MINISTRY OF HEALTH, ZANZIBAR

ZANZIBAR INTEGRATED HIV, TUBERCULOSIS AND LEPROSY PROGRAMME

ANNUAL REPORT

2013

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List of Abbreviations

AB	Abstinence and Being faithful
ACSM	Advocacy Communication and Social Mobilization
ANC	Ante Natal Care
ARV	Anti Retro Viral
ART	Anti Retroviral Therapy
BCC	Behavioural Change Communication
CDC	Center for Disease Control and Prevention
CHBC	Community Home Based Care
CMS	Central Medical Stores
CTC	Care and Treatment Clinic
CTRL	Central Tuberculosis Reference Laboratory
DHMT	District Health Management Team
DMO	District Medical Officer
DNA	Deoxyrebo Nucleic Acid
DOT	Directly Observed Therapy
DSAPR	Department of Substance Abuse Prevention and Rehabilitation
DSO	District Surveillance Officer
DTLC	District TB and Leprosy Coordinator
DTHC	District TB/HIV Coordinator
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child Transmission of HIV
FA	Formative Assessment
FP	Family Planning

FSW	Female Sex Worker
FBO	Faith Based Organizations
HBC	Home Base Care
HBHTC	Home Based HIV Testing and Counselling
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
IEC	Information Education Communication
IPC	Infection Prevention and Control
ISO	International Organization for Standardization
KP	Key Populations
LEC	Leprosy Elimination Campaign
MAT	Medication Assisted Therapy
MDR TB	Multi Drug Resistant Tuberculosis
MDT	Multi Drug Therapy
M&E	Monitoring and Evaluation
MMH	Mnazi Mmoja Hospital
MOH	Ministry of Health
MSM	Men who have Sex with Men
NGOs	Non Governmental Organizations
NSP	Needle Syringe Programme
OI	Opportunistic Infection
PCR	Polymerase Chain Reaction

PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PHCU	Primary Health Care Unit
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PMU	Procurement Management Unit
PWID	People Who Inject Drugs
RA	Rapid Assessment
RCH	Reproductive and Child Health
RDS	Responded Driven Sampling
RTI	Reproductive Tract Infection
RTLC	Regional TB and Leprosy Coordinator
SAPEL	Special Action Programme for Eliminating Leprosy
SOPs	Standard Operating Procedures
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SU	Substance Users
SW	Sex Worker
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
TOT	Training of Trainers
TWG	Technical Working Group
VCT	Voluntary Counselling and Testing

WHO	World Health Organization
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Programme
ZIHTLP	Zanzibar Integrated HIV, Tuberculosis and Leprosy Programme
ZTLP	Zanzibar Tuberculosis and Leprosy Programme

1. General Institutional Background Information

1.1. Introduction

The Zanzibar Integrated HIV TB and Leprosy Control Program (ZIHTLP) is one of the development programs under the Directorate of Preventive Services and Health Education of the Ministry of Health Zanzibar. It is a result of two combined programs, namely Zanzibar AIDS Control Program and Zanzibar TB and Leprosy Control Program. The two programs were officially joined in February, 2012 in order to maximize provision of services for two interrelated diseases and to optimize utilization of resources. The program is mandated to coordinate health sector response of HIV, TB and Leprosy in the islands.

1.2 The vision:

Zanzibar is free of new HIV, TB and Leprosy infections, people infected or affected by HIV, TB and Leprosy are not stigmatized or discriminated against and most at risk populations are accessing HIV, TB and Leprosy services and information

1.3. The Mission:

To provide technical leadership and collaboration with other sectors and actors in ensuring that there is access, availability and equity of quality HIV/AIDS, TB and Leprosy services for general and most at risk populations.

1.4. Program Goal:

To provide technical leadership and collaboration with other sectors and actors in ensuring that there is access, availability and equity of quality of HIV,TB and Leprosy services for general and most at risk population

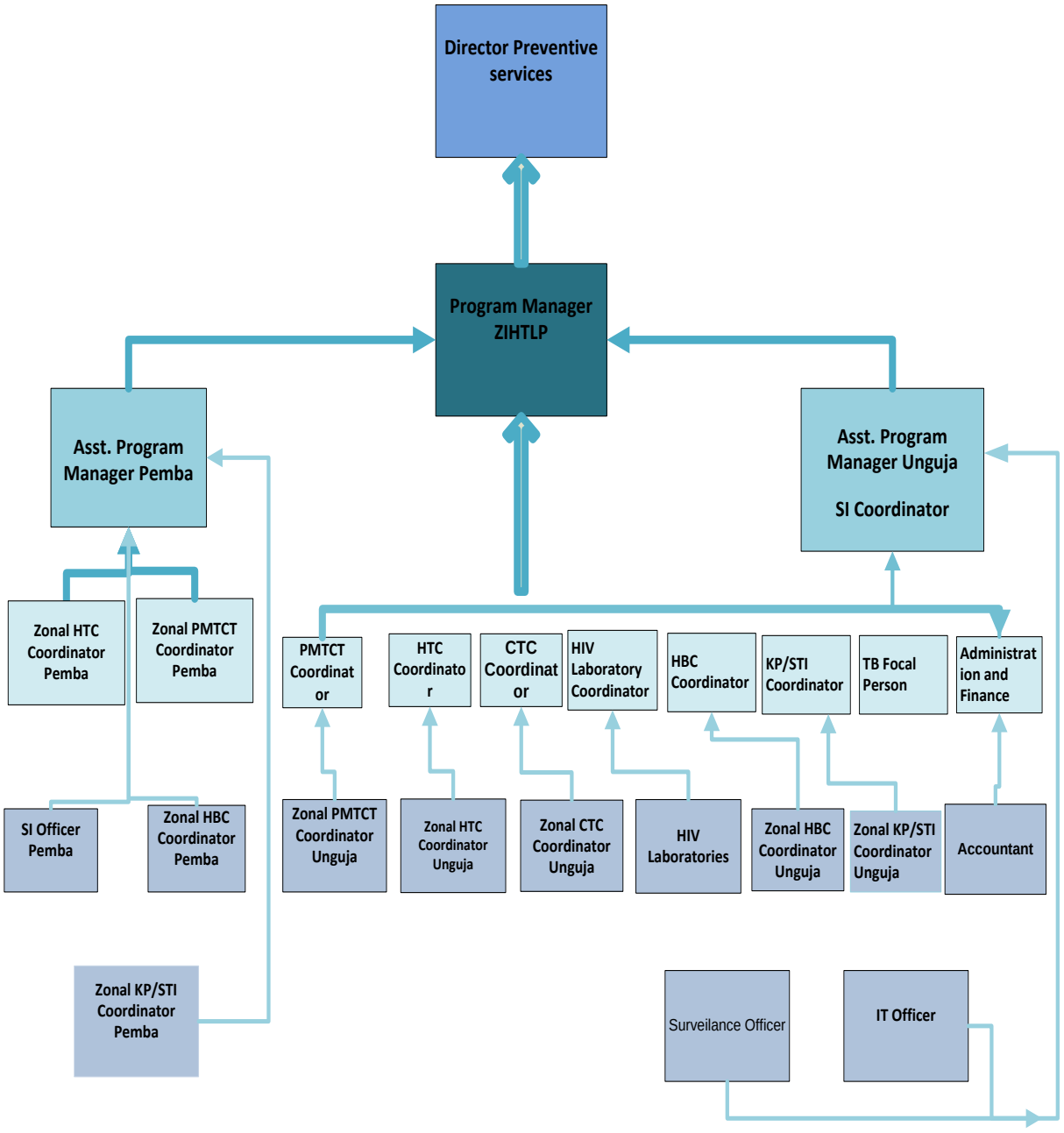
1.5. Program Core Functions

The ZIHTLP coordinates all activities pertaining HIV/AIDS, TB and Leprosy control in the country. It is also responsible for advising and guiding the Ministry of Health on health issues related to HIV, TB and Leprosy, building capacity of health care workers on the management of the three diseases, monitoring quality of services and strengthening strategic information system to monitor trends of the diseases. In line with above, the program ensures that control and prevention initiatives of HIV, TB and Leprosy infection are in line with the Government key policy documents and the health sector strategic plan.

1.6. Organizational Structure

This is an area of authority, responsibility and accountability. ZIHTLP contains eleven (11) technical units, each unit coordinated by coordinator. While the program manager is the overall in-charge of the program, coordinators oversee execution of program plans and implementation of activities under their respective program areas. They ensure that program plans are in line with the key strategic plans, develop and monitor adherence of the developed guidelines by service

providers. Current program units are: HIV Counseling and Testing, Prevention of Mother to Child Transmission of HIV, Care and Treatment, TB and Leprosy, Faith Based Leaders, IEC/BCC and other Prevention, Key Populations & Sexually Transmitted Infections, Home Based Care, HIV Laboratory, Strategic Information and Program Administration and Finance. The following below is the Organizational Chart of the program:



2. HIV Counseling and Testing services

2.1 Background

The HIV testing and counseling services are provided through three main approaches including:

1. Client Initiated Counseling and Testing (CITC) /Voluntary Counseling and Testing (VCT)
2. Provider Initiated Testing and Counseling (PITC)
3. Home Based HIV Testing and Counseling (HBHTC)

By 2013, HTC services have been established in **97** sites which are located in all 10 districts of Zanzibar. These services are operating under the support of Government facilities, NGOs, FBOs as well as Private hospitals and clinics. Amongst them, **43** sites provide CITC services alone, **27** provide PITC services alone and **27** provide both PITC and CITC services. In the year 2013, HTC Unit established a new approach of Home Based HIV Testing and Counseling (HBHTC) in Zanzibar. This was implemented as a pilot in two shehias (Koani and Kidimni) at Central district of Unguja. In 2013, a total of **115,565** clients were counseled and tested for HIV through HTC services, among them **1,423 (1.2%)** clients were diagnosed to be sero -HIV positive

In strengthening HTC services the following support have been put in place and operationalized:

- Strengthen capacity of health care workers (HCWs) to provide quality HTT service
- Procure and provide all the necessary equipments, reagents, supplies and accompanying technical support.
- Strengthen linkages of HTC services with other HIV related services through referral system
- To increase demand for the use of HTC services through IEC/BCC.

2.2 Goal

The goal of HTC services in Zanzibar is to ensure increased accessibility of free quality HTC services and to create demand for the services.

2.3 Objectives and Activities Implemented in 2013

Objectives 1: To improve quality of HTC service delivery

Implemented Activities

1.1 Conduct supportive supervision for counselling and testing services

In collaboration with Laboratory and Strategic Information Units, CITC supportive supervision was conducted biannually (once every six months) whereby 99% of CITC sites were covered.

Also biannually (once in every six months) PITC supportive supervision was conducted and about 99% of the sites were reached in both Unguja and Pemba.

The objectives of the supervision were to monitor the progress of the delivered services and to support service providers to improve their performance in providing quality care. Gaps that were observed during supervisions include:

- Low number of patients provided with PITC service compare to number of patients treated or admitted in the PHCU and hospitals
- Transfer of skilled PITC providers
- Inadequate counseling skills for some of the providers due to being trained a long time ago without refresher training/mentorship

In addressing the above gaps, immediate feedback was provided. In addition feedback forum were organized where general and specific challenges were addressed and possible way forward were also discussed and agreed.

1.2 Conduct HBHTC supportive supervision

The Counseling unit in collaboration with Laboratory unit conducted HBHTC supportive supervision at two shehias (Kidimni and Koani) of central district. Sessions supervised were mobilization sessions for CHBC in 16 households and HIV counseling and testing sessions for counselors in 4 households.

Among the gaps identified

- Inadequate knowledge and skills for CHBC to provide information regarding HBHCT services
- High demand for HIV testing at house hold, compared to number of counselors

1.2 Conduct feedback meetings for HTC service providers

Following supportive supervisions of CITC and PITC services, feedback meeting were conducted. The aims of the meetings were to discuss the gaps and challenges facing service providers, and to plan way forward to overcome the challenges for improving the quality of HTC service. Participants in the meetings included HTC service providers, laboratory technicians, peer counselors, hospital management and DHMTs members. The issue that was discussed and the agreed way forward are explained below:

- Low number of patients who received counseling and testing for HIV in PITC service delivery site. Suggestion made was that Hospital managers and DHMTs should do the

following: conduct internal supervision within their wards and facilities, ensure PITC activities are recorded routinely in the report book and PITC data are displayed in order to help providers to measure their performance. Also it was recommended that Ward Doctors should request PITC services as a routine investigation for all admitted patients.

- Counseling procedure does not comply with standard Operating Procedure (SOP) for HTC. The agreed way forward was to conduct refresher training, mentorship and on job training.

- Poor referral and linkage to Care and Treatment clinic. In linking the positive clients we agreed that, health providers should strengthen referral system among patients who were identified positive in the ward by ensuring that they are referred and enrolled to CTC before discharge

1.3 Conduct HTC stakeholders meeting

Bi-annual coordination meetings with 35 key HTC stakeholders were conducted. The participants were from NGOs, private hospital and dispensaries, DHMTs, ZAC and Board of Private Hospitals. The meeting was conducted after HTC supervision which aimed at improving collaboration with key actors of HTC service. The meeting mapped out existing challenges and identified gaps on provision of the services.

Issues discussed were:

- Low uptake of PITC services where by the agreed way forward was, the ZHMT and DHMT should include PITC services provision as an agenda in their regular quarterly meeting with health care providers and incorporate PITC services in their plan Also it was recommended that ZIHTLP in collaboration with HTC partner to have a system of providing a motivation for those facilities that reach the higher performance of the PITC services such as a certificate of appreciation.

- Inadequate system of managing CITC outreaches services. To address this, suggestion was made to conduct special meeting between HTC Unit and all institutions that provide outreach services to discuss outreach requirements and set a well organized system for better implementation of CITC outreach activities.

- During Coordination meeting, it was note that, some of the private facility e were authorized to provide CITC services but were not followed guidelines protocols. While others were not authorized to provide services but they were providing. Suggestion was made that, ZIHTLP/ Counseling Unit should inform the head of private hospitals board (Ministry of Health) on the existing problem in the private

facilities. To address this challenge, an integrated supervision activity was conducted to those private hospitals with authorization but they did not comply with CICT protocols, following the assessment some of the facility were allowed to provide services according to HTC protocol and others were suspended.

Objective 2: To strengthen HTC services at facility level

Implemented Activities

2.1 Conduct Client Initiated Testing Counseling (CITC) Pilot training

In-depth four weeks CITC training was conducted for **30** HCWs (20 Unguja and 10 Pemba). The participants were invited from new and existing sites. The main objective of the training was to equip health care workers (HCW) with knowledge, skills and attitudes to facilitate delivery of comprehensive care through CITC services, to pre- test the new developed CITC training materials and to scale up CITC services. Following this trainings, 9 new CITC sites were established (5 in Unguja and 4 in Pemba). It was expected that, after training the HCWs will apply the knowledge and skills to provide quality comprehensive CITC services.

2.2 Conduct PITC Training for Health Care Workers

Six days PITC trainings were conducted for **60** HCWs (30 in Unguja and 30 in Pemba) in 2 sessions. The participants were invited from new and existing sites. The main objective of the training was to build capacity of HCWs to provide PITC services and improve access of HCT services. Following this training, 9 **(5** in Unguja and **4** in Pemba) PITC sites were established. It was expected that, after the training HCWs will provide quality PITC services and the number of clients provided with PITC services will increase.

2.3 Conduct CITC refresher training

Following the development of comprehensive HTC guideline, six days refresher training was conducted for **28** CITC counselors from Unguja. Most of the participants were derived from Central district sites for the rationale of initiating HBHTC. The main objective of the training was to update CITC providers on newly developed comprehensive HTC guidelines which incorporate all HTC approaches including HBHTC. It was expected that, quality of CITC services will be improved.

2.4 Conduct training of Community Home Based Care (CHBC) providers on (HBHTC)

Three days training for **35** CHBC providers from Central district was conducted. The objective of the training was to equip them with knowledge and skills on mobilizing community in

utilization of HTC services through HBHTC. It was expected that, after training, the CHBC provider will apply knowledge and skills to mobilize community on importance of HBHTC service utilization.

2.5 Printing of HTC comprehensive guideline

Following the finalization of comprehensive HIV Testing and Counseling (HTC) guideline, **250** copies were printed and distributed to CITC and PITC service delivery site of Unguja and Pemba. The objective of the activities was to assist HTC providers to provide quality services and to ensure uniformity on providing counseling and testing services.

2.6 Procurement and distribution of HIV test kits and related supplies

HIV testing reagents and commodities were procured and distributed to public and non-public HTC site and NGO sites which provide free HTC services in Zanzibar. A total of **1,177** HIV testing kits (Determine kits pack of 100 tests per kit) were distributed.

Objective 3: Promote HIV counseling and testing services

Activities implemented

3.1 Conduct Community mobilization meeting on HBHTC services

Three community sensitization meetings were conducted to educate district and community leaders on importance of new approach of HBHTC services. The objective of the meeting was to encourage them to assist in mobilizing people at their villages on utilization of HBHCT/ door to door counseling and testing services. The meetings involved **28** district officials and **70** community leaders (shehas, religious leaders, influential people and leaders from community groups) of Central district of Unguja.

Also community mobilization meetings at shehia level were conducted. The objective of the meeting was to create awareness on HBHTC services and to publicize on importance of utilization of HBHTC (door to door) services. A total of **10** shehias of Central district were mobilized. At the end the meeting community showed interest in utilizing the service once it started.

Objective 4: To increase access of HTC services

Activities implemented

4.1 Conduct HBHTC services

HBHTC is one of the HTC approaches which were introduced with the aim of increasing accessibility and uptake of HTC. A pilot service was established in August 2013in two shehia of

Central district. The rationale of initiating HBHTC in this area is due to high proportion of HIV infection (2.6%), and limited HIV related services. By December 2013, a total of **480** household were covered and **3,555** people were counselled and tested. Among them 12 clients was HIV sero-positive.

