PMTCT access: as of December 2011, 93 percent of reproductive and child health clinics provided PMTCT; about 98 percent of women attending reproductive and child health clinics agree to be tested for HIV; about 80 percent of HIV-infected women received ARVs for PMTCT. Yet only 11 percent of pregnant women were started on ARVs for themselves. In addition, the Reproductive and Child Health Section recognizes that less progress has been made on the family planning piece and sees the need to use all available entry points—not only PMTCT, but also childhood immunization and growth monitoring—to strengthen family planning services for HIV+ women.

“There are opportunities for much stronger integration of services, especially through pediatric care,” noted Dr. Neema Rusibumayila, acting chief medical officer and assistant director of preventive services, Reproductive and Child Health Section. She specifically mentioned integration of family planning within HIV and HIV within family planning through provider initiated counseling and testing.²⁰ She went on to describe that these gaps are partly due to the fact that HIV has been the main focus for U.S. funding due to PEPFAR, which has had few links to the Reproductive and Child Health Section, but that GHI has brought a new push to integrate HIV with reproductive and child health services. “The challenge,” she continued, “is that each [implementing] partner can decide what they will integrate, and how to use the funding...to strengthen integration. We need to be clear on the key components.”

¹⁹ IPPF, UNFPA, WHO, UNAIDS, “Tanzania: Rapid Assessment of Sexual and Reproductive Health and HIV Linkages,” 2011, <http://www.who.int/reproductivehealth/topics/linkages/RAStanzania.pdf>.

²⁰ Interview with Dr. Neema Rusibumayila, acting chief medical officer, Reproductive and Child Health Section, Ministry of Health and Social Welfare, April 17, 2012.

Program Examples

There are a range of examples of programs moving to integrate family planning and HIV in Tanzania. The following illustrate some of the different approaches being developed, many of which leverage the PEPFAR platform.

- **EngenderHealth's ACQUIRE Tanzania Project (ATP)**, primarily supported by USAID/Tanzania with resources from Office of Population and Reproductive Health, and from PEPFAR for PMTCT, supports the Ministry of Health to integrate family planning at PMTCT sites to deliver family planning services to HIV+ women and others, as well as some ARV initiation at antenatal/PMTCT clinics for clients who qualify. Through its capacity-building work with the Ministry of Health, ATP is involved in training of trainers for clinical services, supervision and quality assurance; capacity building for district and regional monitoring and evaluation officers; and minor renovations and equipping of health facilities. As part of PMTCT, ATP has supported scale-up of basic emergency obstetric care and focused antenatal care. ATP has had good integration results, with over 80 percent of PMTCT and comprehensive postabortion care (cPAC) clients receiving family planning information. By integrating family planning into its work, ATP is emphasizing the importance of service delivery and family planning outreach and enhancing facility-community linkages for strengthening integration. EngenderHealth is also working on male involvement in HIV and family planning services by encouraging men to seek services for themselves and their partners.²¹
- **Pathfinder International** has leveraged private funding to provide community-based family planning services as part of its HIV/AIDS community home-based care program (CHBCP). These private funds complement the CDC PEPFAR funds for community HIV services by supporting community-based distribution of condoms and pills, in addition to full counseling on clinical methods. This has resulted in over 69,000 new and 112,000 continuing contraceptive clients. The 473 community-based distributors each have 100 to 150 active clients, while CHBCPs have about 30, illustrating the importance of using the family planning platform for HIV information and services. Community integration allows clients to discuss all of their family planning options with these providers, including longer acting contraceptive methods, without the stigma often associated with issues involving family planning and safer pregnancy for HIV-infected women.²²
- **Marie Stopes Tanzania (MST)**, registered as a local organization but affiliated with Marie Stopes International, has programs in mainland Tanzania and in Zanzibar that integrate maternal and child health, family planning, and HIV testing. Service delivery focuses on three channels: 12 static clinics, one at a hospital and the other 11 at dispensary-level facilities,

²¹ Interviews at EngenderHealth in Dar es Salaam, April 16, 2012.

