Delivering Health Services to Key and Vulnerable Populations at Cross-Border Sites in the East African Region

Summary of Research Findings from Tanzania

INTRODUCTION AND STUDY OBJECTIVES

The Cross-Border Health Integrated Partnership Project (CB-HIPP) undertook a study in Tanzania in 2017 to assess the availability of health and HIV services for key and vulnerable populations in two cross-border sites—Holili (land) and Kirongwe (wet). The objectives were to:

- Describe the readiness of health facilities (infrastructure and services) in the cross-border sites to provide services to the target populations
- Describe the readiness of health care workers (attitude, perceptions, training) to provide high-quality and friendly health and HIV and AIDS services to the target populations
- Describe health-seeking behaviors among key, vulnerable, and migrant populations in the selected study areas
- Assess barriers and facilitators affecting access to health and HIV and AIDS services among members of the target populations
- Describe the vulnerability of women from key and vulnerable populations in cross-border sites, based on a vulnerability index checklist

This brief presents the study approach and a summary of the key findings.

Overview of CB-HIPP

The Cross-Border Health Integrated Partnership Project (CB-HIPP) (September 2014–August 2019) is supported by the U.S. Agency for International Development with funding through the U.S. President's Emergency Plan for AIDS Relief. The project is designed to extend quality integrated health care services in strategic border areas and other transport corridor sites in Eastern, Central, and Southern Africa.

In addition to expanding service delivery for key and vulnerable populations, the project recognizes the need for alternative health-financing models to increase uptake and sustainability of services within an enabling policy environment. In this regard, the region's intergovernmental bodies (i.e., East African Community, Intergovernmental Development Authority, Southern African Development Community) are expected to play a key leadership and partnership role in the project's implementation.

The goal of CB-HIPP is to catalyze and support sustainable and African-led regional health development partnerships to improve health outcomes among mobile populations and vulnerable communities residing along Eastern, Central, and Southern African transport corridors and cross-border sites. This is expected to be achieved through three result areas:

- Increased access to and uptake of integrated health and HIV and AIDS services at strategic cross-border sites and regionally recognized HIV transmission "hot spots" along Eastern, Central, and Southern transport corridors
- Alternative health-financing models identified, implemented, and tested to strengthen the long-term sustainability of networked health and HIV and AIDS service delivery
- Strengthened leadership and governance by intergovernmental institutions to improve the health of mobile and vulnerable populations

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RESEARCH METHODS

The integrated health services assessment combined quantitative and qualitative components. Researchers used structured questionnaires to conduct a cross-sectional survey of 768 people from key and vulnerable populations in two cross-border sites in Tanzania—Holili and Kirongwe (Table 1). The study also included interviews with 31 health care providers in six facilities in Holili and Kirongwe to assess their readiness to provide services to key and vulnerable populations.

Table 1. Summary of study population in the quantitative survey

Study Group	Number in Sample	Border Site
Female sex workers	100	Holili, Kirongwe
Fisher folk	309	Kirongwe
Long-distance truck drivers	185	Holili
Clearing and forwarding agents	23	Holili
Vulnerable women and girls	26	Holili
People living with HIV	125	Holili, Kirongwe

A separate qualitative formative assessment was also conducted to better understand factors that influence demand for and uptake of health services among the study populations. The qualitative assessment was conducted among the same population groups in the quantitative survey, as well as with men who have sex with men (MSM), people who inject drugs (PWID), a range of stakeholders in the health sector, and local business owners at the study sites. Ten focus group discussions, 14 key informant interviews, and 22 in-depth interviews were conducted in the two sites. The checklist used to assess the vulnerability of women was adapted from CARE's WE-MEASR tool,[1] designed to measure women's empowerment in health programs.

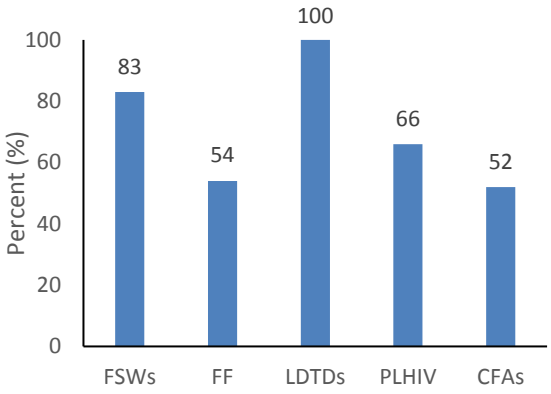
KEY FINDINGS

Sociodemographics of the study populations varied. Except for long-distance truck drivers (LDTDs) and clearing and forwarding agents (CFAs), nearly all other respondents in the quantitative survey were Tanzanian nationals. Over half of the LDTDs and 26 percent of the CFAs were Kenyan nationals. Most respondents were married/living in union or were single with a sexual partner. Among people living with HIV (PLHIV), 50 percent were married and living with their partners, while 36 percent were widowed. Nearly one-third (27 percent) of vulnerable women and girls (VWG) and 38 percent of female sex workers (FSWs) were divorced or separated. The large majority of respondents across all groups had either some primary school or some secondary school education. Thirty percent of CFAs had a college or university education.