4.2 Support CITC outreach services

In collaboration with different stakeholders, outreach HTC services were provided in special community and national events as follow:

Table 1: Outreach HTC services provided in special community and National events, Zanzibar 2013

NO	IMPLIMENTORS	**EVENT**	**PLACE**	**TOTAL TESTED**	**TOTAL POSITIVE**
1.	AFRICA MUSLIM ORGANIZATION	Village health Day	Uzini Village	41	0
2.	DHMT URBAN	Village health day	K/Mtipura,Gulioni,Kikwajuni juu Kikwajuni bondeni, Kimajongoo	268	0
3.	GOLD STANDARD MNAZIMMOJA	HIV sensitization Student. -Community sensitization, Anniversary of Nursing day Fourth Annual Joint Health Sector Review	Ben Bela and Lumumba secondary school. Tanzania Revenue Authority At Maisara ground Ocean View Hotel	279	1
4.	JWTZ UBAGO CAMP	Exercised of testing under 5 children	Koani, Ubago, Kidimni	409	3
5.	JWTZ BUBUBU	Exercised of testing under 5 children	West District shehia	400	0
6.	ZAPHA + PEMBA ZANZIBAR OUT REACH PROGRAM(ZOP)	-Mwenge celebration -Sensitization of road construction Staff -Village health day	Micheweni, Madungu, Utaani Sec School, Mzambarauni, Kangani, Pandani, Ukunjwi, Wakijijini , Vitongoji, Mtambile Mkoani, Tibirinzi, Msingini, JKU	1,385	2

			Wawi, Chanjaani, Wawi School, Ngombeni, Shungi Magereza, Ole, Makongwe Chwale, Piki		
7.	JWTZ VITONGOJI CAMP PEMBA	Mwenge celebration	Fidel Castro Sec School	280	0
8.	ZAYADESA PEMBA	Mwenge celebration And Youth day	Mkoani , Kiwani Village	218	0
9.	DHMT TEAMs of SOUTH, CENTRAL, URBAN WEST & NORTH "A" and "B"	Mwenge celebration	Makunduchi, Dunga, Sebleni Shakani, Kivunge, Kiwengwa	489	10
	ZAYADESA UNGUJA	Community Sensitization	Lumumba, Miembeni, Matarumbeta, Mwembeladu and Bombay kwa mchina Sober house	385	4
10.	MADRASA RESOURCE CENTRE	Village health day	Mchangani shamba, Chwaka Maungani, Fumba	184	0
11.	JUWAZA	World Parents day	Amani kwa wazee ,Dunga	195	0
12.	DHMT MICHEWENI	Village health day	Kidodi village	22	0
14.	DHMT WEST	Village health day	Chukwani, Kijichi ,Dole, Kibweni Kisauni	547	0
15.	DHMT CENTRAL DISTRICT	Village health day	Tunguu Shehia Mwera	365	0
16.	DHMT SOUTH DISTRICT	World AIDS day Village health day	Paje shehia, Tasani Makunduchi	256	0
17.	JKU	Recruit of a new soldiers	JKU saateni PHCU	400	0

HTC services indicators and trend from 2011-2013

	Indicator	2011	2012	2013
1	Number of health facilities and sites offering HTC services	**66 HTC sites** (34 VCT alone, 10 PITC alone and 22 both VCT & PITC)	**79 HTC sites** (34 VCT alone, 18 PITC alone and 27 both VCT & PITC)	**97 HTC sites** (43 VCT alone, 27 PITC alone and 27 both VCT & PITC)
2	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results	**87,418**	**84,146**	**115,565**
	• Those tested positive	**1,777**	**1,468**	**1,423**

1. Number of sites offering HTC services

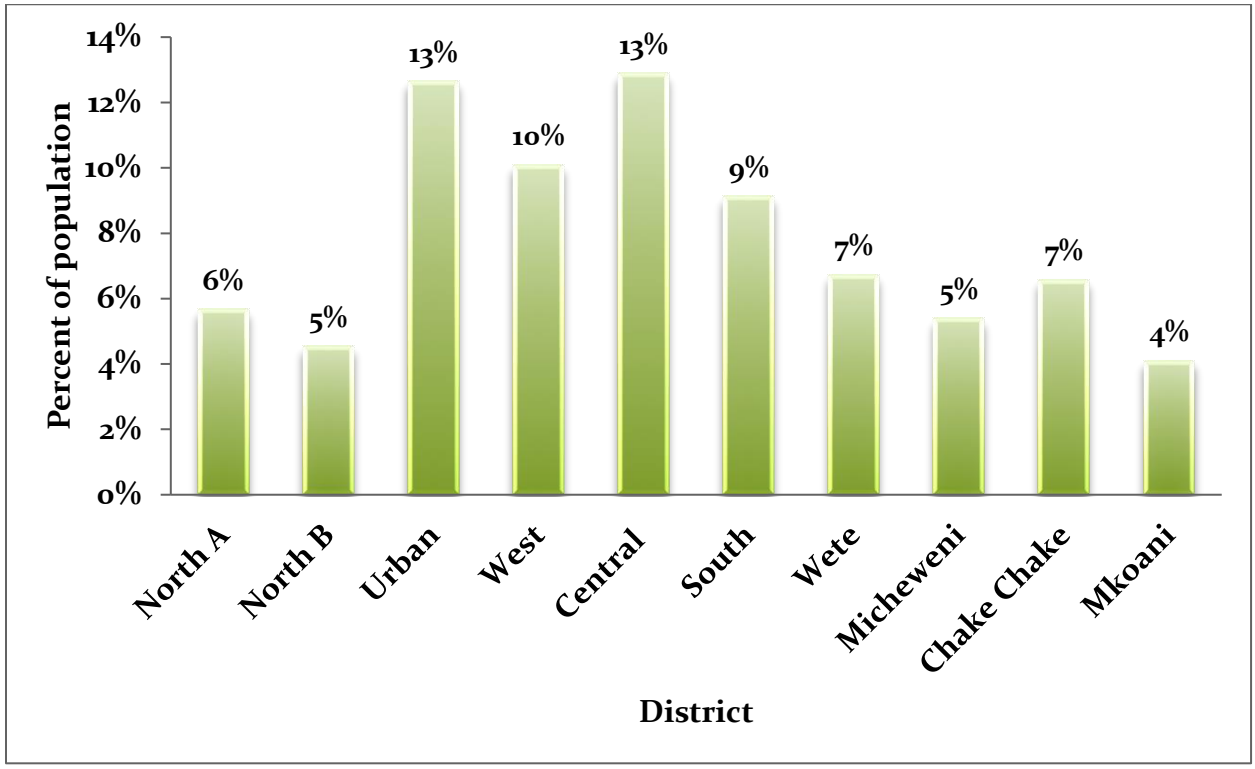
HTC sites have increased from **79** in 2012 to **97** in 2013. The scale up of the sites is due to several PITC training conducted in 2013 and CITC pilot training which leads to increase **9** new PITC sites (5 in Unguja and 4 in Pemba) and 9 new CITC sites(5 in Unguja and 4 in Pemba). Therefore accessibility of HTC services to the population has increased, hence facilitating utilization of the services. The list of facilities providing HTC services in Zanzibar is shown in Appendix I.

2. Number of individuals who received HIV Testing and Counseling (HTC) services and received their test results

In 2013, a total of **115, 565** people were counseled and tested for HIV in Zanzibar; this is equivalent to **8.6%** of the Zanzibar population. This shows an increased number of people who were counseled and tested whereby in 2012 it was 7%. Among the reason of increasing in the number of people counseled and tested in HTC is due to scaling up of HTC services. The details

of this indicator by month are demonstrated (Appendix II). By district, Urban and Central district had the highest proportion of people testing while Mkoani district had the least (Figure 2.1).

Figure 2.1: Percent of population who received HTC services by district, Zanzibar, 2013



In 2013, a total of **1,423** people **(1.2%)** were identified to be HIV positive, out of 115,565 people tested. HIV proportion among tested was two times higher in Unguja **(1.4%)** than in Pemba **(0.6%).** North B district had the highest HIV proportion among tested **(1.7%)** and was followed by Central and West district **(1.4%).** All the districts in Unguja had higher HIV proportion than those of Pemba.

Table 2.1: HIV proportion among tested by district, Zanzibar, 2013

District	Number tested for HIV	Number HIV positive	Percent positive
North A	6166	74	1.2
North B	3806	64	1.7
Urban	28987	374	1.3

West	38405	533	1.4
Central	10110	143	1.4
South	3677	51	1.4
Unguja	**91151**	**1239**	1.4
Wete	7448	44	0.6
Micheweni	5752	41	0.7
Chake Chake	6564	43	0.7
Mkoani	4119	17	0.4
Pemba	**23883**	**145**	0.6
Outside Zanzibar	526	39	7.4
Note specified	5	0	0.0
Total	**115565**	**1423**	**1.2**

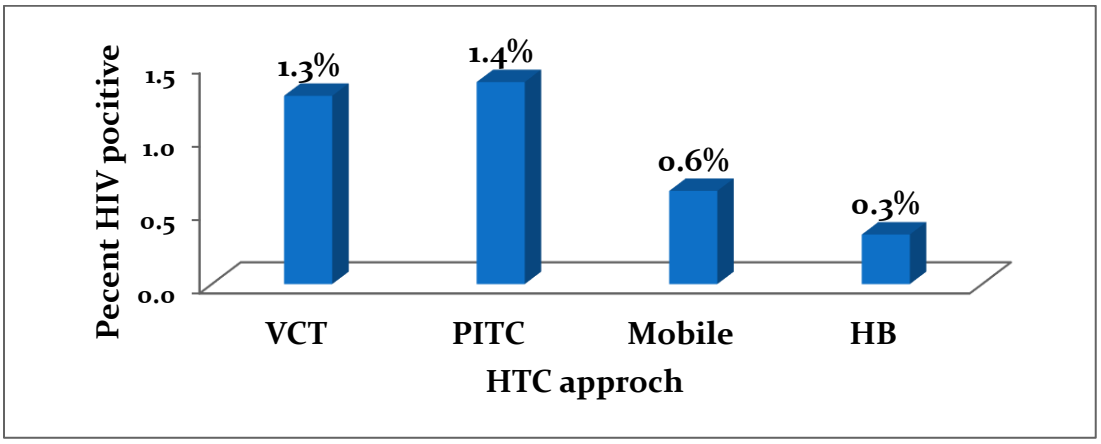
Out of all the people tested **59,003 (51%)** were females and **56,562 (49%)** were males, with HIV proportion being higher among females **(1.6%)** than males **(0.9%).**

Table 2.2: HIV proportion among tested by age and sex, Zanzibar, 2013

Age Group (Years)	Female			Male			Total		
	Number tested for HIV	Number HIV positive	Percent HIV positive	Number tested for HIV	Number HIV positive	Percent HIV positive	Number HIV tested	Number HIV positive	Percent HIV Positive
0-4	2069	23	1.1	2273	18	0.8	4342	41	0.9
5-9	930	16	1.7	930	11	1.2	1860	27	1.5
10-14	887	9	1.0	748	7	0.9	1635	16	1.0
15-24	25841	205	0.8	15411	32	0.2	41252	237	0.6
25-34	18141	371	2.0	22249	193	0.9	40390	564	1.4
35-44	7214	182	2.5	9276	149	1.6	16490	331	2.0
45-54	2644	84	3.2	3824	69	1.8	6468	153	2.4
55+	1277	27	2.1	1851	27	1.5	3128	54	1.7
Total	**59003**	**917**	1.6	**56562**	**506**	0.9	**115565**	**1423**	1.2

Of the people tested, 23.8% (**27,526/115,565**) were reached through PITC approach while the majority 66 %**(76,451/115,565)** were reached though CITC approach. However, HIV proportion among those tested through PITC was higher (1.4%) than the proportion for those tested through CITC (1.3%) (Figure 2).

Figure 2: HIV proportion among tested by HTC approach, Zanzibar, 2013



2.4 Challenges

- Transfer of trained service providers without replacement
- Low uptake of PITC services
- Inadequate number of skilled CITC counselors
- Poor referral and linkage to Care and Treatment clinic

2.5 Way forward

- To conduct CME (Continuing Medical Education) and mentorship for HCWs
- To motivate/reward the sites which perform well in providing PITC services
- To conduct PITC and CITC training

2.6 Major achievements

1. Increased number of HTC sites from 79 to 97 sites
2. Establishment of HBHTC
3. Increased number of people counseled and tested for HIV from 84,146 to 115,565

2.7 Plans for 2014

1. Scaling up PITC services

3. Prevention of Mother to Child Transmission of HIV (PMTCT) services

3.1 Background

PMTCT unit was first established nine years ago with the purpose of preventing vertical HIV transmission from mother to child. Following the adaptation of New WHO recommendation of option B+ and PMTCT guidelines all pregnant and lactating women with HIV infection are eligible to lifelong ART regardless of WHO Clinical Stage or CD4 count; this focuses to Elimination of New Pediatrics HIV infections and improving care for infected partners and their children.

As of Dec2013, there were **153** PMTCT service centres in all ten districts of Zanzibar, attached (***Appendix I* and *Appendix II)*.** In 2013, a total of **56,221** pregnant women from ANC clinics, labour and delivery were counselled and tested for HIV which was equivalent to 95.8% of all women estimated to be pregnant in 2013. The proportion of pregnant women accessing PMTCT considerably increased from 2,714 (in April2005) pregnant mothers to 53,110 (in 2013).

The PMTCT Unit has been strategically using different approaches to improve and increase access to and utilization of PMTCT services, through the following strategies:

- Capacity Building
- Advocacy
- Integration of PMTCT services into HIV service networks
- Procurement of essential reagents and other commodities – Securing all relevant commodities and supplies, and other equipment enhance PMTCT services.

3.2 Goal

The goal of PMTCT services is to reduce mother to child HIV transmission and improve care for infected partners and their children.

3.3 Objectives and Activities Implemented in 2013

Objective 3.3.1: To improve quality of existing PMTCT services

Activities implemented

3.3.1.1 Conduct new PMTCT training for HCWs

Two PMTCT new trainings were conducted following Facility needs assessment. The first training was conducted in Unguja which involved **36** participants (24 Unguja 12 and Pemba) and the second one was in Pemba which involved **35** health care providers who were from Pemba alone. The purpose of these trainings was to scale up PMTCT services (scaled up to 153 in 2013 from 137 in 2012 i.e. 6 facilities Unguja and 10 – Pemba) and impart health providers with PMTCT option B+ knowledge. The expectation of the post training was to have Option B+ established in various PMTCT sites.

3.3.1.2Conduct training on HIV Early Infant Diagnosis (EID)

Two trainings on HIV EID were conducted one in Unguja and one in Pemba. A total of **67** participants were trained, **32** from Pemba and the remaining from Unguja. The purpose of the training was to build the capacity of the health care service providers and enable them to establish these services in their PMTCT sites. In addition, the training included providers from existing EID sites in order to strengthen those sites by having more staff trained on EID. Following that training PMTCT unit expected to establish 10 new EID care services at their facilities and the provision of EID services improved.

3.3.1.3 **Training on the use of haemacue machine**

In collaboration with Laboratory Unit of ZHITLP, the PMTCT Unit conducted a three days training on the use of *haemacue* machine for **35** PMTCT service providers in Unguja in order to strengthen the PMTCT services in their facilities. The training purpose was to improve skills to PMTCT providers on using those machines so as to facilitate them to perform tests for *haemoglobin* level at their sites. Following the haemacue use training, participants were expected to enable to use those machines and *Hb* level checked

3.3.1.4 Conduct Supportive Supervision

PMTCT supportive supervision was conducted in **143** PMTCT sites by two comprehensive teams of supervisors. A total of 80 PMTCT sites from Unguja and 63 from Pemba were supervised.

Objectives of supervision

- To assess the quality of PMTCT service delivery and implementation of PMTCT option B+.
- To identify and solve problems during provision of PMTCT services

- To assess accuracy of the ARV drug management, laboratory testing & counseling
- To review quality of recording and reporting

Issues identified

- Inappropriate documentation of positive clients
- Inconsistence of recording and reporting of PMTCT data, whereby data source in the register did not match with the summary report
- Loss to follow-up of PMTCT mothers and their infants
- Shortage/excessive turnover of staff and there were some new staff not trained on PMTCT

During the course of supervision it was mutually recommended that:

- There was a need to conduct mentorship/PMTCT training to improve, PMTCT intervention, documentation, recording and reporting of PMTCT related information
- To ensure all positive mothers and their infants are not lost and followed up appropriately

Way forward: It was jointly agreed that PMTCT service providers, DHMT members and facilitators (supervisors) to follow up on recommendations, implement and in cooperate those recommendations in their routine supervisory visits. Also DHMTs should find a solution to resolve the problem of frequency transferred of trained providers.

3.3.1.5 Feedback meeting with PMTCT service providers

Following supportive supervision, feedback meetings were conducted in Unguja and Pemba to highlight best practices/ knowledge sharing and identified gaps and bottlenecks towards improving provision of PMTCT services in all PMTCT sites. During the meetings matters/issues discussed and emphasized were:-

- Proper documentation of positive clients
- Proper recording and reporting of PMTCT data
- Importance of Providers to be familiar with their positive mothers
- Improvement and strengthening counsel and referral mechanism to reduce loss to follow of positive mothers and their infants

3.3.1.6 Conduct mentorship to PMTCT service providers

A one day mentorship was conducted in **20** health facilities (10 in Unguja and 10 in Pemba). The mentorship followed supportive supervision to address the identified gaps during the supervision.

Issues identified and mentored were: Filling of registers, HIV testing, pre- and post- test HIV counseling and implementation of PMTCT option B+. Current Status after mentorship: There is a still difficulty on mother-to-follow for the positive

3.3.1.7 Review and update of PMTCT training manuals and Job Aids

Two days TWG meeting to review and update PMTCT training manuals and Job Aids was conducted. A total of 20 members of the TWG from ZIHTLP, IRCHP, Nutrition Unit, Zanzibar AIDS Commission, Mbweni College of Health Science, Health Promotion unit of MoH, ZAPHA+ and PMTCT providers participated in the meeting. The meeting was facilitated by two technical staff from François Xavier Bagnoud (FXB).

Objective of the meeting was to review and update the training materials and Job Aids in line with the adaptation and implementation of WHO option B+ that took place since December 2012.

3.3.1.8 Conduct PMTCT study visit to Bagamoyo

Five days study visit to Pwani Regions in Mainland Tanzania (Bagamoyo, Mlandizi and Kisarawe districts) was conducted. Five participants took part in the visit, which included Zonal PMTCT Coordinators, District RCH Coordinators from Kaskazini A and B districts and CTC coordinator. The visit was organized by ZIHTLP, IRCHP and hosted by Tanzania Health Promotion Services (THPS).

Objectives of the visit were to:

- Learn how Psycho-Social Groups (PSG) are formed and managed
- Learn how RCH platforms integrated with CTC at the RCH settings.