²² Interviews with CHBCPs in Kinondone district, Dar es Salaam, April 18, 2012.

which provide the full range of services; outreach services, involving 16 mobile teams that each go to the field for 18 days per month, 11 months per year, and provide a range of family planning methods (including tubal ligations and intrauterine devices) and also include voluntary counseling and testing (VCT); and six *bajaji* or auto-rickshaw models, in which family planning providers circulate in peri-urban areas using three-wheeled motorized rickshaws to provide all family planning methods except tubal ligation, for which they refer to clinics. MST charges user fees at their clinics to subsidize its family planning services, but the outreach and *bajaji* teams offer free services, funded by donors.²³ Most of MST's mobile outreach and VCT work is supported by the UK Department for International Development (DFID) and administered by USAID.

Despite the guidelines and high-level support for integration, most HIV clinics are not yet providing effective family planning–HIV integration. For example, the Mwananyamala Clinic in Dar es Salaam, built by PEPFAR, serves about 200 HIV+ people and exposed infants per day. The clinical staff report that they provide family planning methods, but when pressed, they acknowledge that they only have condoms at that site; a broader range of family planning methods are available at the family planning clinic across the street. However, the staff also conceded that unless the women are actually escorted to the family planning site, most don't go. In addition, young people are referred to a separate “youth-friendly clinic” nearby.²⁴

Similarly, in the Iringa Regional Hospital, the HIV care and treatment services and the reproductive and child health services are not integrated but rather rely on a referral model, although the reproductive and child health staff will soon receive training to provide HIV care. This means that family planning services are not offered at the care and treatment sites; rather, clients are referred to the RCH clinic, about 20 per month. However, ANC/PMTCT clients receive family planning information to prepare them to use methods of their choice after delivery. Cervical cancer screening is available through the RCH, and women are referred from the care and treatment center.²⁵

The United States and Other International Donors

Tanzania is heavily reliant on foreign aid, with approximately one-third of its budget financed by direct budget support from international funders,²⁶ and over 80 percent of HIV funding coming from PEPFAR and the Global Fund.²⁷ The United States is the primary funder in health,

²³ Interviews with MST, Dar es Salaam, April 15, 2012, and in Zanzibar, April 23, 2012.

²⁴ Interviews in Dar es Salaam, April 18, 2012.

²⁵ Interviews at Iringa Regional Hospital, April 19, 2012.

²⁶ USAID, “Tanzania BEST Action Plan 2010-2015: Best Practices at Scale in the Home, Community, and Facilities,” March 25, 2011.

²⁷ United Republic of Tanzania, “Country Progress Reporting,” p. 41.

especially as other donors are reducing their contributions to the health sector in Tanzania, and in the wake of the Global Fund crisis.

U.S. Policy

PEPFAR's stated commitment is to improve synergies between family planning and HIV as a way to improve HIV outcomes "where feasible, efficient and consistent with U.S. government statutory requirements."²⁸ This commitment stems from PEPFAR's recognition of the importance of the bidirectionality of integration, with PEPFAR platforms reaching large numbers of women, including those living with HIV, and with family planning programs in high HIV prevalence areas providing an entry point for HIV/AIDS services. As a representative of the Office of the Global AIDS Coordinator (OGAC) explained: "Ultimately, individuals should be able to receive HIV, family planning, and other necessary reproductive health services at a single health care site."²⁹

PEPFAR's focus is to provide integrated services to prevent unintended pregnancy and to help HIV-positive women and their partners plan their pregnancies as safely as possible, through PMTCT platforms. PEPFAR policy is to support integration by providing family planning counseling and referrals at its sites, training health care providers on family planning, and strengthening commodity logistics and procurement systems, but stopping short of purchasing family planning commodities, other than condoms.

To benefit from lessons learned in this area, a new effort is being undertaken by an interagency team composed of OGAC, CDC, and USAID/PRH and USAID/OHA to conduct an integration scan in five countries (Malawi, Uganda, Nigeria, Swaziland, and Burundi) to identify what is and is not working in integration and how to catalyze country-level efforts. The countries were picked to reflect different levels of implementation of integrated programs, government commitments, GHI strategy priorities, PMTCT scale-up plans, and the presence of USAID family planning programs.