The study populations had varying levels of geographic mobility. Geographic mobility and its associated sexual practices can increase the risk of HIV infection and impede access to health care services. The groups interviewed frequently moved away from their usual residence (Figure 1). For instance, among FSWs, 83 percent had practiced sex work away from their usual areas of residence in the six months preceding the survey. Among fisher folk (FF), 54 percent had travelled or slept away from home for their work in the past six months, with 24 percent having stayed away from home for more than a month. Mobility also was high among LDTDs by virtue of their work, and 49 percent reported that it took

[1] http://www.universalaccessproject.org/wp/wp-content/uploads/2015/06/Overview_Measuring-Womens-Empowerment-in-SRMH-Programs.pdf

Figure 1. Percentage who traveled away from their district of residence or border post in previous six months



them four or more days to complete a round trip on their regular transport routes. About half of CFAs had also travelled to other towns or border posts for work, and another half planned to travel to other posts within the next three months. Sixty-six percent of PLHIV reported that they frequently travelled to other districts, and 58 percent planned to travel to a neighboring country.

The formative assessment findings showed that mobility affects LDTDs' access to health care services, including HIV services.

> *"For truck drivers who may be HIV positive, some may have challenges accessing HIV services because they are mobile. It might happen [that] the day when they should be going for clinic, they have been assigned to travel outside the country. So it becomes very difficult for them to access such services compared to the other person who is settled at home."*
>
> – Focus Group Discussion, LDTDs

Some groups in the study populations engage in transactional sex. One-third of LDTDs (36 percent) had either received or given money or goods in exchange for sex in the three months preceding the survey, the highest percentage across all priority population study groups. Seventeen percent of FF, nine percent of CFAs, and 10 percent of PLHIV also reported having engaged in transactional sex in the same period.

The most frequently sought health care services among the study populations were treatment for common illnesses, laboratory services, and HIV testing and counselling. Access to and use of health services varied across study groups. For instance, more FSWs (89 percent), PLHIV (79 percent), and FF (68 percent) ever visited a health facility in the past 12 months than the other groups. Very few LDTDs (6 percent) reported ever seeking services from a local health facility. More than 80 percent of those who sought care reported that they had received the services they needed at the facility. The majority traveled by foot or motorcycle taxi, taking less than one hour, on average, to arrive, which suggests that facilities are relatively conveniently located.

Respondents preferred to seek care at facilities closest to their residence or those considered to be offering high quality services. In the formative assessment, study participants in both sites complained of what they perceived as a long distance to travel to health facilities. For instance, in Holili, participants said the public health facility was located as far as five kilometers away, which added transport costs and thus deterred those who could not raise the funds. In the quantitative survey, distance to a facility was cited as a key consideration in deciding where to seek health care services, closely followed by quality of services. FSWs (61 percent) and PLHIV (74 percent) cited closeness to residence, whereas FF (67 percent) most frequently cited quality of care as their first consideration.

The majority of those who sought care were either mostly or very satisfied with the services they received. However, findings also show that lack of drugs, delays, and long waiting times in public health facilities were key barriers to seeking services. Participants, including PLHIV seeking antiretroviral therapy, were reluctant to go to a facility where long waiting times were common.

"Even before you get treatment, the queue is so long before you can see the doctor, by the time you see the doctor, they prescribe the drugs, then go for tests. That back and forth at the laboratory you take a long time to wait for results. So, by the time you get the treatment and the results, and back to the doctor; the line is long, it takes hours."

– In-depth interview, FSWs

Participants said that having to pay for health care was a major barrier to services. The qualitative study findings show that participants paid for health care services either by cash directly to the health facility (user fees) or through various insurance schemes. However, most participants did not have health insurance and mostly paid in cash. Interview participants noted that the community health fund was limited to public health facilities and not extended to private ones, meaning that people living in areas with more private facilities faced problems accessing services due to inability to pay. Participants also said the cost of treatment—even in public facilities—was high, forcing some to take loans from friends or relatives to cover medical bills.

"When you go to that facility and you don't have the health insurance scheme, they ask you to pay cash, but charges are very expensive and that is why most young men don't like going to this facility. For adults, the facility charges Ksh 220 which is about Tz sh 4500 and that is very expensive for most of the people here."

– In-depth interview, FF

Very few respondents sought health care across the border in a neighboring country. Except for LDTDs (21 percent) and CFAs (22 percent), few respondents had sought health care services in a neighboring country. Those who did were seeking HIV testing services, treatment for common illnesses, and laboratory services; they cited quality of services and provider attitudes as reasons for seeking treatment there. Reasonable cost was also cited as a reason by some participants.

The formative assessment included reports of patients from Kenya crossing over to seek services at Holili facilities due to perceived lower costs.