Lesson learnt:

- Integration of PMTCT services and care and treatment services at RCH settings
- Development of PSG , tools and PSG running cost

Way Forward

- Following the visit, planning for establishing a pilot PSG site and training on PSG package was put into account.
- Integration of PMTCT services and care and treatment services at RCH settings

3.3.1.9 Procurement of PMTCT reagents and other commodities

Throughout 2013, the PMTCT unit procured and distributed list of items as summarized in the **Table Number 1** below

Table Number 1: Items procured and distributed by PMTCT unit, Zanzibar-2013

Item	**Quantity**
Determine HIV test kits	902 kits of 100 tests
Unigold HIV test kits	281 kits of 20 tests
Syphilis test kits	1173 kits of 50 tests
Gloves	1050 cartons
Aprons	88pieces
Plastic boots	88 pairs
Vaccutainer tubes and needles	580 packs of 100 pieces
Micro pipette	63 pieces
Microtips (yellow tips)	67packs of 1000 pieces

Table 2: PMTCT services indicators and trends in 2011 - 2013

Indicators		Trends		
		2011	2012	2013
		n/N (%)	n/N (%)	n/N (%)
1	Number of health facilities providing RCH services that also provide both HIV testing and counseling and ARVs for PMTCT on the site	51/154 (33)	137/156(88)	153/156 (98)
2	Number and percent of pregnant women who were tested for HIV and know their results	39,040/52,622(74)	46,221/54,352(85)	56343/58661(96)
3	Number and percent of known positive pregnant women	282/316(89)	281/326(86)	347/352 (98.5)
4	Percent of HIV- positive pregnant women who receive ARVs to reduce the risk of mother-to-child transmission of HIV	236/316(75)	211/326(65)	248/352(70.5)
5	Percent of HIV positive pregnant women delivering in health facilities	191/316(60)	173/326 (53)	231/352(66)
6	Percent of male partners of pregnant women who are tested for HIV in last 12 months	1,819/52,622(3.5)	1,785/54352(3.3)	1804/58661(3)

7	Percent of infants born to HIV-positive pregnant women who are started on cotrimoxazole within two months of birth	119/171(70) (June–Dec.11)	170/281 (60)	195/248(79)
8	Percent of infants born to HIV positive mothers who receive HIV antigen test (DNA PCR) within 2 months of birth	(185/282(66)	148/281(53)	252/248(102)
9	Percent of HIV-positive infants started on ART	8/20(40)	6/7(85.7)	15/18 (83.3)

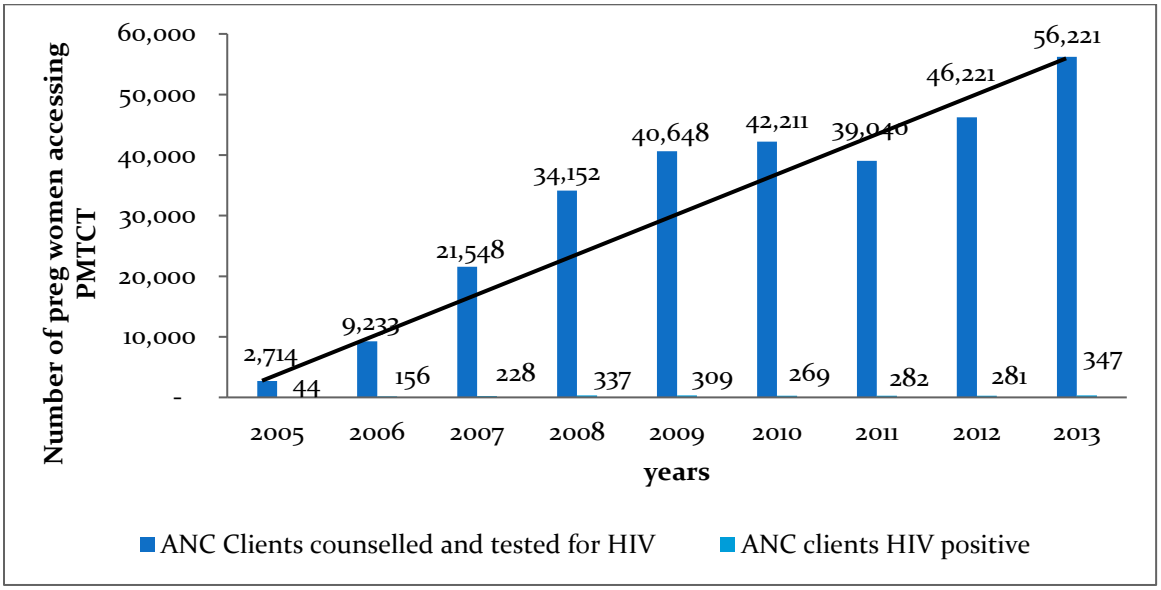
1. **Number of health facilities providing RCH services that also provide both HIV testing and counseling and ARVs for PMTCT on the site**

   Health facilities providing RCH services with HIV testing, counseling and ARVs for PMTCT increased from 137 (2012) to 153 (2013). Ninety health facilities in Unguja while 63 in Pemba. This shows that, the coverage of PMTCT services are well distributed, which may facilitate increasing the number of pregnant women who may get PMTCT services across Zanzibar.

2. **Number and percent of pregnant women who were tested for HIV and know their results**

   Utilization of PMTCT services showed upward trend from 85% (46,221/54,352) in 2012 to 96% (56,343/58,661) in 2013. This may be contributed to increasing number of health facilities providing PMTCT services and improved awareness and utilization of this service among Women of Reproductive Age, see figure 1 below.

Figure 1: Trends of ANC clients counselled & tested v/s ANC clients identified HIV positive 2005-2013



3. Number and percent of known positive pregnant women

The number and proportion of known positive pregnant women has increased from 86% (282/326) in 2012 to 98.5% (347/352) in 2013. The increased proportion might be due to increase accessibility to PMTCT servies and awareness.

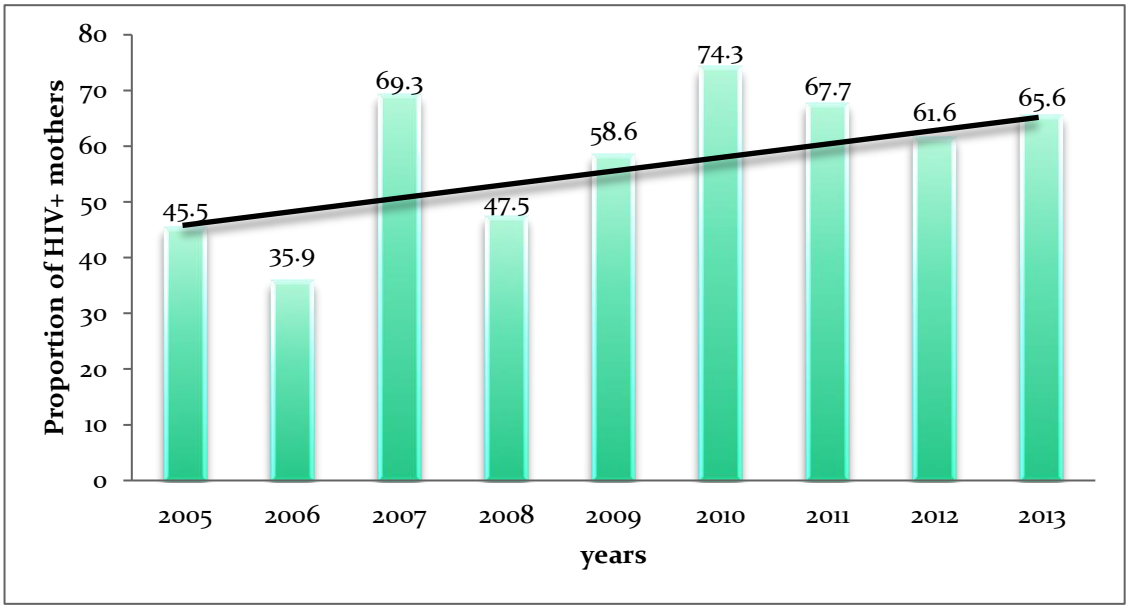
4. **Percent of HIV positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission of HIV**

The proportion of HIV positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission of HIV has improved from 65% (211/326) in 2012 to 70.4% (248/352) in 2013. The increase in those who received ARVs may be attributed to improved escorted which improve referral mother and change in eligibility criteria for pregnant women.

5. **Percent of HIV positive pregnant women delivering in health facilities**

Proportion of HIV positive pregnant women delivering in health facilities increased from 53% (173/326) in 2012 to 66% (231/352) in 2013 ***figure 2*** below. This might be contributed to overall percentage of pregnant women delivered at the health facilities increased from 49.4% (2012) to 56.6% (2013), which is probably due to demand creation of free delivery services for pregnant women

Figure 2: Proportion of HIV positive mothers delivering in the hospitals (2005 – 2013)



6. **Percent of male partners of pregnant women who are tested for HIV in last 12 months**
   Male involvement in PMTCT services is still low, whereby there is slight decrease of male involvement from 3.3% (1785/54352) in 2012 to 3% (1804/58661) in 2013. This shows that awareness of male partners in utilizing RCH/CTC services need special attention to explore the underlying factors.

7. **Percent of infants born to HIV positive pregnant women who are started on cotrimoxazole prophylaxis within two months of birth**
   The proportion of exposed infants starting on Co-trimoxazole prophylaxis within the first 2 months of birth relatively decreased from 60% (170/281) in 2012 to 56% (195/347) in 2013. This may be contributed to poor follow up of infants born to HIV positive mothers and shortage of cotrimoxazole

8. **Percent of infants born to HIV positive mothers who receive HIV antigen test (DNA PCR) within 2 months of birth**
   Proportion of infants born to HIV positive mothers and received HIV antigen test (DNA PCR) within 2 months of birth showed a marked increase from 53% (148/281) in 2012 to 73% (252/347) in 2013.

9. Percent of HIV positive infants started on ART

The actual number of HIV positive infant has increased in the year 2013, however the percentage of infants enrolled on ART dropped from 85.7% (6/7) in 2012 to 83.3% (15/18) in 2013.

In addition we are not able to reach the target of 100% this might be due to poor follow up of infants born to HIV positive mothers

3.4 Challenges

- Loosing mothers and their infants to follow-up of PMTCT
- Low Male involvement
- Frequent transfer of PMTCT service providers
- Proportion of HIV exposed infant is high compared with WHO target for option B+

3.5 Proposed way forward

- Establishing of mother-infant case based surveillance
- Enhancing advocacy for male involvement: Male involvement and participation in the RCH/PMTCT services with their spouse, together with couple counseling and testing for HIV increases use of the interventions for HIV prevention
- DHMT should take in consideration the available services at the site

3.6 Achievements

- Number of facilities providing PMTCT services increased from 137 in 2012 to 153
- Increased proportion of pregnant women attending ANC and counseled for HIV test increased from 86% in 2012 to 98%
- Proportion of infants born to HIV positive mothers and received HIV antigen test (DNA PCR) increased from 53% in 2012 to 73%in 2013

3.7 Activities Planned for the year 2014:

- Identification of focal person to follow up all positive mothers and their children
- Establish integrated CTC services in RCH Scale up of PMTCT sites to 100% of all existing health facilities

4. Faith Based Interventions (AB)

4.1 Background

The Faith Based Organization (FBO) Technical Working Group (TWG) was formed on 6th January 2006. The team has been working in collaboration with Zanzibar Integrated HIV, TB and Leprosy Programme (ZIHTLP), and its members are drawn from Christian and Muslim's institutions respectively. The involvement of religious leaders in AB campaign therefore, had been complementing other prevention strategies used by different partners to reduce new HIV infections in Zanzibar.

The main purpose of this TWG is to support functional youth and faith-based initiatives that positively promote abstinence, faithfulness, partner reduction, and delayed sexual debut in a holistic manner as an important strategy for the prevention of new HIV infection in Zanzibar.

The HIV/AIDS Faith Based Intervention targets youths and adults focusing on the following:

- Spiritual, Social, psychological and health gains associated with abstinence and faithfulness;
- Personal risk assessment;
- Adherence to faith-based teachings on abstinence and faithfulness contained in the Qur'an and Bible;
- Awareness about the role of abstinence and faithfulness in the prevention of unplanned pregnancies and prevention of sexually transmitted infections, and HIV & AIDS
- Promotion of spiritual and pre-marriage counseling for couples

4.2 Goal:

The goal of the FBO TWG is to bridge gaps of information and services within the ministry of Health so that the intended populations are changed their behaviors in accessing the related services that could help in HIV/AIDS prevention in Zanzibar.

4.3 Objectives and implemented activities in 2013

Objective 1: To empower the community to develop culturally appropriate Approaches in prevention of HIV transmission

4.3.1. Conduct FBO Technical Working Group meetings.

The purpose of the FBO TWG meetings was to plan and review the implemented activities with the aim of assessing success, challenges and plan for the way forward. A total of 7 FBO TWG meetings were conducted. Some of the FBO TWG meetings were involving other stakeholders whom were invited to share their experiences & expertise as well assist the TWG on resolving

different issues needed their inputs. The invitees included ZIHTLP's heads of units (Coordinators), Districts AIDS Coordinators (DAC), radio and TV staff, districts education officers, Religious leaders and member of School Health Clubs.

During meeting sessions among other issues discussed were the delays of report submission from implementing stakeholders. It was then resolved that the TWG should make follow-up and take necessary action to collect, write and submit FBO TWG quarterly reports to ZIHTLP accordingly. It was also noted that there was inadequate IEC/BCC materials that would boost FBO campaign of promoting A&B among youth and community at large. It was resolved that that FBO should consider to produce relevant IEC/BCC

4.3.2 Conduct Spiritual Counseling sessions at Mnazi Mmoja Gold Standard Centre:

A total of 723 individuals PLHIV (males and females) received spiritual counseling, while a total of **109** PLHIV received spiritual counseling in group sessions. Also, a total of **96** couples who were preparing for marriage were spiritually counseled. The main purpose of spiritual counseling was to remedy mental stress, physical ailments, as well as social difficulties with the aim of enabling a client to live positively. The FBO TWG therefore, provided spiritual counseling sessions to PLHIV attended care and treatment clinic. Spiritual Counseling sessions were maintained on weekly basis during Mondays, Wednesdays and Fridays at Mnazi Mmoja CTC.

In Pemba, Spiritual counseling services are available at Chake Chake CTC, provided by JUMAZA whom have been co-opted to provide the service in the area. In Unguja lobbing were done to other CTCs of Mwembeladu, Al-Rahma, Military Hospital Bububu, Kivunge Cottage and Makunduchi, with the aim of initiating spiritual counseling services. The main challenges in the Spiritual Counseling are the referral system from the implementing partners to the CTC as well as the filling of reporting forms.

4.3.3. Conduct Home Visits to PLHIVs and Their Families.

In collaboration with HBC and CTCs staff, FBO TWG conducted home visits in 3 districts, including the hard to reach areas of Uzi Island in South and Tumbatu Island in the North. The purposes of the visits were to visit and counsel PLWHA who seems to have difficulties in adhering ART or had conflict with family members. A total of 113 PLWHA were visited at their homes.

Among other challenge it was noted that PLHIV visited lacks social support from the communities especially those coming from mainland as they have no relatives. The visited PLWHA however, were spiritually counseled and advised to adhere to ART, to report and attend their clinics regularly and take necessary care for their health. Families and relatives were also

encouraged to support them. Villages visited included Makunduchi, Paje, Unguja Ukuu, Uzi, Fuoni and Kombeni.

4.3.4 Conduct Supportive Supervision to School Health Clubs

The objective of this activity was to assess the effectiveness of the school health clubs in raise awareness on HIV & AIDS prevention as well as promote A & B to students who are in and out of schools. FBO TWG team visited school health clubs in Unguja and in Pemba. A total of 64 School Health Clubs and 12 Youth Interfaith Committee at district level in 10 Districts Unguja and Pemba were supervised.

Out 64 school Health clubs visited, It was noted that only 16 clubs were furnished with equipments and furniture such as TV, video, radio, cupboard, table and chairs. It was observed that the supported school health clubs were running their meetings accordingly and make good use of the provided TVs, and CD machines for showing films. The only challenge identified was the unavailability of suitable CDs for the school health clubs. During the supervision visits, reporting tools also were reviewed and collected. FBO TWG discovered that there were still some difficulties in filling the report tools properly. However more coaching was done.

The team also discovered that there have been other partner institutions visiting the school health clubs with similar interest with ours. Among those partners include UMATI, ZIADA, Red Cross, and Ministry of Health whom came to give a talk, and lecture on different subjects related to HIV infection. The FBO TWG was able to visit some of these partners NGOs such as NGO Cluster, UMATI, ZIADA, ZAPHA+, ZCF in Unguja and Pemba. Some of these partners have projects that support School health clubs.

4.3.5 Conduct meetings with fbo institutions

The FBO TWG Team had also an opportunity to meet with religious leaders from JUMAZA, ZIADA, MARKAZ and Anglican Church. The meeting aimed at discussing issues emerged during the visit, exchange experience and seek their support in promoting A & B in their respective areas as well as encourage them to visit school health clubs.

4.3.6 Record and airing of Radio and TV programmes

4 Radio and TV programs (Two for radio and two for TV) were prepared with written scripts, then recorded and aired. The messages prepared aimed at promoting Home-Based Care and Pre-marital HIV counseling and testing in the community using religious perspective.

Furthermore, FBO TWG in collaboration with IEC/BCC Unit aired 2 Radio and **2 TV** programs on Home Based Care majoring on the issues of adherence to HIV treatment, reducing stigma and support to PLHIV. In these programs the general public was urged and encouraged to test for HIV to know their health status and live a responsibly life.

4.3.7 Conduct Meetings with Traditional healers to discuss the adherence of ART to PLHIV

One of the major issues raised during Home visits was the adherence of ART. It was reported that traditional healers were convincing PLHIV to stop taking ARVs and instead they prescribed their herbal medicines a situation which was putting PLHIV lives at stake. The workshop therefore was conducted with the aim of bringing on board all traditional healers so that they can cooperate and work together to ensure that PLHIV adhere to ART. Two days meetings were held in Unguja and Pemba, and a total of 60 Traditional healers attended.

Among other things the following were Key issues discussed:

1. How traditional healers would contribute to the adherence of ART to PLHIV.
2. How Traditional healers would cooperate and work together with CHBC and FBO in ensuring PLHIV are adhering to ART.

It was resolved that traditional healers should undergo CHBC training so as they can be supportive to PLHIV.

3.4 Challenges

- Inadequate Spiritual counseling skills of FBOs institutions leaders.
- Unavailability of IEC/BCC materials to support FBO activities.
- Limited financial resources to support FBO TWG activities Unguja and Pemba.
- Lack of coordination with other partners with similar interest who have school programs

3.5 Proposed way forward

1. Build capacity of FBO religious leaders in providing circular & spiritual counseling skills
2. Support more school health clubs with equipments & furniture
3. Build the capacity of FBO TWG to plan, implement and manage their activities.
4. Assess and determine the effectiveness of IEC/BCC materials distributed and TV & Radio programs aired.
5. Involve more partners/stakeholders to attend TWG meetings

6. Widen scope of spiritual counseling services, to other main hospitals such as Bububu, Mwembeladu, Al-Rahma, etc
7. Produce relevant and appropriate IEC/BCC materials especially relevant CDs for school health clubs
8. Encourage families and community at large to render social support to PLHIV

3.5 Achievements

- Stigma and discrimination reduction is observed among religious leaders and to the general population:
- Some of the Lost to follow patients were returned back to care and treatment clinics after being provided with spiritual counseling.
- School health clubs are effectively functional.

5. Information, Education and Communication/ Behavior Change Communication

5.1 Background

There is wide spread knowledge of HIV/AIDS prevention methods. About 69% of women and 77% of men know that a person's chance of getting the HIV virus can be reduced by using condoms. Also 84% of women and 87% of men know that the chance of becoming infected with the HIV virus is reduced by limiting sexual intercourse to one uninfected partner who has no other partners. The vast majority of Tanzanian adults know that people infected with HIV do not necessarily show signs of infection while 80% of women and 86 % of men know that a healthy-looking person can have the virus that causes AIDS.

85% of women and 79% of men know that HIV can be transmitted through breastfeeding; 68 % of women and 63 % of men know that the risk of mother-to-child transmission (MTCT) can be reduced by the mother taking special drugs during pregnancy.HIV/AIDS-related educational programmes have been developed and aired through the mass media; 48% of women and 62% of men have seen or heard an HIV programme on TV or on the radio or in a magazine in the past 12 months **(THIMS, 2011/12)**. Condom uses differ among KPs in Zanzibar. As noted that it is higher among SW 78.9% compared to 25.6% on MSM and 17.5% on PWID **(IBBSS 2011-12)**.