PEPFAR is also looking at integration through the lens of the PMTCT acceleration plans. As part of the planning process, country teams were asked to address all four prongs of PMTCT—including prong 2 on preventing unintended pregnancies in HIV-infected women.

Yet family planning–HIV integration continues to be a complicated issue for PEPFAR. Both the Bush and Obama administrations have proceeded cautiously due to resistance in some quarters of the U.S. Congress, which often equate family planning with abortion, despite the fact that U.S. foreign assistance funds prohibit abortion to be used as a method of family planning. In fact, PEPFAR does not allow its funds to be used to purchase contraceptive commodities, beyond male

²⁸ Daniela Ligiero, "The Global Health Initiative, Gender, and Integration" (presentation at CSIS conference, March 13, 2012), <http://smartglobalhealth.org/page/signup/the-global-health-initiative-gender-and-integration>.

²⁹ Ibid.

and female condoms, even though that is not explicitly prohibited by the legislation that reauthorized PEPFAR. Nevertheless, PEPFAR's guidelines make clear that family planning methods must come from other sources, including national governments, USAID's family planning programs, UNFPA, or other funders.

U.S. funding levels to Tanzania are significant, with approximately \$700 million in development assistance in FY2011, focusing particularly on health and education issues.³⁰ About half of this amount (\$357 million) came from PEPFAR. Family planning funding in FY2011 was approximately \$22 million, focused on interventions such as increasing access to, demand for, and use of contraceptives. Maternal/child health activities were supported by USAID, with \$8 million in funding in FY2011. These stark differences in funding levels underscore the important opportunities for PEPFAR to support integrated programs that advance its HIV goals, particularly in the areas of training and ongoing support for both HIV and family planning providers to ensure quality, integrated services.

The U.S. GHI strategy for Tanzania, released in September 2011, clearly states that “[g]ender is a GHI priority in Tanzania.”³¹ The strategy calls for aligning U.S.-supported programs in HIV/AIDS, malaria, tuberculosis, nutrition, family planning and reproductive health, and maternal, newborn, and child health and to scale up integrated programs that work. The strategy states: “Under GHI, the USG [U.S. government] endorses a strategy to achieve major improvements in health outcomes through the integration of existing USG programs in partnership with the MOHSW’s Reproductive and Child Health Services (RCHS). Leveraging the robust service delivery platforms strengthened under PEPFAR and PMI [the President’s Malaria Initiative], efforts will now turn to ensuring that a more complete range of highly effective MNCH, nutrition, sanitation and hygiene, and FP/RH interventions are available throughout Tanzania to help address the major causes of maternal and under-five mortality.”

UK Department for International Development (DFID)

The government of the United Kingdom is active in Tanzania, although it provides most of its assistance in the form of budget support. The United Kingdom is less engaged in the health sector and does not contribute to the health basket, in part a reflection of a division of labor among the donors, but it has focused support on reducing maternal mortality and supporting family planning.

³⁰ U.S. Department of State, “Background Note: Tanzania,” December 2011, <http://www.state.gov/r/pa/ei/bgn/2843.htm#relations>.

³¹ Global Health Initiative, “Tanzania Global Health Initiative Strategy 2010-2015,” September 2011, <http://www.ghi.gov/documents/organization/175135.pdf>.

Since 2010, the United Kingdom has been engaged in innovative efforts to work with USAID to ensure a sustainable supply of contraceptives. Specifically, DFID has entered into three separate memoranda of understanding (MOUs) to provide funding to USAID to address disruptive stock-outs in the Tanzanian public sector: in December 2010, £6.5 million for family planning commodities; in June 2011, £8 million for family planning outreach, focused on Marie Stopes Tanzania; and in February 2012, £15 million, with 40 percent for family planning commodities, 40 percent for MCH commodities, and 10 percent each for quantification and advocacy. This innovative model of joint financing between the United States and the United Kingdom provided \$40 million to USAID to fill the gap in family planning and maternal health commodities for the public sector.