Screening for diseases and health conditions varied. Use was moderate for hypertension screening and low for diabetes and cervical cancer. More than half of VWG (58%) and about 40 percent of PLHIV and LDTDs had ever been screened for hypertension, compared to 14 percent of FF and 27 percent of FSWs. Twenty-three percent of LDTDs reported ever being screened for diabetes, the highest proportion among all groups. Screening for cervical cancer among female respondents was equally low, with the highest rate among PLHIV (18 percent). However, the majority (more than 80 percent) of respondents had ever been tested for HIV, with near universal testing among FSWs. More than 90 percent of PLHIV reported that they were enrolled in HIV care and had initiated antiretroviral therapy.

Health facilities deliver a wide range of services; however, gaps in health care worker training existed for some of the services provided. Interviews with stakeholders and health sector leaders indicated that all the health facilities provide a range of services. HIV information is widely available from dispensaries across Holili and Kirongwe. Although some key informants said local facilities do not offer specialized services for key populations, participants said they received HIV information and related services, such as condom education and voluntary counseling and testing from local health centers. Drugs are supplied to facilities through the Medical Stores Department in a system coordinated through the district pharmacist.

Key informants also reported that Tanzania has policies and guidelines for provision of health services to key and vulnerable populations. These include the national 2015 HIV Testing and Counselling Policies and

Guidelines, which detail procedures in providing services to various populations, including MSM, FSWs, VWG, and PWID, as well as discordant couples. However, participants felt the guidelines do not directly cover provision of services to LDTDs. It was not clear whether guidelines existed for the district or health facility level.

Findings showed that some health care workers provided services for which they had not been trained. The largest gaps were in training on basic laboratory services (32 percent) and making referrals (29 percent). Other gaps were in training for the provision of comprehensive postabortion care services (19 percent) and screening and management of hypertension and diabetes (16 percent).

Among key populations, perceived negative staff attitudes were a key deterrent to seeking health care. Nearly half (48 percent) of the staff interviewed in the quantitative survey thought that health facilities were supportive of providing services to key populations, and a similar number thought the local community was equally supportive. However, six of 25 of health care workers said they were not comfortable discussing sexual behaviors related to HIV or STIs with their clients. The formative assessment showed that staff attitude is a key concern for some key population members; perceived negative attitudes are a critical deterrent to seeking care. Many study participants reported that they hid their lifestyle while seeking care because they feared stigma and discrimination and were concerned that personal information might be unethically disclosed in their community by health care workers. These concerns prevented some from seeking health services or, as in the case of some MSM, led some participants to conceal STIs for fear of fueling discrimination.

The majority of women in the study population held gender-related beliefs and stereotypes that increase their vulnerability to gender-based abuse and exploitation. Female respondents were asked a range of questions to assess their vulnerability to and perceptions of partner violence, rights to sex, and ownership of assets. When asked whether a husband/male partner had the right to beat a woman/wife, about half of FSWs, female FF, and female PLHIV agreed that he did if she went out without telling him. Sixty-five percent of FSWs, 50 percent of female FF, and 60 percent of female PLHIV thought he was right to beat her if she argued with him. However, younger women (VWG) were less likely to hold these negative gender-related beliefs. For instance, 12 percent of VWG thought a man was justified in beating a woman if she refused to have sex with him or if she did not cook the food properly.

The study also found that the majority of female respondents were economically vulnerable based on generally low ownership of assets including land, paid work, and savings. FSWs and VWG were more economically vulnerable compared to female FF and PLHIV. More female PLHIV owned land (60.7 percent), and more female FF had savings (52 percent). However, female FF were vulnerable to exploitation by males in the fishing trade. Participants reported that fishing was dominated by males, whereas vending of fish, selling food, and other supportive tasks that depended on fishing were dominated by women, and that fishermen used this advantage over women to demand payment for fish with sex.

> *"You must offer something in order to get something. Thus, there must be a win-win situation between fishermen and vendors who work in one area."*
>
> – In-depth interview, Female FF

CONCLUSIONS

The results of this study provide insights to inform interventions aimed at improving health care services for key and vulnerable populations in the cross-border sites surveyed. For instance, there was frequent movement away from participants' usual residences among the groups interviewed, and some groups spent extended periods of time away from home. Although the proportion seeking health care services across the border was small, the level of mobility indicates a need to harmonize health and HIV services among members of the East African Community so that clients receive similar quality and standards. In addition, although health care workers are delivering quality services and largely have the appropriate attitude and perceptions about their work, the identified training gaps need to be addressed with a tailored capacity development program to improve their technical skills and competence. These steps would lead to increased access to and uptake of integrated health and HIV and AIDS services.

Screening for noncommunicable diseases should be promoted to address the low rates of screening found, especially for diabetes and cervical cancer. Creating awareness about screenings can be included as part of a program to provide the services. Negative gender-related beliefs and low level of assets among women also need to be addressed. A multipronged approach can be applied to provide information on gender equality and to build women's empowerment and reduce their vulnerability.

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