Based on these data, it is necessary to raise public awareness and facilitate changing those behaviors that put individuals at the risk of contracting or transmitting HIV and other sexually transmitted diseases.

5.2 Goal

To bridge the existing gap of information and services within the Program's units so that the intended populations both General and Key Populations are changing their behaviors positively

from the risk behaviors and accessing the related services that could help in HIV prevention in Zanzibar.

5.3 Objectives and implemented activities in 2013

Objective 1: To empower the community to develop culturally appropriate approaches in prevention of HIV transmission

Activities Implemented

4.3 Sensitization workshop to CBO's, FBO's and Community leaders on HIV prevention to Key Populations

A total of **270** Faith-Based Organizations (FBO), Community Based Organizations (CBO) and Community leaders (162 Unguja and 108 Pemba) were sensitized on HIV prevention to Key Populations from **10** districts in Zanzibar. The objective of the workshop was to sensitize them to identify these groups and facilitate stigma reduction in the community that will promote Health seeking behavior among KP's and hence utilization of KP services.

4.4 Conduct training on Pathways to behavior change game

A total of **30** Key Populations Peer educators from Unguja were trained on Pathways to behavior change game as a tool which facilitates behavior change process. The objective of the training was to educate peer educators on how to use this game so that they use it in their interventions to identify barriers and facilitators that influence their clients behavior change and what risk behaviors might put them on the risk of transmitting or contracting HIV among People Who Inject Drugs (PWID), Male Sex Male (MSM) and Commercial Sex Workers (CSW). At the end of the training we expected KP peer educators to use the game in their HIV interventions to facilitate the trend of the behavior change in these groups.

4.5 Participate in Exhibitions

IEC/BCC unit participated in 2 exhibitions; **one was held** on 1st December 2013 in commemoration of World AIDS Day at Paje, South Region of Unguja. Another **exhibition** organized by Ministry of Health was in Annual Joint Health Sector Review meeting held on 27-28 November 2013 at Ocean View Hotel. In this exhibitions HIV counseling and testing services were offered to the participants, 65 clients tested for HIV. In both exhibitions, various IEC/BCC materials (brochures, posters, books, guidelines, wrist band and handkerchiefs) with different HIV and TB related messages were displayed and distributed to the participants.

Objective 2: To raise public awareness about behaviors that put individuals at the risk of contracting or transmitting HIV and other STD

Implemented activities

2.1 Developing IEC/BCC materials

a) A 4 days meeting to develop Post Exposure Prophylaxis (PEP) IEC materials. The team involved **8** participants from the Zanzibar Integrated HIV, TB and Leprosy Programme, Zanzibar AIDS Commission (ZAC) and Health Education Unit. The aim of developing these materials was to promote and enhance the use of PEP services in Zanzibar to General and Key Populations. Following the activity, about **8000** materials for Post Exposure Prophylaxis were printed and distributed to the Health facilities, NGO's and community.

b) A meeting was held to develop IEC materials for school health clubs to promote life skills education to students including HIV/AIDS and Sexual Reproductive Health. A total of **22** participants from Unguja and Pemba from Z A Co, Health Education Unit, District AIDS Officer, THESODE, Teachers and Z I H,T L P attended. About **21,000** IEC materials for School Health Clubs have been printed and distributed to 24 School Health clubs supported by TWG .

2.2 Printing and distribution of IEC/BCC materials

IEC/BCC Unit printed number of IEC materials include brochures and posters and distributed to targeted populations. The aim of this material is to raise awareness and provide wide knowledge and understanding on HIV and TB services. The following table describes the materials developed, printed and distributed in 2013.

Table 2.2 1: Number of printed HTC IEC/BCC materials per unit, 2013

Unit	Type of materials	Theme	Target population	Number printed
HTC	Pamphlets	1. Pata Ushauri Nasaha na Pima VVU kujua afya yako (Attend for counseling and test for HIV to know your Health status)	General population	7,500
		2. Umuhimu wa wenza Kupima VVU kwa pamoja kabla ya ndoa (Importance of pre-marital HIV counseling and testing for couples)	General population	7,500
		3. Pata huduma ya Upimaji VVU baada	General	7,500

		ya huduma za matibabu (Test for HIV after treatment services)	population	
		4. Fahamu Kuhusu VVU na UKIMWI(Know about HIV and AIDS)	General population	7,500
		5. Umuhimu wa ushauri nasaha na upimaji wa VVU kwa wenza na wana ndoa (Importance of HIV counseling and Testing for couples and married ones)	General population	7,500
	Poster	1.Pata huduma ya Upimaji VVU baada ya huduma ya matibabu(Test for HIV after treatment services)	General population	3,000

Table2.2.2: Number of printed KP IEC/BCC materials per unit, 2013

Unit	Type of materials	Theme	Target population	Number printed
KEY POPULATIONS	Brochures	1. Huduma ya "PEP" kuzuia VVU kwa makundi maalum (PEP services to prevent HIV to KP)	Key Populations	2000
		2. Ukweli kuhusu "Post Exposure Prophylaxis"(Fact on PEP)	General population	2000
		3. Pata Huduma ya "PEP" kuzuia VVU(Get PEP to prevent HIV)	General population	2000
	Poster	4. "PEP" ni mkombozi wangu dhidi ya maambukizi ya VVU (PEP is my savior against HIV infections)	Health Care workers	2000

Table2.2.3: Number of printed CTC IEC/BCC materials per unit, 2013

Unit	Type of materials	Theme	Target population	Number printed
		1. Tumia dawa za kupunguza makali	PLWHA	2,500

CTC	Brochures	ya VVU kwa usahihi (Use ARV appropriately)		
		2. Epuka Kifua Kikuu Sugu (Avoid chronic TB)	PLWHA, TB Patients	2,500
		3. Tumia dawa za kupunguza makali ya VVU na Kifua Kikuu kwa usahihi (Use ARV and TB drugs appropriately)	PLWHA, TB Patients	2,500
		4. Ufuasi Mzuri wa matibabu ya Kifua Kikuu (Adherence to TB treatment)	PLWHA, TB Patients	2,500
		5. Matibabu kwa Mgonjwa mwenye Kifua Kikuu na UKIMWI (Treatment for TB and AIDS patients)	PLWHA, TB Patients	2,500
	Poster	1. Epuka Kifua Kikuu Sugu (Avoid chronic TB)	PLWHA, TB Patients	2,500
		2. Najali Afya Yangu (I care for my health)	PLWHA, TB Patients	2,500
		3. Chunguza Kifua Kikuu na Pima VVU mapema (Screen for TB and test for HIV earlier)	General Populations	2,500

Table 2.2.4: Number of printed FBO IEC/BCC materials per unit, 2013

Unit	Type of materials	Theme	Target population	Number printed
FBO	Brochures	1. Elewa unufaike (Understand to benefit)	School Students	3,000
		2. Tambua athari ya dawa za kulevya(Know the effects of drug abuse)	School Students	3,000
		3. Mimba za umri mdogo (Early pregnancies)	School Students	3,000
		4. Ninachopaswa kujifunza kuhusu magonjwa ya kujamiiana (What I supposed to know about STD's)	School Students	3,000
		5. Tambua mabadiliko ya mwili wako (Understand Your Puberty)	School Students	3,000
		6. Kuwa Mjanja Tambua kuhusu VVU Uishi kwa Salama (Understand HIV to be secure)	School Students	3,000
	Poster	1. Acha Unyanyapaa (Avoid Stigma)	School Students	3,000

2.3 A total number of **100** copies of "JINASUE" DVD films recorded and distributed to School Health Clubs and other stakeholders in both Unguja and Pemba which are supported by Programme through Faith-Based Organization (Technical Working Group).Main themes were the risk behaviors among students which facilitate them to contract or transmit HIV and reflection on the question of stigma in school community.

2.4 A total of **6** display posters and **100** copies of A4 leaflet were printed with the themes on HIV counseling and testing services from 2005-2012, PMTC services in 2012, ART Services in 2012, HIV Epidemiological profile in 2012, Integrated Bio-Behavioral Surveillance among Key Populations in 2011/12, Population Size Estimation among PWID, SW and MSM in 2011/12 in Zanzibar and were displayed at Paje in commemoration of World AIDS Day.

3.1 Airing Radio/TV Spots programs

3.2 Development and airing Radio/Television spots and programme

In 2013, IEC/BCC Unit in collaboration with other units within ZIHTLP and other stakeholders developed and aired Radio/Television spots to educate community on the HIV and HIV services as illustrated in the table below**:-**

Table 3.1.1: Frequency of airing of Radio/Television spots per unit, 2013

Unit	Type of spot	Theme	Frequency
HTC	Radio and TV spots	1. Importance Utilizing PITC services for Community	30 days
		2. importance of pre-marital HIV couple counseling and testing services	30 days
CTC	Radio and TV spots	3. Adhere on ART for People Living HIV.	30 ays

5.1 Achievements

1. Recording and printing **100** copies of school film known as "**JINASUE"** which reveals on HIV risk behaviors and stigma to school students.

2. A pathway to Behavior Change game has been useful in KP interventions to facilitate clients to identify their HIV risk behaviors and facilitate them to change.

5.2 Challenges

1. Post-test IEC materials not yet conducted, hence its quite difficult to measure the trend of behavior changes to the target populations
2. Low utilization of PITC services to the community
3. Poor adherence of ART services to PLWHA
4. Low male involvement in PMTCT and ART services
5. Stigma to PLWHA is still there for both community and some Health care workers

5.3 Way Forward

1. Conduct post-test IEC materials to measure the trend of Behavior changes to the target populations

2. Panel discussion on importance of community utilizing of PITC services
3. Panel discussion on importance of utilizing ART services to PLWHA.
4. Conduct meeting to HCW's, FBO's and Community leaders on importance of male involvement in PMTCT
5. Conduct meeting to HCW's, FBO's and Community leaders on stigma reduction to PLWHA.

5.4 Plan for 2014

- Conduct training on Pathway to behavior change game to KP peer educators

6. Key Populations (KPS) services

6.1 Background

Key Populations are populations that are at higher risk of being infected by HIV. They play a key role in driving HIV epidemic and their involvement in HIV interventions is vital for an effective and sustainable HIV response. Also they are at higher risk of acquiring other infections such as syphilis and viral hepatitis. In Zanzibar three groups have been documented to be at higher risk of HIV infection including Men having Sex with other Men (MSM), Sex Workers (SW) and Peoples who inject drugs (PWID). Ministry of Health through Zanzibar Integrated HIV, TB and Leprosy Programme (ZIHTLP) is mandated to coordinate and implement all health services related KPs interventions in Zanzibar.

HIV related interventions for KPs started in 2003 by involving peer educators on conducting home visit activities at community level so as to identify other KPs and provide HIV/STIs prevention education and condom distribution as well as refer detected positive clients to care and treatment and other related clinics. To date there are a number of local NGOs and one International NGO in collaboration with other KPs stakeholders continuing to implement KPs intervention in Zanzibar.

6.2 Goal

The goal of Key Populations services in Zanzibar is to reduce new HIV and other Sexually Transmitted Infections and provide care, treatment and support to KPs.

6.3 Objectives and activities implemented in 2013

6.3.1 Objective 1: To expand access and improve quality of HIV services for KPs

Activities Implemented

6.3.1.1 Conduct sensitization workshop on KPs services for Shehas, religious leaders and Ward Counsellors

A total of **304** community leaders at ward and shehia levels (184 from Unguja and 120 from Pemba) which includes District Administrative Officer, DACCOM, Religious Leaders, Shehas, and Ward Counselors from 10 district of Unguja and Pemba were sensitized on the importance of KPs interventions in Isles. The objective of the workshop was to orient these leaders on KPs and their importance in STI and HIV/AIDs interventions in Zanzibar so as to facilitate programs ownership at district and community level. This will in turn help to reduce stigma and discrimination to these populations, promote their health seeking behavior, and hence increase number of KPs who are accessing health services. The number of these community leaders

sensitized on KPs interventions have increased from **288 (2012) to 592** (2013). The participants were expected to continue sensitize others in their areas on the importance of HIV/AIDS health related interventions to Key populations.

6.3.1.2 Conduct supportive supervision of KPs activities at facilities (NGOs) and hot spot outreach services.

Ten days of supportive supervision to NGOs implementing KPs interventions and outreach services was conducted (five days in each island i.e. Unguja and Pemba). A total of **twelve facilities** and **five** hot spot outreach visits were supervised as indicated in the table number 6.3.1.2 bellow. The objective of the supervision was to assess types and quality of services offered to KPs as well as assist service providers in improving quality of service provision to the target clients.

The types of services provided differ from one organization to another depending on the category of KPs served. Most of the services offered to KPs include, HIV education, HIV counseling and testing, STI, TB and viral hepatitis education, escorted referrals of KPs for further investigation and management of health problems, distribution of condoms and IEC/BCC materials.

Table 6.3.1.2: Name of NGOs per district working with KPs supervised in Unguja and Pemba

Name of NGOs	District
WAMATA, JUKAMKUM, ZAPHA+, KPs Network (ZAC)	Chake Chake
ZANGOC, UMATI	Wete
ZAYADESA	Mkoani
ZANGOC	Micheweni
ZAIADA, ZANGOC,	West Unguja
Detroit Sober house, ZYF,	Urban Unguja

6.3.1.3 Conduct peer educators supportive meeting

Bi annual peer supportive meeting have been conducted in Unguja (two days each). A total of one hundred **(100)** peer educators, outreach workers and other staff from ZAYEDESA, ZYF, ZANGOC, ZAIADA, ZAMELSO, KPs Network, Clinicians from KPs friendly clinic, Private hospitals and Sober houses were involved in the meeting. The objective was to discuss various issues on KPs interventions implemented by different stakeholders. These platforms were also used to update peers on new, current and emerging HIV, STIs, TB, Viral Hepatitis information

that enable them to be familiar and competent in implementing KPs interventions in Zanzibar. Among the issues discussed were;

- Low quality of peer education sessions conducted. It was discussed and agreed that NGO programme coordinators in collaboration with ZIHTLP KPs unit staff to conduct regular supportive supervision during the peer education interventions to ensure effective peer education and strengthen escorted referral of the suspected and HIV positive tested clients.
- Inadequate collaboration between the peer educators from different NGOs. It was discussed and agreed that there should be a good cooperation and coordination between peer educators irrespective of the NGO they are working with.

6.3.1.4 Conduct Key Population stake holder's meeting

Two days KPs stakeholders meeting were conducted. A total of **35** members from ICAP, ZACP, ZAYEDESA, ZNCDC, ZAC, ZYF, ZANGOC, MMH, ZAPHA+, ZAIADA, UMATI, THESODE, KPs Network Leaders, KPs friendly clinic clinicians, ZAMELSO and Anglican Church attended the meeting. The aim of this meeting was to strengthen coordination and feedback mechanism among key implementers by sharing experiences and discuss various barriers and facilitators towards the implementation of KPs interventions so as to find and have unified strategies on improving KPs services in Zanzibar. Among the issues discussed were;

- Unclear coordination and collaboration between stakeholders working with KPs in Zanzibar. It was discussed and suggested that each and every NGO should have and share the schedules for their interventions especial outreach services to reduce duplications between them.
- Poor reporting system of the activities implemented by NGOs (especially KPs reached, tested and referred to different clinics). It was discussed and agreed that each NGOs should send their monthly, quarterly and annual reports to both their respective authority and ZIHTLP KPs unit

6.3.2 Objective 2: To improve availability and accessibility of KPs interventions.

Activities Implemented

6.3.2.1 Provide KPs friendly services

Mnazi mmoja KPs friendly clinic continues to offer service to the targeted populations. Services that have currently been offered include STIs, screening and vaccination of viral hepatitis, TB, as well as HIV testing and counselling. The objective is to facilitate provision of friendly service such as STI treatment, HTC and other services that will increase the number of KPs accessing health services. A total of 120 (86 others and 36 KPs) clients attended the clinic with different

health complaints as indicated in the table number 6.3.2.1 below. It was noted that, the number of clients attended KPs friendly clinic has been slightly increased from **102 (in 2012) to 120 (in 2013)**. Despite the increased number of KPs who attend in this clinic, there are still challenges for them to attend due to stigma from some of the health care workers and fear to attend public health facilities.

Table 6.3.2.1: Number of cases diagnosed at the KPs friendly clinic at MMH – CTC, January – December, 2013

Category	Diagnosis					
	Attended	**Vaginal discharge**	**Urethral discharge**	**Genital Ulcer**	**Pelvic inflammatory disease**	**HIV**
PWID	7	3	2	1	0	1
FSW	26	24	0	1	1	0
MSM	1	0	1	0	0	0
Others	86	56	11	2	16	0
Total	**120**	**83**	**14**	**4**	**17**	**1**

6.3.2.2 Conduct HBV screening and vaccination for KPs in Mnazi Mmoja Hospital

Hepatitis B virus screening and vaccination continues to be offered to KPs at Mnazi Mmoja Hospital and in some sober houses in Unguja. The objective of this service was to screen KPs in Zanzibar as they are known to have high infection rate of viral hepatitis compared to other populations. A total of **43** clients tested negative for viral hepatitis B and hence were eligible and received vaccine against HBV as indicated in the table 6.3.2.2 below. The number of KPs who were tested declined from **233 (2012) to 43** (2013). Among the reasons for this decline was; due to difficulties to convince and reluctance of some KPs to go for the test as they are scatted here and there.

Table 6.3.2.2: KPs screened and vaccinated for HBV, at MMH, January – December, 2013

Category	Tested		Results		HBV vaccination		
	Male	**Female**	**HBV +ve**	**HBV –ve**	**1st dose**	**2nd dose**	**3rd dose**
PWID	9	2	0	11	11	4	0
SWs	8	17	0	25	25	1	0

MSM	3	4	0	7	7	7	0
Total	**20**	**23**	**0**	**43**	**43**	**12**	**0**

6.3.2.3 Conduct escorted referrals to CTC for tested HIV positive KPs

All Key Populations are eligible to start using ARVs once they are confirmed HIV positive. The unit in collaboration with the NGOs promoted escorted referral for KPs diagnosed with HIV. This is to reduce the chances of lost to follow up when they referred for care and treatment services. During the reporting period a total of **12** KPs were escorted to MMH - CTC as indicated in the table 6.3.2.3 below:

Table 6.3.2.3: Number of Tested HIV positive KPs escorted to CTC Jan – Dec. 2013

SN	CATEGORY	NUMBER
1	**SW**	**4**
2	**PWID**	**6**
3	**MSM**	**2**
Total		**12**

6.3.3 Objective 3: To enhance staff capacity on KPs interventions

Activities Implemented

6.3.3.1 Conduct training of HCWs on Post Exposure Prophylaxis (PEP)

Seven days PEP training for health care workers was conducted. A total of sixty six Health Care Workers (**36 from Unguja and 30** Pemba) health facilities attended. The objective of this training was to equip service providers with necessary knowledge and skills in relation to the prevention of infection with Blood Borne Pathogen and provision of appropriate clinical management of exposed health worker and other client in the most efficient and effective way. The participants were expected to start using the existing PEP standard guideline in the management of the exposed clients.