A USAID official reportedly went directly to the development partners group and made it clear that Tanzania was out of money for commodities and needed the assistance of the development partners. As the USAID representative explained: “It was a perfect storm—everyone looked at their own particular problem and put patches on. So we lumped it together, and it became an important amount of money.”³² Since DFID had the available resources and USAID had the technical staff in Tanzania, this led to a convergence of priorities and abilities.

Global Fund to Fight AIDS, TB, and Malaria

In recent years, the Global Fund has increased its ability to provide funding for linkages between HIV and family planning. The Global Fund can fund family planning commodities beyond condoms for PMTCT and HIV prevention, such as avoiding unintended pregnancies in HIV-infected women, but each applicant country decides what to put in its proposal through its Country Coordinating Mechanism (CCM).

Tanzania included some HIV–family planning integration in its recent Global Fund proposals, although the proposals themselves were not always successful. However, its Round 7 Global Fund grant, which aimed to integrate reproductive health services by training health workers to offer family planning, as well as antenatal care, provider initiative counseling and testing (PITC), ARVs, and STI diagnosis and treatment, was successful.³³ The Tanzanian National Coordinating Mechanism endorsed including family planning in its Round 10 proposal.³⁴ However, Tanzania’s Round 10 application was not awarded.

³² Interview in Dar es Salaam, April 17, 2012.

³³ WHO, “Making the Case for Interventions Linking Sexual and Reproductive Health and HIV in Proposals to the Global Fund to Fight AIDS, TB, and Malaria,” 2010, http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.02_eng.pdf.

³⁴ Dr. Deborah Kajoka, MOHSW, “Integrating Family Planning and HIV Services: Tanzania’s experience” (presentation at a meeting on integration of FP/HIV/MNCH in Washington, DC, March 2011), http://www.aidstar-one.com/sites/default/files/technical_consultations/fp_hiv_mnch_integration/day_1/Tanzania.pdf.

Health and HIV Baskets

The health sector donors work with the government of Tanzania through a sector-wide approach (SWAp). Most of the bilateral and multilateral donors provide support through the health basket, although the United States provides it only on a bilateral basis, while still being involved in the discussion related to the Health Basket Partners' Group. The basket funds such things as commodities, training at the central level, and the implementation of the comprehensive council health plans at the district level. There has been an effort on the part of the donors to encourage the government to focus more on maternal and child health and primary health care and to help build the capacity of the Tanzanian government in the health arena. The total basket funding was approximately \$115 million in 2011, of which only a small amount—about \$2.5 million—was dedicated to family planning commodities.³⁵

Two bilateral donors (Canada and Denmark) also participate in an HIV basket, but given the overwhelming dominance of the United States and the Global Fund in that area, few other donors provide significant resources specifically for HIV. The HIV basket therefore focuses on non-health areas, such as support for orphans and vulnerable children and people living with HIV/AIDS, prevention activities, youth empowerment, and helping children to stay in school. Out of \$1 billion annually for health in Tanzania (on budget and off budget), close to half is for HIV/AIDS, largely from PEPFAR and the Global Fund.

Conclusion

For U.S. government programs, the Global Health Initiative provides a supportive framework to pursue strategic integration, and the PEPFAR platform provides important opportunities to advance these programs. Whatever the future of GHI, U.S. government agencies should continue the momentum on integration by leveraging the PEPFAR platform to support linkages with family planning and reproductive health. Important lessons are being learned from U.S. investments in Tanzania, where integration of family planning and HIV/AIDS programs has moved forward with the support of the national government, as well as national and international implementing partners.

However, sustaining this approach will require continued progress in certain key areas: political and financial commitment from the national government; training of HIV and family planning providers to deliver quality, integrated services; and targeting donor resources to promote family planning–HIV integration as a core component of HIV programs. By supporting family planning–HIV integration as part of more comprehensive health services, PEPFAR can advance its HIV/AIDS goals while contributing to better health outcomes for women and girls in Tanzania.

³⁵ Interview in Dar es Salaam, April 17, 2012.



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