6.3.3.2 Attend study tour for ministerial official and programme officers on Medical Assisted Therapy (MAT) in Dar es Salaam

Five days MAT study tour in Dar es Salaam was conducted. The total of eight **(8)** delegates (2 - ZIHTLP, 2 – Zanzibar National Coordination for Drug Control (ZNCDC), 2 – Mental hospital, one from CMS and one from Ministry of Health) visited several MAT sites in Dar es Salaam. Two MAT clinics (Muhimbili and Mwanayamala), and six NGOs (YOVARIBE, Blue Cross, Kimara Peers and CHRP, MDM, and MKIKUTE) involved in MAT services and several community outreach and caravan were visited. The objective of this tour was to learn different

issues related to MAT operations, to be equipped with an in-depth orientation on MAT programme hence will facilitate smooth establishment and running of similar MAT programme in Zanzibar. The tour will help to establish comprehensive health related services targeting heroin users especial PWID in Zanzibar.

6.3.3.3 Attend HIV/AIDs monitoring and evaluation (M&E) training programme in University of Pretoria, South Africa

Three ZIHTLP staffs (KPs Coordinator, M&E officer and Assistant Programme Manager – Pemba) attended **10** days HIV/AIDS M&E training that was conducted under the Measure Evaluation in collaboration with University of Pretoria in South Africa. The objective of this training was to reinforce the capacity of participant's knowledge on state-of-the-art tools and techniques to monitor and evaluate of HIV/AIDS programs. The participants were expected to use the acquired knowledge and skills in their daily operation of HIV/AIDS interventions and also will transfer acquired knowledge to other programme staff.

6.3.3.4 Conduct training of trainers (ToT) on minimum packages for KPs

Two ToT (Three days each) on minimum packages for Key Populations was conducted. A total of 50 (30 in Unguja and 20 in Pemba) programme officers working on KPs interventions attended. The training was conducted after the development of the package. The objective of this training was to impart knowledge and skills on the recommended packages for KPs interventions in Zanzibar. The participants were expected to use the acquired knowledge and skills to train others and adhere to KPs minimum package in their daily operations of the KPs interventions.

6.4 KPs indicators

Table 6.4: Key Populations indicators and Trends in 2011-2013

SNo.	Indicators	Achievement		
		2011	2012	2013
1	Number and percentage of MARPs (KPs) who received an HIV test in the 12 months and who know their results	1,421	1,563	969
	a) MSM	572	401	121
	b) SWs	503	787	360
	c) PWID	346	375	488

6.4.1 Number of KPs who received an HIV test in the last 12 months and who know their results

Number of KPs who received an HIV test has reduced from **1,563** in the year 2012 to **969** in the year 2013. The results shows that many KPs who received an HIV tests were reached through Voluntary Counselling and Testing sites (70.5%) than those who received the services at

outreach as illustrated in the tables 6.4 above and 6.4.2 bellow. This decline in number of KPs who received HTC services is related to low number of outreach interventions conducted by NGOs and decline in financial capacity of some NGOs working with KPs

Table 6.4.1: Number of KPs and their category who received an HIV test by HCT from January to December, 2013

KPs category	Outreach services			VCT clinics		
	Number Tested	Number Positive	Percent Positive	Number Tested	Number Positive	Percent Positive
IDU	124	3	2.4%	364	23	6.3%
MSM	49	0	0.0%	72	3	4.2%
CSW	112	8	7.1%	248	13	5.2%
Total	**285**	**11**	**3.9%**	**684**	**39**	**5.7%**

6.4 Challenges

i. Stigma by some of HCWs professionals and nonprofessionals to key populations still persist.
ii. Low turn up of KPs to attend KPs friendly clinic
iii. Low enrollment of key populations to CTC
iv. Low number of KPs to go for Viral screening and vaccination for Hepatitis B

6.5 Proposed way forward

i. Scale up of KPs friendly services to NGO based services.
ii. Conduct mobile KPs HBV testing and vaccination in Unguja and Pemba.
iii. Conduct mobile HTC to Key Populations

6.6 Plan for 2014

i. Scale up KPs friendly services to NGO based at ZAYEDESA Miembeni Unguja

7. Sexual transmitted infections services

7.1 Background

Sexual Transmitted Infections (STIs) and other Reproductive Tract Infections (RTIs) are highly prevalent in many communities worldwide. They cause considerable morbidity, while increasing the risk of acquiring HIV infections and are costly to the individual and the society in general.

Effective management of STIs and RTIs is one of the cornerstones of their control, as it prevents the development of complications, decreases the spread of those infections and HIV in the community and offers unique opportunities for targeted educations about reproductive health. Early and appropriate treatment of STIs/RTIs at the first contact between patients and health care providers is an important public health measure. Condom programming including promotion and distribution is another cornerstone of prevention of HIV/STIs in Zanzibar. STIs/RTIs services are provided in all **220 (145 in Unguja and 75 in Pemba)** health facilities providing health care services in Zanzibar.

7.1 Goal

The goal of STIs services is to reduce new HIV and Sexually Transmitted Infections and to provide care and treatment to all people in Zanzibar.

7.2 Objectives and activities implemented in 2013

Activities Implemented

7.2.1 Objective 1: To expand quality of STIs services and increases its utilization

7.2.1.1 Conduct STI refresher training for health care workers.

Two five days refresher trainings were conducted in Unguja and Pemba. A total of **85** participants (40 from Pemba and 45 participants from Unguja) were trained. The objective of the training was to impart the updated knowledge and skills to HCWs on STI/RTIs. At the end of the training participants were expected to provide quality STI services.

7.2.1.2 Conduct STIs supportive supervision at health facilities.

STIs supportive supervision at health facilities was conducted in Unguja and Pemba. The objective of the supervision was to assess the quality of STIs services provided as well as to assist health care workers in improving quality of services provided to clients. A total of **100** health facilities **(**70 public and 3 private health facilities in Unguja and 26 public and one private health facilities in Pemba) were supervised. The most observed challenges were:

- Improper filling of monitoring tools
- Poor utilization of STI guidelines
- Poor partner tracing in some of the facilities.

Onsite feedback was provided in each health facility visited whereby strengths and challenges encountered were discussed. Demonstration on how to fill monitoring tools and brief orientation on using STI guideline especially Flow charts was done.

During the visits some of the STIs working tools (Male and Female genital models for demonstration, STI guidelines, STI Registers and condoms) were distributed.

7.2.2 Objective 2: To reduce new sexually transmitted infections among Zanzibaris.

Implemented Activities

7.3.2.1 Distribute condom

A total of **122,382** pieces of male condoms were distributed through various condom outlets as indicated in the table 7.3.12.1below. There is slight decrease number of condom distributed in this year compared to 2012 where 131, 272 pcs of condom were distributed. This decline was due to stock out of the male condom in few months.

Table 7.3.2.1: Number of male condoms distributed by different outlets, Jan.–Dec, 2013

	FACILITY	TOTAL
NGOs		
1	ICAP	4,556
2	ZAYEDESA	2,720
3	ZAIADA	1,500
4	ZYF	600
5	ZANA	200
6	ZANGOC	1,000
7	ZAPHA+	400
8	Nyota njema NGO	586
9	Anglican church	500
Health Facilities		
10	M/LADU	1,000
11	CTC/VCT Mnazi mmoja	12,708
12	Makunduchi hosp	1,000
13	KPs Friendly Clinic	300
14	VCT MMH	9,708
15	Kitope PHCU	300
16	TPDF Welezo	500
17	Al Tabib Clinic	432

Outreach		
18	Outreach (Peer educations)	43,444
19	**Army forces**	
20	Chukwani Camp	2,500
21	Army Force Units	11,514
Other		
22	During STI Training	200
23	During supervision in Health facilities	13,664
24	Hotels	1450
25	Sea Port	720
26	Hotels	2,016
27	SHACCOM- Kidimni	432
28	AJHSReview meeting exhibition	432
29	TRA	2,000
Total		**122,382**

7.3 STIs indicators

Table 7.4.1: Sexual Transmitted Infections Indicators and Trend in 2013

SNo.	Indicators	Trend		
		2011	**2012**	**2013**
1	Number of health facilities provide STIs care and treatment with staff trained in STIs care and treatment	50	50	85
2	Number of women and men with an STI presenting at health facilities who are appropriate diagnosed according to the national guidelines	21,143	9,492	9,596
3	Percentage of sexual partners of an individual with an STI treated at health facilities whose sexual partners are notified of their infections	14.8% 1,468/21,143	12.5% 1,184/9,492	10.7% 1,029/9,589
4	Number of male condoms distributed		131,272 pcs	122,382 pcs

7.3.1.1 Number of health facilities provide STIs/RTIs care and treatment with staff trained in STIs care and treatment

Number of health facilities provide STI services with trained staff has increased from **50** to **85**. This is because there were STI refresher trainings which were attended by some trained and new health staff.

7.3.1.2 Number of women and men with an STI presenting at health facilities who are appropriate diagnosed according to the national guidelines

A total of **9596** patients were diagnosed and treated with STI. Among them, 2397 (25%) were males and 7199 (75%) were females. However, compared to 2012 data, there was slight increase in STI cases diagnosed (9,492 in 2012 to 9,589 in 2013). The table number 7.4.1.2 below illustrates the number of STI cases diagnosed and treated by gender and age.

In terms of distribution, the Urban district was observed to report high number of STI cases (33%), followed by West district and Central District with 15% and 12% respectively. Micheweni district was observed to have few cases (3%) of STI. Vaginal discharge syndrome 42% have the highest number followed by female with lower abdominal pain (23%) as indicated in the tables number 7.4.1.2 and 7.4.1.3 below:

Table no 7.4.1.2: Number of STI cases diagnosed and treated by age and gender, Zanzibar 2013

Diagnosis	Age and gender						Total
	Male			Female			
	0-14	15-24	25 +	0-14	15-24	25 +	
Syndromic Diagnosis							
Genital Ulcer (GU)	0	69	83	3	109	115	379
Inguinal Bubos (IB)	2	8	14	2	6	12	44
Lower abdominal pain (LAP)				70	917	1308	2295
Vaginal Discharge(VD)				38	1600	2416	4054
Urethral Discharge (UD)	8	364	1060				1432
Painful Scrotal Swelling	18	84	117				219
Neonatal Conjuctivitis (0-28 days)	291						291
Tota Syndromic Diagnosis	**319**	**525**	**1274**	**113**	**2632**	**3851**	**8714**
Aetiological Diagnosis							
Gonorrhea	0	42	116	0	62	108	328

Syphilis	0	16	26	2	30	42	116
Trichomonas Vaginalis	0	9	21	4	80	88	202
Chlamydia	0	0	1	0	11	13	25
Candidiasis	1	4	12	3	32	81	133
HIV	0	3	22	2	10	27	64
Hepatitis B	0	3	3	0	5	1	12
Hepatitis C	0	0	0	0	1	1	2
Total Aetiological diagnosis	**1**	**77**	**201**	**11**	**231**	**361**	**882**
Total	**320**	**602**	**1475**	**124**	**2863**	**4212**	**9596**

Table no 7.4.1.3: Number of STI/RTI cases by District, Zanzibar 2013.

Diagnosis	Districts by Zone										
	Pemba				Unguja						Total
	Chake	Micheweni	Mkoani	Wete	North "A"	North "B"	Central	South	West	Urban	
Syndromical diagnosis	972	310	318	770	332	537	968	490	1,365	2,832	8,714
Aetiological diagnosis	2	1	5	41	57	42	214	2	164	354	882
Total	**794**	**311**	**323**	**811**	**389**	**579**	**1,182**	**492**	**1,529**	**3,186**	**9,596**
% of all STI cases	**8.3**	**3.2**	**3.4**	**8.5**	**4.1**	**6.0**	**12.3**	**5.1**	**15.9**	**33.2**	**100.0**

7.3.1.3 Percentage of sexual partners of an individual with an STI treated at health facilities whose sexual partners are notified of their infections

In 2013, a total number of sexual partners whose sexual partners are notified of their infections were 1,184. Compared to 2012, the number of sexual partners treated decreased from 1,184 to 1,029 in 2013.

7.3.1.4 Number of male condoms distributed

Number of male condoms distributed through various condom outlets in Zanzibar has declined from 131, 272 to 122,382 in 2012 and 2013 respectively. This was due to frequent stock out of the male condom.

7.3 Challenges

- Sex partners are still reluctant to access management of STIs (partner tracing)
- Shortage of STI drugs in most of the health facilities.
- Shortage of condoms
- Shortage of trained STI providers.

7.4 Way forward

- Sensitization workshop to community on partner involvement in STI services.
- STI drugs to be procured and distributed to all health facilities regularly.
- Conduct training for new staff.
- Mentorship for STI providers in health facilities
- Improve condom programming

7.5 Activities Planned for the Next year

- Review STI guideline to incorporate new information including Key Populations.

8. HIV CARE AND TREATMENT SERVICES

8.1 Background

ZIHTLP started provision of care and treatment (ART) services in 2005 at Mnazi Mmoja Hospital. The goal is to reduce HIV/AIDS related morbidity and mortality through provision of quality care and support to people living with HIV and AIDS, provision of ART to eligible patients and improve linkages with other HIV related services. Currently, there are 10 Health facilities providing care and treatment services, 6 in Unguja and 4 in Pemba. ART services are provided in both public (9 clinics) and private hospitals (1 clinic).

As of December 2013, a total of **6998** patients have been enrolled in care and treatment clinics (CTC) of whom **4526** (68 %) are ever started on ARVs at these facilities. However, patients who are currently on ARVs are **3107**.

8.2 Goal

The goal of HIV care and treatment services is to reduce HIV related morbidity and mortality in Zanzibar.

8.3 Objectives and activities implemented in 2013

Objective 1: To strengthen existing ART services

Activities Implemented

1.1Conducts supportive supervision to Care and Treatment clinics

A total of three supportive supervisions to all Care and Treatment Clinics (**6** in Unguja and **4** in Pemba) including under one roof TB/HIV clinic was conducted using supervision tool. The supervision team constituted of CTC coordinator, clinician, nurse counselor, laboratory technician, pharmacy technician and M&E personnel. The objective of supervision was to monitor the standards and quality of services provided in CTCs according to the Zanzibar new ART guidelines. During the supervision the CTCs were found to some extent to comply with the ART guideline, however the following gaps were observed:

- Improper filling of patient CTC2 Cards, incomplete filling of Pre ART, ART and Cohort registers.
- Delayed 6 monthly monitoring of patients CD4.
- Poor monitoring of patients adherence
- In some clinics patients were refusing to start on ARVs for various reasons including knowledge of old ART criteria.
- Irregular eligibility meetings.

To overcome the identified challenges emphasis was made on importance of conducting regular eligibility meetings, ongoing adherence counseling for the clients refusing to start ART and proper filling of patients monitoring forms

1.2 Feedback supportive meeting

One day supportive meetings to Care and treatment service providers were conducted in Unguja and Pemba following all supportive supervision. The objective of the meetings were to provide feedback of supportive supervision, provides an opportunity of sharing experience, best practices and challenges experienced by different CTCs. A total of **63** Providers from Unguja and **45** from Pemba, including Clinicians, Nurse Counselors, pharmacy staff, laboratory technicians, data clerks, orderlies, peers and representative from District health management teams (DHMT) attended both meetings. The discussed issues during the coordination meetings included:

- CD4 sample transportation, in Pemba during the supervision it was observed that in some CTC the delayed six monthly monitoring of patients CD4 was due to unclear mechanism of sample transportation, suggestions for solving the transportation problem were made and since the feedback meeting was conducted proper mechanism of CD4 sample transportation was reported.
- Improvement on standard of care, including proper adherence monitoring, it was suggested that all Clinicians should ensure that adherence tools are used and documented, simultaneously there should be consistence in filling of adherence monitoring tools and CTC2 Card.

A part from discussing gaps identified during supportive supervision, the following emerging issues were also discussed:-

- Retention of patients, presentation on retention rate per facility was done, which indicated Patient Pre ART and ART retention for each facility and participants were given opportunity to discuss strategies to increase retention. Some of the suggestions made were to engage actively home based care providers and peers from when the patients have been enrolled into care and strengthening Health education and ongoing counseling.
- Sharing of treatment as prevention (TasP) targets to all CTCs, enrollment and ART initiation targets were shared and Participants were informed on importance of enrolling more patients into care and initiate all eligible patients on ART for achieving the targets, however the anticipated challenge on achieving Tasp targets was reported to be low number of enrollment due to a decrease in referred cases from entry points such as HTC.

1.3 Conduct mentorship to care and treatment clinics

Mentorship to care and treatment clinics was conducted for the purpose of addressing gaps identified during supportive supervision, and to build capacity of health care providers to provide appropriate care and treatment to HIV/AIDS patients. Two days mentoring was conducted to five care and treatment clinics, three in Unguja which are Al Rahma, Kivunge and Makunduchi and two Micheweni and Mkoani in Pemba.The areas which were mentored are Adherence counseling and filling of Pre ART, ART and cohort registers.

1.4 Conduct continuing medical education for CTC staff

A half day continuing medical education was conducted in all six care and treatment clinics in Unguja. The objective of the training was to build capacity of CTC providers and update them with new knowledge in order to provide appropriate care and treatment for their patients. The topics presented were on nutritional assessment. Continuing medical education was also provided to central medical store staff so as to update them on new Zanzibar ART guidelines.

1.5 Training on TB/HIV co - infection management for DHMTs staff

Care and Treatment unit conducted five days training on TB/HIV collaborative services to District Health Management Teams (DHMT) in Unguja and Pemba. A total of 30 DHMT staffs from all six districts in Unguja and 25 from all four districts in Pemba had been trained. The objective of the training was to orient DHMT members on TB/HIV co-infection management and collaborative services, so as to effectively monitor the delivery of services at their respective districts in order to improve the quality of care. Trained DHMT staffs are expected to utilize the acquired knowledge to monitor the delivery of services in their respective districts.

1.6 Pediatric TB/HIV training

Five days pediatric TB/HIV training was conducted. A total of 35 health care workers (20 from Unguja and 15 from Pemba) participated in the training. The participants included new CTC Clinicians and providers from other health facilities. The Objective of this training was to equip health care workers with knowledge and skills in: TB diagnostic approaches including using score card, how to collect sputum specimen from a child, TB/HIV relationship, TB and HIV treatment for children and management of drug interaction, BCG vaccination and Diagnosis and management of children with drug resistant TB. Following this training participant are expected to increase efficiency in their facilities through proper management of pediatric TB/HIV.

1.7 Conduct ART refresher training for CTC providers.

Three days ART refresher training was conducted for all CTC providers in Unguja and Pemba. Aim of this training was to update care and treatment providers on new Zanzibar ART guidelines, that have additional ART eligibility criteria and new proposed default first line regimen which is TDF+3TC+ EFV

The additional eligibility criteria are:

- All positive pregnant women and breast feeding mothers regardless of WHO stage or CD4 Cell count
- All Key populations (IDUs,MSM,CSW) regardless of WHO stage or CD4 Cell count
- HIV positive partner in sero discordant couple
- All TB patients co- infected with HIV
- All hepatitis B, C /HIV co – infected individual

1.8 Conduct TB/HIV under one roof assessment

The assessment was conducted in Pemba. The facilities assessed were Chake Chake, Micheweni and Wete Hospitals. The objective of this assessment was to identify potential health facilities for establishment of TB/HIV under one roof clinic as it is recommended that patient with TB/HIV Co infection should receive TB and HIV care under TB Clinic. During this assessment Micheweni and wete was not qualified due to inadequate of space and low number of patients. Chake Chake Hospital was qualified as potential site for establishment of under one roof clinic due to various reasons, including sufficient space and rooms to allow for proper patients flow from triage, nurse, clinician to pharmacy.

1.9 Conduct comprehensive Basic ART training for CTC providers

Nine days comprehensive ART training was conducted. Objective of the training was to equip the CTC health care providers with knowledge and skills on proper provision of ART services. A total of **32** health care workers (**11** from Pemba and **21** from Unguja) participated in the training. Some of these participants were new staff who were not trained on ARVs, new staff who are going to establish TB/HIV under one roof clinic in Pemba and other participants were coming from other hospital wards who can be used as CTC backups.. The training was being facilitated by National ART trainers from NACP. Following this training participants from Chake are expected to establish TB/HIV under one roof clinic and others to fill gaps during shortage of human resource.

1.10 Conduct pilot study on HBV/HIV co infection among HIVclients attending mnazimmoja care and treatment clinic

Pilot study on HBV for PLHIV in Mnazi Mmoja CTC started on 16th July 2012. The objective of the study is to determine Hepatitis prevalence among HIV patients. Patients who test negative for HBV receives vaccination and those positive are initiated/shifted to proper ARV regimen. Up to December 2013 a total of **2002** have been enrolled, **713** have received vaccination and those positive are receiving treatment according to Zanzibar ART guidelines.

1.11 Print and distribute CTC patient forms

A total of seven type of monitoring tools was printed in booklet forms and distributed to all ten care and treatment clinics in order to overcome frequent stock out. Forms printed and distributed are as follows:

- Patient ARV form - 500 booklets
- Follow up after ARV initiation - 200 booklets
- Adult ARV elligibility form - 300 booklets
- Adult ARV prescription form - 500 booklets
- Pediatrick ARV prescription - 200 booklets
- Padeatrick ARV eligibility - 100 booklets
- Consent form - 300 booklets
- Patient flow chart - 300booklets

1.12 Conduct home visiting to track loss to follow up patients

In collaboration with peers, Care and treatments clinic staff conducted home visit for patients who are bed ridden and those who default from the clinics. A total of **567** patients from Mnazi Mmoja Hospital, Kivunge, Mwembe Ladu, Bububu , Wete, Al Rahma, Chake chake, mMicheweni and Mkoani and have been visited during this year as shown on the table below

Table 8.1: Implementation of home visiting to trace loss to follow up patients and those who are bed ridden from five care and treatment clinics in Unguja, Jan – December 201

Clinic	Patient who were visited at home			Wrong address	Death	Returned to clinic	Refused to come back to clinic	Travel with no information	Other reason
	Bed ridden	Loss to follow up	Total						
MMH	5	374	379	74	36	98	30	68	68
Mwembe Ladu	0	54	54	5	11	38	0	0	0
Kivunge	0	29	29	0	0	12	0	17	0
Bububu	0	44	44	7	7	25	0	0	5
Alrahma	0	30	30	7	3	12		8	0
WETE	0	8	8	0	0	8	0	0	0
MKOANI	0	9	9	0	1	2	2	4	0
MICHEWENI	0	6	6	0	0	0	5	1	
Chake Chake	0	8	8	4		1	3		
TOTAL	**5**	**562**	**567**	**97**	**58**	**196**	**40**	**98**	**73**

Objective 2: Improve Linkages with HIV/AIDS and other related Programs

Implemented Activities

2.1Conduct Meeting between ZIHTLP, PMU and CMS Staff

Three coordination meetings for ZIHTLP, Central Medical store and procurement Unit of MOH staff were conducted. The aim of these meetings was to discuss various issues related to procurement and supplies of HIV related commodities. During the meeting, issues discussed include presentation on status of HIV commodities in CMS, delayed transport of ARVs to Pemba, future consideration for integrating distribution of HIV commodities under ZILS (Zanzibar Integrated Logistic system) and ART refresher training need to CMS staff .As of December 2013 there was improvement on timely transportation of ARVs drugs to Pemba.

2.2 Conduct Collaboration meeting between CTC and TB clinic staff

Two collaboration meetings in Pemba and one In Unguja between CTC, Hospital management and TB clinic staff were conducted. Aim of the coordination meetings were to discuss implementation of TB/HIV Under one roof services, enhance collaboration, referrals and linkages between CTC and TB clinics. The meeting involved Clinicians, Counselors, TB DOTS nurses, TB clinics staff, DTLCs and ZIHTLP staffs.

Major issues discussed during this meeting were:

- Low contribution of TB Patient from Care and Treatment Clinic in Pemba, constituent of 16% of all TB Patients compared to Unguja which contributes to more that 60% of TB Patients. Hence CTC providers were emphasized to effectively screen all the patients for TB, and patient with cough of any duration should be screened for TB.

2.3 Conduct Coordination meeting between CTC staff and ZAPHA+ members

During this year three meetings between CTC Staff and ZAPHA+ members were conducted two meetings in Pemba and one meeting in Unguja. The objective of the meeting was to discuss success and challenges faced by patients in receiving care and treatment services. Participants on these meetings were CTC, HTC and HBC Coordinator, CTC staff, ZAPHA+, CHBC and expert patients.

The following were among the issues discussed during the meeting:

- Lost to follow up, during discussion various reasons contributing to lose to follow up such as stigma, uses of traditional medicines and migrants were mentioned. Some of the suggestions made to overcome lost to follow up were to engage actively home based

care providers and peers once the patient is enrolled into care and strengthening health education and ongoing counseling.

- Patients refusing to start ART, it was discussed that some of the patients refuses to start ART for various reasons including not being ready for lifelong treatment, uses of other traditional medicines and knowledge on previous ART criteria, hence proposed strategies for overcoming the mentioned problem s include strengthening of adherence and ongoing counseling and referral of such patients to peers for more advance on going counseling.

- During discussion it was raised that despite of good services at care and treatment clinics, there are still some challenges such as:

    i. Stigma still persists in the hospital wards

    ii. Lack of enough space in some of the clinics such as M/Ladu, Al Rahma and Makunduchi CTCs in Unguja andChake in Pemba

2.4 Conduct TB/HIV Sensitization meeting to CHBC and community leaders

CTC unit in collaboration with TB/leprosy conducted 8 sensitization meetings on TB/HIV for community leaders in Unguja and Pemba. A total of 316 participants (216 in Unguja and 100 in Pemba) attended the meeting. The participants of this meeting included Sheha and religious leaders from different shehias of each district from Unguja and Pemba, the meetings also involved community home based care providers. The objective of the meeting was to orient community leaders on TB/HIV services.. This meeting also provided opportunity for strengthening collaboration among community and religious leaders as well as Community home based care providers. Following this, community leaders and CHBC are expected to collaborate and sensitize the community on TB/HIV services and monitor TB cases that have been identified at their shehias.

Table 8.2: HIV care and treatment indicators and trend 2011- 2013

	Indicator	**2011**	**2012**	**2013**
1	Number of health care facilities that have the capacity and conditions to provide basic HIV counseling and testing and to manage HIV and AIDS clinical services.	10	10	10
2	Percentage of adults and children with HIV still alive and known to be	75.6	78.7	79.8

	on treatment 12 months after initiation of antiretroviral therapy			
3	Number of PLHAs attending HIV treatment and care settings, who were screened for TB symptoms, in the preceding 12 months	3435/3535(97%)	3735/3844 (97.1)	4390/4396(99%)
4	Number (%) of adults and children with advanced HIV infection currently receiving ART	2171	2947	3107
5	Number of persons provided with Post-exposure prophylaxis (PEP)	1	76	104
6	Number of health facilities providing comprehensive TB/HIV collaborative activities	1	1	2

1. Number of health facilities that have the capacity and conditions to provide basic HIV counseling and testing and to manage HIV and AIDS clinical services.

By 2013, ten ART clinics were operational in both Unguja and Pemba. All clinics carry out HIV testing with six clinics carrying out full-blood tests (FBT) including CD4 counts. Of these ten clinics, nine are public and one is a private health facility. The clinics are distributed in all 4 districts in Pemba and 4 out of 6 districts in Unguja. Districts which lack CTC are North B and Central. There was increased enrollment of 962 patients in 2013, compared to 746 patients enrolled in 2012.

Table number 8.3: Shows Patients enrollment by age group in CTC - 2013, Zanzibar

Age group	Mnazi Mmoja		Kivunge		M/Ladu	Alrahma		Bububu			Makunduchi		Chake		Wete		Micheweni
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
< 1	3	5	0	1	0	2	0	0	0	0	0	1	0	0	1	2	0
1 -4	4	4	8	8	3	0	0	0	1	0	1	0	1	0	0	0	1
5 - 14	6	6	5	8	3	3	0	1	1	2	0	1	0	0	1	1	2
> 14and above	134	241	15	36	43	153	10	16	34	78	5	15	15	19	15	18	3
TOTAL	147	256	28	53	49	158	10	17	36	80	6	17	16	19	17	21	6

2. **Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy**

For each group of patients who start ART at the same period/month (cohort), they are monitored for survival and computed to determine the proportions that are alive after a period of 6, 12, 24, or 60 months. The table below shows the proportion still alive and on treatment at 12 months for each care and treatment center.

It is observed that in this reporting period overall percentage of patients who are still alive have been increased from 75.6% in 2011, 78.5% in 2012 to 79.8% in 2013

Table 8.4: Percent of HIV patients alive after 12 months initiation of ART by CTC for , 2013,

Name of CTC	Number of patient jan – Dec 2012	No and Percent of patients alive by Dec 2013
Al Rahma	26	19(73.07)
Bububu	55	47(85.45)
Mnazi Mmoja	447	345(77.2)
Mwembeladu	97	81(83.5)
Kivunge	17	14(82.4)
Makunduchi	17	14(82.4)
Unguja	**673**	**533(79.2)**
Chake Chake	28	26(92.9)
Mkoani	8	5(62.5)
Wete	18	15(83.3)
Micheweni	14	12(85.7)
Pemba	**68**	**58(85.3)**
Zanzibar	**741**	**591(79.8)**

Cohorts of Jan-Dec 2012, reported in 2013

3. Number of PLHIVs attending HIV treatment and care settings, who were screened for TB symptoms, in the preceding 12 months, 2013

An HIV infected client attending care and treatment services are screened for TB at each encounter. These include patients on ART, not on ART, on IPT or stopped IPT, adult male, female and children, with the exception of those on TB therapy. Five screening questions are

asked to the client for yes or no response. On answering yes to one of the question the client is referred for further TB examination (sputum or X-ray) followed by treatment if TB infection is diagnosed. Percentage of patients screened for TB has increase from 97.1% in 2011 and 2012 to 99% in 2013.The table below shows the number of HIV patient who were screened for TB out of those who received care during the period and those started on TB treatment

Table 8.5: Number of HIV patients screened for TB by facility, 2013

CTC	TOTAL VISITS	SCREENED FOR TB		STARTED ON TB TREATMENT	
		<14 Yrs	>14 Yrs	<14 Yrs	>14 Yrs
Al Rahma	140	6	134	0	1
Bububu	377	18	358	1	8
Kivunge	224	19	205	2	4
Mnazi Mmoja	2521	216	2303	18	62
Mwembeladu	606	41	565	1	3
Chake Chake	217	23	191	1	5
Mkoani	35	2	33	0	1
Wete	157	25	132	1	10
Micheweni	63	13	50	0	2
Makunduchi	56	4	52	0	0
TOTAL	4396	367	4023	24	96

4. Number (%) of adults and children with advanced HIV infection currently receiving ART

As of December 2013, a total of **6998** patients have been enrolled in care and treatment clinics (CTCs) of whom **4526** (68 %) are patients who were ever started on ARVs at these facilities. However, patients who are currently on ARVs are **3107**.

5. Number of persons provided with Post-exposure prophylaxis (PEP)

During the reporting period a total of 104 people have received PEP from six care and treatment clinics which are M.mmoja , Bububu, Al Rahma, Chake, Mkoani and Wete hospitals.

6. Number of health facilities providing comprehensive TB/HIV collaborative activities

Currently there are two sites providing comprehensive TB/HIV activities (Mnazi Mmoja and Chake chake hospitals). TB patients who are diagnosed as HIV positive are treated at TB clinic and receive ARV drugs until they finish TB treatment when they are referred to CTC. A total of **71** patients received ART at TB/HIV under one roof clinic in 2013.

8.4 Achievement

- Establishment of TB/HIV under one roof clinic in Pemba
- Revision and implementation of New ART guidelines

8.5 Challenges

- Inadequate space in some CTCs
- Tracing the lost to follow up patients

8.6 Way forward

- Strengthen collaboration with HBC providers.
- Strengthening health education and ongoing counseling.
- Strengthen communication and referral from the entry points
- Plan for year 2014
- Establishing care and treatment clininic in NGO
- Strengthening IPC system in TB/HIV under one roof clinic in M.Mmoja hospital

9. Laboratory service

9.1 Background

The laboratory service structure in Zanzibar is a three-tier system consisting of Referral, District and Cottage hospital laboratories. Laboratory services support HIV prevention, care and treatment in undertaking the following functions:

a. Diagnose HIV infected clients
b. Staging of HIV infected patients for treatment eligibility
c. Monitor treatment efficacy for patients who are on treatment or follow up disease Progression for those who are not yet on treatment
d. Monitor HIV drug resistance in patients who are on treatment or in the community

The main strategies used by laboratory unit are provision of guidance on HIV/AIDS related laboratory trainings; technical assistance and leadership in assuring highly functional and operational testing systems, assuring quality systems integration and building the capacity of health laboratories to support HIV/AIDS prevention, care and treatment in Zanzibar.

9.2 Goal

The main goal of ZIHTLP laboratory unit at is to oversee and strengthen the national HIV laboratory related services.

9.3 Objectives and Activities implemented in 2013

9.3.1 Objective1: Provide technical assistance in assuring highly functional and operational testing systems

Activities Implemented

1.1 Conduct Samples testing to supports care and treatment services, 2013

As of December 2013, a total of **24,707** tests were conducted in care and treatment laboratories. Among them **5,572** for CD4 Counts, **1,281** Hematological analysis and 17,854 for clinical chemistry analysis to support care and treatment services as shown below:

Table no 9.1 Number and type of tests conducted in Care and Treatment Laboratories, Zanzibar, -2013

Period	Type of test		
MONTHS	**CD4**	**HAEMATOLOGY**	**CHEMISTRY**
JANUARY – MARCH, 2013	1,726	54	5,297
APRIL – JUNE - 2013	1,184	799	4,088
JULY – SEPTEMBER , 2013	1,331	335	3,820
OCTOBER – DECEMBER,2013	1331	93	4,649
TOTAL	**5,572**	**1281**	**17,854**

The table no 9.1 shows that, there was an increased number of tested samples for CD4 analysis from 5,390 (2012) to 5,572 in 2013 while Chemistry analysis from 14,245 (2012) to 17,854 samples in 2013 while in hematological there was a decreased number of samples from 2,606 (2012) to 1,281 in 2013. This reduction was contributed to frequent stock out of reagents, machine break down and long procurement procedures of reagents.

1.2 Transport DBS samples for HIV DNA PCR testing

The laboratory unit collected and transported 259 dry blood spot samples from exposed infants to Muhimbili National Hospital, Dar es Salaam for HIV DNA PCR testing. The results for 252 samples were received and 18 (6.9%) samples found to be HIV positive as shown below

Table 9.2: Number of DBS samples transported for HIV DNA PCR testing, Zanzibar-2013

Period	No. of samples transported	No. of results received	Positive samples
Jan –March	50	50	5
April –June	59	58	2
July - Sept	88	88	10
Oct- December	62	56	1
Total	**259**	**252**	**18(6.8%)**

There is increased number of exposed children who were tested for DNA PCR from **194** infants in 2012 to **259** in 2013. This shows the increased PMTCT coverage and acceptance of mothers to send their infant for the services.

Objective 2: To improve and maintain quality system in HIV testing services

Activities Implemented

2.1. Distribute proficiency test panels to HCWs for assessment on HIV testing performance

Proficiency test (PT) is one of the methods used to assess quality of HIV testing performance by service providers. The samples are pre- tested at Mnazi Mmoja Pathology Laboratory to enable comparison of results with the individual testing sites. In collaboration with HCT and PMTCT units, a total of **277** dry tube samples (DTS) were distributed to HIV service providers (154 in Unguja and 109 in Pemba) for analysis in their respective sites. This activity enabled the supervisors to assess the skills of trained care providers on the performance of HIV tests and provide direct feedback to services providers so that they can improve the observed situation. Out of 277 distributed panels in testing sites, 275 results were returned on time (99.2 %). The performance rate of 217 (78.9%) providers who received PT panels and returned results there was above 98% (acceptable) and 58 (21%) providers performed below 98%. (Un-acceptable).

Table No. 9.2.3 the table below shows the result performed on Proficiency test in Unguja

Districts	Panel distributed	Returned	Returned with results	Returned without results	Performance above 98%	Performance below 98 %
Urban	55	55	54	1	49	5
		100%	**98.1%**	**1.8%**	**89%**	**9.0%**
West	30	30	30	0	23	7
		100%	**100%**	**0%**	**76.6%**	**23.3%**
Central	27	27	27	0	26	1
		100%	**100%**	**0%**	**96.3%**	**3.7%**
		20	20	0	19	1

North A	20	**100%**	**100%**	**0%**	**95%**	**5.0%**
North B	16	16	16	0	11	5
		100%	**100%**	**0%**	**68.7%**	**33.3%**
South	20	20	20	0	17	3
		100%	**100%**	**0%**	**85%**	**15%**
Total	**168**	168	167	1	145	22
		100%	**99.4%**	**0.6%**	**86.3%**	**13.1%**

Proficiency testing performance in Pemba:

Districts	**Panel distributed**	**Returned**	**Not returned**	**Returned with results**	**Returned without results**	**Performance above 98%**	**Performance below 98 %**
Chake chake	**29**	29	0	29	0	24	5
		100%	**0%**	**100%**	**0%**	**82.7%**	**17.2%**
Wete	**26**	26	0	26	0	17	9
		100%	**0%**	**100%**	**0%**	**65.3%**	**34.6%**
Mkoani	**24**	24	0	23	1	7	16
		100%	**0%**	**95.8%**	**4.2%**	**30.0%**	**69.6%**
Micheweni	**30**	30	0	30	0	24	6
		100%	**0%**	**100%**	**0%**	**80%**	**20%**
Total	**109**	**109**	**0**	**108**	**1**	**72**	**36**
		100%	**0%**	**99.1%**	**0.9%**	**66.6%**	**33.3%**

2.3 Feedback meeting for proficiency testing

Feedback meeting was conducted in four sessions, for **70** PMTCT providers in two groups of **35** participants each day who participated in PT exercise and **70** HTC providers (VCT and PITC) also in two groups of **35** participants each day in Unguja and three sessions for Pemba. The objective of the meeting was to present the general findings of the Proficiency test exercise and discuss challenges and propose way forward.

Key issues which observed and discussed were:

- Improper filling of tracer form : The finding shows that some of the providers did not fill the forms properly as there are some information such as expiration date and lot numbers of the test kit that were not filled

- Improper performance of HIV test using National algorithm: Health care workers received known sample and they were observed on proper usage of SOP and they were expected to reproduce the correct results. However, some health care workers did not perform correctly.

- Incorrect Interpretation of test results: It was found that some of provider did interpret incorrectly result of discordant samples which mostly t report negative. During the meeting providers had an opportunity to clarify all issues

2.4 Conduct training on laboratory quality system for laboratory technicians

Two trainings of 5 days on laboratory quality system for laboratory technicians were conducted. A total of 60 participants were selected and trained from all laboratories and testing sites in Unguja and Pemba, 30 in each island. The training objective was to familiarize laboratory staffs on quality system. The expected output of this training was to contribute in improving the quality of laboratory services in daily laboratory practices.

2.5. Conduct training on HIV rapid tests for laboratory technicians

A five days training on HIV rapid tests for 30 laboratory technicians was conducted in Unguja to service providers who did not perform well on proficiency test. The aim of the training was to orient laboratory technicians on the revised HIV rapid testing algorithm and introduce participants on the quality system approach in HIV testing that will expected outcome was to enable them to provide accurate, reliable and timely results.

Objective No 3 Strengthening of the National health laboratory services

Activities Implemented

3.1 Conduct supportive supervision

The objective of the supervision was to strengthen laboratory performance in the CTC site laboratories. It was conducted in nine CTC laboratories in Unguja and Pemba namely: Mnazi Mmoja, Kivunge, Mwembeladu, Bububu, Makunduchi for Unguja and Mkoani, Chake Chake, Micheweni and Wete for Pemba. The following were observed during supervision:

Gaps identified

- Mixing of items in the refrigerator,
- Shortage of reagents and supplies in most laboratories
- Lack of proper record keeping
- Most of the laboratory not have up dated SOPs

The way forward

During the meeting it was agreed to conduct a mentorship in order to improve services for gaps identified as a follow up after supportive supervision.

3.2 Conduct Mentorship to CTC Laboratories Technicians

This mentoring activity was organized following supportive supervision. The supervision report highlighted some of challenges and gaps which need mentoring in order to improve care and treatment laboratory services. Eight laboratories were mentored namely Kivunge, Makunduchi and Mwembeladu for Unguja ,Mkoani, Micheweni ,Wete and Chake Chake for Pemba where by specific tool was used with the targeted intervention for improvement as summarized below:

The mentorship focused on three major areas within the quality system - Specimen management, quality control and record keeping

Laboratory services indicators and trend from 2011- 2013

Indicator	**2011**	**2012**	**2013**
1.Number of testing facilities (laboratory) with capacity to perform quality clinical laboratory tests for HIV	3out of 9	10 out of 10	10 out of 10
3.Number and percent of laboratory that implement at least three Laboratory Quality Management elements	3	5	5
4.Number of HIV testing sites participating in	44	167(56 for HCT &111 for	212 (56 for HCT &153 for

proficiency testing for HIV testing		PMTCT)	PMTCT)

9.4.1. Number of testing facilities (laboratory) with capacity to perform quality clinical laboratory tests for HIV

All ten CTC laboratories provide HIV related tests which include Chemistry, Heamatology and syphilis tests for monitoring of HIV patients. However the challenge of frequent stock outs for reagents still exists in all sites

9.4.3 Number and percent of laboratory that implement at least three Laboratory Quality Management elements

There are five laboratories which practice at least 3 laboratory quality management elements that include safety precautions, availability of SOPs and implement proficiency tests. These laboratories are MnaziMmoja, Bububu and Mwembeladu for Unguja ,ChakeChake, Vitongoji and Wete for Pemba.

9.4.4 Number of HIV testing sites participating in proficiency testing for HIV testing

Following the training on proficiency testing for VCT and PMTCT services providers; the HCT sites which participated in the proficiency testing increased from 79 to 97 in 2013 and from 111 to 153 for PMTCT sites in the year 2013.

9.4 Challenges

- Frequent stock out of reagents for CD4, Chemistry and Hematology and break down of machines
- Delay in receiving DBS Sample results.
- Lack of DNAPCR technology in Zanzibar which leads to delay in managing HIV exposed infant

9.5 Proposed Wayfoward:

- Solicit more funds to support laboratory care and treatment services
- Continues strengthening capacity for laboratory staff
- Facilitate availability of HIV/DNA/PCR machine for infant diagnosis

10. Home Based Care services

10.1 Background

Zanzibar started Home Based Care services in 1988 for AIDS patients only. To date, HBC services have been established in all 10 districts for HIV AIDS patients and other patients with chronic illnesses. ZIHTLP implements Home Based Care services in cooperation with community volunteers and peers from PLWHAs. These community HBC providers are working under the supervision of facility based providers. Each health facility has a contact person (facility focal person) who is answerable for all HBC services within the catchment area of the facility. Increased access to care and treatment in many settings has strengthened HBC services and has increased awareness and acceptance of HIV/AIDS services creating a continuum of care that requires good coordination and harmonization of HBC services.

10.2 Goal

The goal of Home Based Care is to provide comprehensive home based care to chronically ill including HIV and AIDS patients in Zanzibar

10.3 Objectives and implemented activities in 2013

Objective 1: To adequately monitor quality of HBC services

Implemented activities:

1.1 Conduct bi-annual home base care (HBC) supportive supervision for community volunteers

Biannual community based supportive supervision was conducted in Zanzibar, The aim of the supervision was to assess Community home based care (CHBC) volunteers and care givers on providing HBC services to the patients and to provide technical assistance to volunteers. A total of **158** patients were visited, 50 with chronic illnesses including diabetes, stroke and 108 were people living with HIV. In addition to the challenge of improper filling of HBC forms, it was observed that, CHBC were not complied in HBC guideline during provision of care. It was recommended that facility HBC providers should give support to community volunteer on how to fill HBC monitoring tools, as well as conducting supportive supervision to CHBC on provision of care provided to community.

1.2 Conduct Supportive Supervision to HBC providers in Facility

Annual supportive supervision was conducted in health facilities providing home based care services. The aim of supportive supervision of the health care provider was to improve performance of home based care service delivery including monitoring tool for proper record keeping and to provide coaching. A total of **63** (36 in Unguja and 27 in Pemba) health facilities were visited. During supervision, it was noted that almost all of health facilities provider adopted the HUWANYU number which is established in home base care services this year, most of the facility use follow up form in preparation of the report. Also some facilities conduct community

HBC providers meeting on monthly basis and their reports do match with monthly follow up forms and registration. However, incompliance of the community providers' in submitting report and report timely lead to underreporting of the services provided. It was recommended that mentorship on HBC tools orientation should be conducted in order to have clear and same understanding among all HBC providers; also capacity building or refresher training will assist in improving under performance.

Objective 2: To increase capacity of HBC implementers at district level

Implemented activities:

2.1. Conduct supportive meetings with District Supervisors, facility-based HBC and Community based Providers

Ten HBC coordination meetings were conducted; for ten districts in Zanzibar involving HBC facility based providers and DHMT staff. The aim of the meetings was to give supervision feedback, among the issued discussed:

- Introduced "Huduma za Wagonjwa Majumbani" (HUWANYU) number. These unique identification numbers was to be used for registering patients enrolled in HBC services, which is for tracking patients receiving HBC services.

- Revision of how to fill the monthly summary forms along with distribution of the guidelines on how to fill monthly summary forms.

2.2. Conduct HBC coordination meeting with Community Home Based Care Volunteers

Coordination meeting with Community HBC Volunteers was conducted in six District of Unguja. The objective was to give supervision feedback and to strengthen collaboration among Community HBC implementers and share working experience and challenges during providing care. Different challenges faced in implementing HBC services were discussed and possible solutions were proposed including emphasizing on monthly meeting during submitting reports and sending HUWANYU number for HIV patient to care and treatment clinics.

2.3. Conduct Home Based Care coordination meeting with stakeholders

Coordination meeting with Stakeholders implementing home based care services was conducted. The meeting objective was to share experiences including successes and challenges by the different NGOs providing HBC services and to come up with strategies on how to improve provision of HBC Services. During this meeting, stakeholders discussed about HUWANYU number and proposed to be used for HBC service and also suggested to conduct mapping assessment which can help to get information related to HBC services. By December 2013 mapping assessment result and HUWANYU number already established

Objective 3: To provide food support to PLWHA

3.1. Provide food support to people living with HIV and AIDs (PLWHA) by prescription

In collaboration with CTC staff, the unit provided nutritional support by prescription to patients identified and recommended by the clinician on the criteria set. The criteria includes patients started ARV, pregnant women, children not started ARV, children under ARV, TB/HIV patients, and patients started on second line ARV drugs. Foods provided include rice, maize flour, beans, cooking oil every month for 3 months. As of December 2013, a total of **1004** patients were received nutritional support.

Objective 4: To support community HBC Providers

Implemented activities

4.1 To Provide incentive package to 290 Community HBC providers for improving work performance

Four meetings were conducted 6 in unguja and 4 in Pemba prior to provision of servicers. A total of **290** (120 Pemba volunteers and 170 Unguja) CHBC providers were provided with incentive in all district. The objective of the meeting was to introduce HUWANYU numbers and share experience and challenge faced during provision of care and how the program can support services.

Table number 9.1: HBC indicators and trends in 2011-2013, Zanzibar

Indicator	2011	2012	2013
1. Number of skilled facility based HBC providers	**204**	**204**	**204**
2. Number of skilled community based HBC providers	**290**	**290**	**290**
3. Number of adults and children provided with home based care (HBC) services	**2,744**	**2947**	**3019**
4. Number of people receiving food/nutrition supplements	**243**	**161**	**1004**

1. Number of skilled facility based HBC providers

Up to end of 2013, a total of **204** health providers have received training on HBC services. Among them, 167 were active in providing HBC services in 2013 and their distribution by district is as shown in Table 9.1 below.

Table 9.2 Number of health facilities and respective active providers implementing HBC services per district as to 2013, Zanzibar

DISTRICT	NUMBER OF HBC SITES	NUMBER OF HBC PROVIDERS ACTIVE IN FIELD
URBAN	11	14
WEST	12	20
SOUTH	11	15
CENTRAL	21	25
NORTH A	13	14
NORTH B	11	12
CHAKE CHAKE	12	17
WETE	13	18
MKOANI	13	17
MICHEWENI	11	14
TOTAL	**129**	**167**

1. **Number of skilled community based HBC providers**

The programme supports **290** skilled community volunteers providing HBC services currently each district has 30 community volunteers in Home Based Services except North B which has 20 community volunteers. The programme planning is to increase coverage of HBC services to the facility and community were not yet provide care, to have at least 2 volunteers in each shehia .

Number of adults and children provided with home based care (HBC) services

The finding of 2013 result has shown that the care and support provided by HBC Providers in each district have achieved the following result:

About **3019** patients received HBC services in which **1729** were people living with HIV where **1137** were females and **592** were males and among those **418** were children below years. Chronically Ill Patients were 1290 where **677** females and **613** males. See table below:

Table 9.3: Number of clients who received HBC Services by disease category, sex and age in Zanzibar, 2013. (I need Asha ussi support)

Age (years)	HIV Patients		Other Diseases		Total
	M	F	M	F	
0 - 4					
5 - 14					
>= 15					
Total					

Caregivers provide patients with basic nursing care, health and hygiene education, psychosocial and spiritual support, referral to health centers, assistance with household duties, monitoring drug compliance and escort them to clinics where needed. During this reporting period, about **1077** patients have been referred to clinics by CHBC for other services. See table below:

Table 9.4: Number of clients received HBC services by age Zanzibar January –December, 2013

Age (years)	*Services provided (frequencies)*										
	Counseling	Body hygiene	Cloth Changing	Wound dressing	Feeding Assistance	ARV problems solved	Physical exercises	Referrals	Others Services	Transfer out	Transfer in
0 – 4	349	107	20	3	3	2	123	14	70	4	1
5 – 14	4288	944	375	66	359	241	946	66	789	12	13
≥ 15	24100	3773	1627	814	1659	739	6370	997	4511	84	71
Total	**28737**	**4824**	**2022**	**883**	**2021**	**982**	**7439**	**1077**	**5370**	**100**	**85**

2. **Number of people receiving food/nutrition supplements**

A total of **1004** patients received nutritional support in which **681** were female and **323** were male, in 2013 and 161 in 2012 and about 243 patients in 2011. The table below shows food distribution through different distribution points.

Table no 9.5: Number of patients received food supplement by distribution point, Unguja and Pemba from April –December 2013

Distribution point	**Patients started ARV**		**Pregnant women**	**Children**		**TB/HIV patients**		**Patients started 2nd line**		**Total**	
	M	**F**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
ZACP	112	236	79	37	44	29	24	5	11	183	394
KIVUNGE	3	11	12	1	0	4	5	0	3	8	31
M/DUCHI	4	13	11	1	2	1	0	0	1	6	27
CHAKE	13	27	23	24	22	5	6	0	0	42	78
WETE	14	17	13	30	20	3	5	0	2	47	57
MI/WENI	12	31	5	7	7	0	3	0	0	19	46

MKOANI	13	17	25	0	5	2	0	3	1	18	48
JUMLA	171	352	168	100	100	44	43	8	18	323	681
JUMLA KUU	**523**		**168**	**200**		**87**		**26**		**1004**	

10.4 Challenges

- Patient self stigmatization increases denial and decrease enrollment on HBC services

10.5 Achievement

- Not yet completed

10.6 Way forward

- Scale up Home based care services to facility and community levels with collaboration with DHMT
- In Collaboration with IEC/BCC FBO We have plan for sensitization meeting to reduce stigma

10.7 Planned activity 2014

- Review HBC guideline to incorporate updated issues

11. Tuberculosis and Leprosy Services

11.1 Background

The Ministry of Health launched the Zanzibar Tuberculosis and Leprosy Programme (ZTLP) in 1987 as a single combined programme. The Ministry is collaborating with various international and local developmental partners in implementing control of TB and leprosy in the country. The program is also collaborating with other units and program within the Ministry of health to scale up public private partnership.

The programme is charged with the responsibility of facilitating early diagnosis, treatment and cure of many tuberculosis and leprosy patients as possible so as to reduce the incidence and prevalence of these diseases until they are no longer a public health problem in the country. In recognition of this, TB/HIV collaborative activities have been incorporated as major components of the Zanzibar TB and Leprosy Programme (ZTLP) and Zanzibar AIDS Control Programme (ZACP). TB/HIV collaborative activities were first introduced in 2005 following the implementation of National TB/HIV Guideline. In 2012, the programme was integrated with Zanzibar AIDS Control Programme.

More over ZIHTLP is increasing her efforts to eliminate leprosy as a public health problem by involving communities. Special intervention recommended by WHO are being implemented include: Leprosy elimination campaigns (LEC) and Special Action Programme for Eliminating Leprosy (SAPEL). These are expected to accelerate the process towards reaching the WHO target.

11.2 Goal

The goal of Tuberculosis and Leprosy Unit is to control the occurrence of Tuberculosis and Leprosy until they are no longer public health problem

11.3 Objectives and implemented activities in 2013

11.3.1 Objectives 1: Pursue high quality DOTS expansion and enhancement

Implemented activities

11.3.1.1 Conduct TB contact tracing

Tuberculosis contact tracing for new smear positive and retreatment TB patients was done by TB and leprosy public health officers (PHOs) in collaboration with other officers from DHMTs and DTLCs in different villages of Unguja and Pemba where those positive TB patients live with their families. The aim was to trace and identify all household members living with smear positive TB patients who had TB presumptive symptoms in order to diagnose, give early, proper and adequate treatment for those confirmed with TB.

In this reporting year, total of 309 smear positive TB patients were traced in their homes in Unguja and Pemba and total of 1,298 house hold members were given health education on TB transmission and the importance of treatment adherence.

Sixty seven people were TB suspects, among them 12 people were diagnosed with Tuberculosis through sputum smear examination, 3 patients diagnosed as extra pulmonary TB , and 1 child diagnosed by score chart. All of them started anti TB treatment and 86 under five children were given Isoniazid (INH) prophylaxis as reflected in table 1.

Table 11.1: Summary of contact tracing findings for 2013, Zanzibar

Description	**Frequency**
Smear positive TB patients traced	309
House hold members reached	1298
Member with presumptive TB symptoms (suspect)	67
Confirmed smear positive TB patients	12
Extra pulmonary TB	3
Diagnosed by score chart	1
Under five Given chemoprophylaxis	86

11.3.1.2. Conduct supportive supervision at all levels

Supportive supervision was conducted by TB Central unit team, Regional TB and District TB and leprosy coordinators (RTLC,DTLC) to different health facilities providing DOT services and diagnostic center in both islands (Unguja and Pemba) public and private facilities. Central and regional levels conducted supervision on quarterly basis while district level conducted in monthly basis.

The aim of the supervisions were to assess the performance of RTLCs, DTLCs and other health care workers working in TB, TBHIV and leprosy within the district health facilities.

A total of 82 facilities were supervised by central unit team, among them 46 in Unguja and 36 in Pemba, 32 health facilities were supervised by regional TB/leprosy coordinator and 175 health facilities were supervised by District TB and leprosy coordinators of Unguja and Pemba in their respective health facilities/ districts.

Key challenges found were:

- Inconsistence and poor utilization of TB cough register
- Low number of staff trained on TB, TB/HIV and leprosy
- Low involvement of private health facilities in provision of TB and leprosy services
- Inadequate follow up for home based DOT patient

Following the supportive supervision proposed solutions were: DTLC and RTLC should strengthen mentorship on proper utilization of cough book, follow up of treatment supporters, to sensitize private owners to provide TB and leprosy services and to conduct TB/TBHIV and leprosy training for health care providers.

11.3.1.3. Conduct laboratory supportive supervision

Laboratory Supportive supervision was conducted to all laboratories performing TB sputum investigation in both private and public facilities. The supervision was conducted by Regional laboratory coordinators (RLTs) of Unguja and Pemba together with District laboratory coordinators (DLTs). The aim of this supervision was to assess the performance and commitment of laboratory technicians on provision of quality TB laboratory services to their respective centers. During this reporting year the supervisors managed to supervise 44 diagnostic centers, among them 25 in Unguja and 19 in Pemba.

Key challenges found were:

- High number of sputum smear negative in laboratory register book
- Existence of water supply problem within the laboratory.

The agreed way forward was to review the criteria for TB sputum collection and to strengthen EQA system. With regards to the water supply problem the program was to discuss with DHMTs and DMOs on solving existing water supply problem within the laboratory. Following these discussion water supply problems has been resolved in some sites

11.3.1.4.Conduct Sputum collection from peripheral health facilities

This activity was conducted by District TB and Leprosy Coordinators in Unguja and Pemba who collects sputum samples from peripheral Health facilities with no laboratory services and sends them to nearby TB diagnostic centers. The aim of this exercise is to increase case detection, early diagnosis and treatment of smear positive TB patients as to prevent transmission of TB disease in the communities

During this reporting period, a total of 1002 samples were collected in Unguja and Pemba whereby 80(8%) were positive as it shown in the table below.

Table11.2: Distribution of samples collected from peripheral health facilities per zone, Zanzibar in 2013.

Zone	Samples collected	Positive Samples
Unguja	819	57(7%)
Pemba	183	23(12.6%)
Total	**1002**	**80 (8%)**

11.3.1.5. Conduct sputum examination for all TB suspects

Zanzibar TB/Leprosy unit emphasizes diagnosis of TB patients by sputum examination, therefore Laboratory smear microscopy is the corner stone of the unit. There are 46 laboratories in Zanzibar (27 Unguja and 19 Pemba). A total of 5720 suspects were examined in 2013, among them 331 were smear positive as stipulated in the table below:

Table.11.3. Number of suspects examine per zone, Zanzibar in 2013

Examination done	2013		
	Unguja	**Pemba**	**Total**
Total cases examine	4405	1315	5720
Positive cases	267	64	331
Negative cases	4138	1251	5389
Total new cases	3736	1259	4995
Positive new cases	228	58	286
Negative new cases	3508	1201	4709
Total follow up cases	669	56	725
Positive cases	39	6	45
Negative cases	630	50	680

11.3.1.6. Conduct External Quality Assurance (EQA)

External Quality Assurance (EQA) was conducted in all diagnostic centers where by slide tested were randomly selected from each diagnostic centre and sent to first reader within the district

(DTLT) for quality assurance. This is to make sure that test results are accurate and hence strengthen the performance of the technologist. For the discordant result the slides are sent to second reader and if confirmed positive follow up is made to trace the patient. A total of **752** slides were sent for EQA, among them 3 (0.4%) had discordant results.

11.3.2. Objective 2: To strengthen collaborative TB/HIV activities

Implemented activities

11.3.2.1. Provision of under one roof services for TB and HIV

ZIHTLP is providing TB/HIV services under one roof whereby clients receive comprehensive TB and HIV services at one place. Currently there are two sites which provide these services (Mnazi mmoja and Chake chake Hospital). A total of **411** TB cases were registered at TB/HIV under one roof clinic of which 80 were co infected. Out of these patients, 52(65%) were referred from CTC. Among the 80 TB/HIV co infected patients, 76(95%) were put on Co-trimoxazole prophylaxis, 71(88.8%) were started on ARVs, and 3 died as illustrated in the table below:

Table 11.1: Summary of TBHIV patients at under one roof Mnazi mmoja Hospital 2013

Description	Frequency	Percentage
Total TB patients registers	411	
TB/HIV patients	80	19.4
TB/HIV patient referred from CTC	52	65
TB/HIV patients diagnosed in TB clinic	28	35
TB/HIV patients on cotrimoxazole preventive services	76	95
TB/HIV patient on ARVs	71	88.75
TB/HIV patients who died.	3	3.75

11.3.2.2. Provide IPT to HIV patients.

Implementation of Isoniazid Preventive Therapy (IPT) services to HIV patients started in 2011 as a pilot through 3Is strategy in Chake chake Hospital. The aim of IPT services is to prevent

PLHIVs from getting active TB. IPT is not provided to patients with active TB, terminal AIDS, and history of TB in the last three years, jaundice, TB suspect and those who refused.

Currently a total of 137 HIV patients have been enrolled in IPT services, of which **99** completed treatment and the remaining 38 stopped treatment for various reason as seen in table below:

Table11.2. Trend of IPT enrolment from August 2011- July 2013

Year	Total Enrollment	Complete	Develop Active TB	Terminal AIDS	TB Suspect	Lost To F/Up	T/Out	Develop Side Effect	Defaulted
2011	84	63	3	2	3	2	6	4	1
2012	35	25	1	2	0	4	2	1	0
2013	18	11	1	0	0	1	1	2	2
Total	**137**	**99**	**5**	**4**	**3**	**7**	**9**	**7**	**3**

The most common challenge of IPT implementation was irregular supply of Isoniazide (INH) and in adequate monitoring of the services, whereby during the course of implementation there were drug stock out for six months.

11.3.2.3. Conduct quarterly DTLC meetings

Four meetings were conducted one per quarter, 2 in Unguja and 2 in Pemba. The meetings involved DTLCs, DTHCs, RTLCs, and RLTs, CTC coordinator, IEC officer and staff from ZIHTLP central office. Other stakeholders such as PATH, ICAP and Zonal administrators also participated in the meetings. The aim of the meetings were to discuss various TB, TB/HIV and leprosy issues including success, challenges and share best practices on implementation of planned activities.

Some of the challenges identified were:

- High proportion of smear negative cases amongst all TB patients
- High number of children with Tuberculosis diagnosed in Pemba
- Low District/ government contribution in TB/HIV and leprosy activities.

The challenges were discussed together and proposed solutions were: RTLC to make follow up to DTLCs and health care providers to follow TB diagnostic algorithm and score chart and to sensitize DHMTs to include TB and leprosy activities in district health management plans.

11.3.3. Objective 3: To strengthen management of MDR TB

Activities Implemented

11.3.3.1. Transportation of TB specimen at Central Tuberculosis Reference Laboratory (CTRL)

A total of 119 sample/culture colonies of MDR TB suspects were sent to Central Tuberculosis Reference Laboratory (CTRL) through Public Health laboratory and no one detected as MDR TB. However, there are 5 patients who were diagnosed with Mycobacterium Other Than Tuberculosis (MOTT) 4 of them from Unguja and 1 from Pemba.

11.3.4. Objective 4: To empower communities on TB, TB/HIV and Leprosy prevention, care and support through Advocacy Communication and Social Mobilization (ACSM)

11.3.4.1. Conduct health education and sensitization meetings on leprosy to community

Public health officers (PHOs) in all five TB and leprosy districts of Unguja and Pemba conducted quarterly health education and community leprosy sensitization meeting to their respective areas. The meeting sessions were mainly focused in high endemic leprosy diseases areas.

The aim of the meetings was to create community awareness on TB and leprosy so as to facilitate early health care seeking behavior and conduct screening for leprosy. The meetings were conducted in **24** villages of Unguja and Pemba whereby **1280** people participated, of them 805(63%) in Unguja and 475(37%) in Pemba. During the meetings, a total of **31** suspects of leprosy were identified (19 in Unguja 12 in Pemba) and 7(22.5%) were confirmed with leprosy (2 from Pemba and 5 from Unguja). Among them 5 were MB and 2 PB, out of the 7 patients 5 had disability grade 0, one had disability grade 2 and one had disability grade 1. In addition, a total of 887 leaflets, 32 fact sheets, and calendars that have TB and leprosy messages were distributed.

11.3.4.2. Conduct Health Education in Village Health Days

TB unit conducted health education in village health day in different communities. This activity was conducted in collaboration with DHMTs in their respective districts. The aim of this activity is to increase community awareness on TB/TBHIV and leprosy so as to increase early case detection of these diseases. In this exercise a total **5,672** people attended. TB suspects were 178 and two were diagnosed as smear positive patients. A total number of 785 TB/HIV leaflets were distributed.

More over the program also conducted health education in schools in both islands of Unguja and Pemba. During this exercise, a total of 3866 students were given health education on TB, TB/HIV and leprosy in different schools focused on signs and symptoms, treatment and preventive measures.

Furthermore, the unit performed live radio program at Nuru and Hits FM station where by different sessions were aired. The audiences were given chances to ask questions, most frequently asked questions were: infectiousness of TB and Leprosy, the relationship of TB and HIV, Clarification on myth and misconception on TB and leprosy was provided.

During the implementation of these activities, program noted that there was increasing collaboration and commitment of some DHMTs in supporting TB and leprosy activities which led to increase case detection especially in leprosy. However, there were some challenge such as inadequate IEC materials for TB and leprosy and low knowledge of TB and leprosy among the community.

11.3.5. Objective 5: Reduce disability grade by 5% of new diagnosed leprosy patients

Implemented activities

11.3.5.1. Conduct MB contact tracing

Leprosy contact tracing was done by RTLCs and DTLCs of Unguja and Pemba in quarterly basis in their respective districts and zones. The aim of this tracing was to identify disease at early stage among house hold members living close with MB leprosy patients so as to provide early treatment and hence prevent disability caused by leprosy. In addition this will reduce transmission to the general community. A total of **216** houses hold members of 61 MB leprosy patients (53 in Unguja and 8 in Pemba) were traced in their homes, whereby 11 suspects were found and 2 leprosy patients diagnosed.

Table 11.1: Summary of Leprosy MB contact tracing, Zanzibar, 2013

Description		**Frequency**
Patients visited		61
Number of contacts	**Males**	176
	Females	90
Number of suspect	**Males**	4

	Females	7
Leprosy patients		2

11.3.5.2. Conduct orientation on leprosy for health care providers from leprosy endemic area

Two days leprosy orientation was conducted to **28** health care providers (20 from Unguja and 8 from Pemba), mainly from areas with high burden of leprosy. The aim of the orientation was to impart knowledge on leprosy issues among Health Care Workers at health facility level so as enable them to suspect, diagnose and provide accurate leprosy treatment.

11.3.5.3. Establishment of Self care group for people with leprosy disability

Three self care groups were established in Unguja, two in South and one in Urban district. The aim is to encourage people affected by leprosy (PAL) on routine proper care of their affected site and to prevent further disabilities. A total of **40** PALs (23 males and 17 females) formed the three self care groups; 16 members from Kizimkazi group, 15 from Makunduchi and 9 from Mnazi Mmoja.

The groups were provided with equipment and supplies for the self care management, such as basins, soaps, dressing gauze, bandages, anti septic and bottles Vaseline and pairs of sandals. The group meets in weekly basis for self assessment and educating each other on caring of the affected areas.

11.3.5.4. Conduct reconstructive surgery

Rehabilitation and reconstructive surgery for people affected by Leprosy was done in Unguja to 4 people (3 male and 1 female). Among operated patients; two had claw finger, one had septic foot and one had lower limb contracture. However, there were 3 other patients who were referred to Morogoro Turiani hospital for special rehabilitation and reconstructive surgery.

11.3.6. Tuberculosis services indicators and trends 2011 - 2013

INDICATORS		**2011**	**2012**	**2013**
1.	Number of all registered TB cases	546	537	685
2.	Number of new smear positive TB cases	280	303	318
3.	TB Cure rate	83.3%	86.8%	87%

4.	TB Treatment success rate	84.4%	86.8%	87%
5.	Number of TB patient tested for HIV	470	470	659
6	Number of HIV positive TB patients	83	79	115
7	Percent of HIV positive TB patients on ART	21.7	52	86
8	% of HIV positive TB patients on CPT	100	75	97.4

1. Number of all registered TB cases

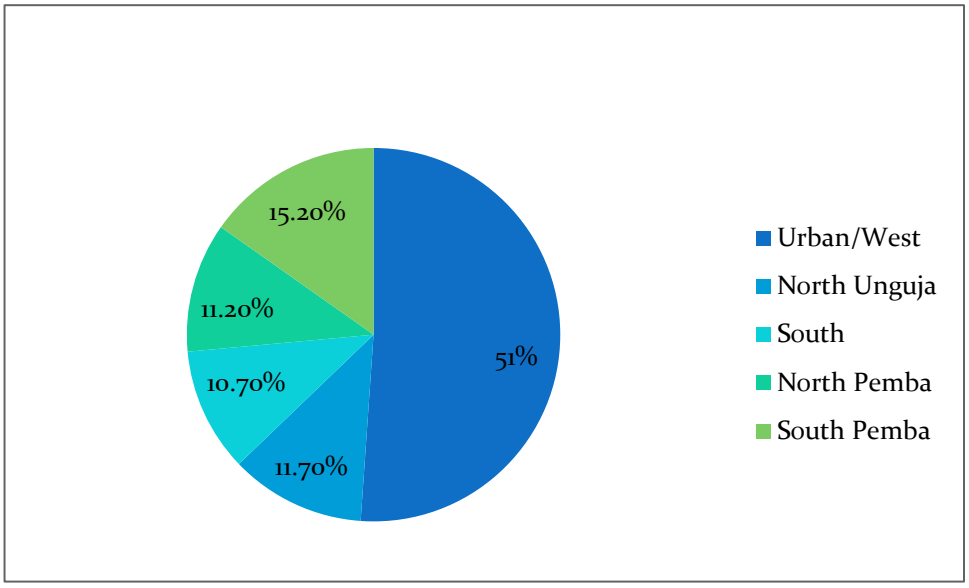
Total of 685 TB cases were notified and registered in 2013 from public and private health facilities with 18.5% being children below 14 yrs, among them 660 (96.4%) patients were new. Out of new patients, 318 (48.2%) were smear positive, 145 (22%) were smear negative and 197 (29.8%) were extra pulmonary. Retreatment patients were 25, among them 18 (72%) were relapse cases, 2 (8%) were failure and 5 (20%) were return after defaulters. Generally there are an increased number of cases notified in 2013 (685) compared to 2012 (537) as shown in the table below:

Table 11.2: TB cases registered (case finding) by age, Zanzibar in 2013

Age (yrs)	**Sputum smear positive (SSP)**				**New pulmonary smear Neg (SSN)**	**New extra pulmonary**	**Other previously treated**
	New cases	**Relapses**	**Failures**	**Return after default**			
0-14	11	18	2	5	37	79	0
≥15	307				108	118	
Total	**318**	**18**	**2**	**5**	**145**	**197**	**0**

As in the previous years, most of the TB cases were notified from Urban and West district. Figure 1 below shows notification of all forms of TB from each district in Zanzibar.

TB notification (smear positive) by districts 2013



2. Number of new smear positive TB cases

The number of smear positive TB cases has also increased by 5% compared to 2012. This shows that, TB infection in the community is still high. As in the previous year, most of those affected are young adults in the age group between 15-44 years. It shows that, 83 (34%) were females and 47(43%) were males. As shown in the table 2 and figure 3 below.

Table no 11.3: Number of smear positive cases by age and gender, Zanzibar 2013

AGE CATEGORY	MALE	FEMALE
0-14	6	5
15-24	41	27
25-34	58	30
35-44	42	20
45-54	34	15
55-64	14	5
65+	14	7
TOTAL	**209**	**109**

3. TB cure rate and treatment success

A total of **303** new smear patients were registered in 2012, among them 264 (87.1%) were cured, 4 (1.3%) were failure, 10 (3.3%) died, 4 (1.3%) were out of control and 21 (6.9%) were transferred out. Cure rate for 2013 is 87%. This percentage is in line with WHO target which is 85%.The treatment success rate for the year 2013 is also 87% because all 264 patients had sputum tested and their result was negative as it shown in the table below.

Table11.4: Treatment outcome for all TB patients registered in 2013

Type	Notified	Cured	T. completed	Failure	Died	Defaulted	T.O.	Total
S. positive	303	264	0	4	10	4	21	303
S negative	126		108		14	0	4	126
Ext. pulm	81		64		11	1	5	81
Relapse	12	10	0	0	1	1	0	12
Failure	5	4	0	0	1	0	0	5
Return	7	3	0	0	1	3	0	7
Others	3		2		0	1	0	3

4. Number of TB patients tested for HIV

A total of 685 TB patients were enrolled in 2013, among them 659 (96.2%) were tested for HIV. Compared to 2012, the proportion of TB patients tested for HIV has increased from 87.5% in 2012 to 96.2% in 2013.

5. Number of TB/HIV co-infected patients

Among all TB patient screened in 2013, a total of 115 (17.5%) patients tested positive. This is an increase compared to 79 (16.8%) patients who were diagnosed to be TB/HIV co infected in 2012.

Treatment outcome of 79 TB/HIV patients who were diagnosed in 2012 (40 smear positive and 39 grouped as others) was as follows:

- Among smear positive patients 27 (67.5%) were cured, 1 (2.5%) was failure, 6 (15%) died, 3 (7.5%) were lost to follow up, 3 (7.5%) were transferred out.
- Out of 39 others, 10 (25.6%) were cured, 13 (33.3%) were treatment completed, 5 (12.8%) died, 1 (2.6%) was lost to follow up, 10 (25.6%) were transferred out.

6. Percent of HIV positive TB patients on ART

The percentage of TB/HIV patients who started ART has increased from 52% in 2012 to 86% in 2013. This shows an increase of 34% although it is still below the required target of WHO, which is 100%.

7. Percent of HIV positive TB patients on Co-trimoxazole preventive therapy

The percentage of HIV positive patients who started co -trimoxazole preventive therapy has increased from 75% in 2012 to 97% in 2013. However the required target of 100% has not yet been reached.

11.5. Leprosy services indicators and trends t from 2011- 2013

INDICATORS		2011	2012	2013
1.	Number of all new registered leprosy cases	80	144	100
2.	% of MB cases among all new cases	65	60	76
3.	% Children among new cases	21	28.5	18
4.	% of WHO grade 2 among new cases	1	7	12
5.	% of female patients among new cases	38	31	38
6	% of MB leprosy patients completing 12 month of MDT amongst those expected to complete their MDT (calculated for 1 year cohort intake)	95.9	98.4	92.7

1. Number of all new registered leprosy cases

In 2013, a total of 100 new leprosy cases were registered. This number is lower compared to 144 cases registered in 2012. However the last year data has been contributed by the survey i.e. Special Action Project for Elimination of Leprosy (SAPEL) done on second quarter of 2012.

2. Percent of Multibacillary (MB) cases among all new cases

Out of 100 new cases registered in 2013, 76% were Multibacillary and 24% were Paucibacillary cases. The high percentage of multibacillary cases among the diagnosed patients is alarming as many infectious cases in the population pre dispose the community to the spread of leprosy infection.

3. Percent of Children in new cases

A total of 18 children were detected and registered in this year which is equal to 18% of all new cases. There is a decrease in proportion of children diagnosed from 28.5% (2012) to 18% (2013). This is in contrast to the finding above, whereby with high number of MB cases which are more infectious, the proportion of children is also expected to be high. Therefore, more efforts need to be made to increase the diagnosis of children with leprosy.

Table 11.6: Number of leprosy patients diagnosed by type of patient and age, Zanzibar 2013

Type of patients	Adult	Child	Total
Multibacillary	65	11	76
Paucibacillary	17	7	24
Total	**82**	**18**	**100**

4. Percent of disability grade 2 among new cases

Percentage of disability grade 2 is 13%. This shows that the level of disability has almost doubled from 7% of 2012 to 13% of 2013. This indicates that, there is still late diagnosis of leprosy patients within the community caused by inadequate knowledge among health care workers and community at large.

Table 11.7: Disability Grade for new leprosy patients diagnosed in 2013

Disability Grade	MB	PB	TOTAL
0	50	24	**74**
1	13	0	**13**
2	13	0	**13**
Total	**76**	**24**	**100**

5. **Percent of female patients among new cases**

Among the total patients identified in 2013 the percent of female patients is 38. This shows that the percentage of female cases has increased from 31 in 2012 to 38 in 2013.

6. **Percent of MB leprosy patients completing 12 month of MDT amongst those expected to complete their MDT (calculated for 1 year cohort intake)**

Among **55** Multibacillary leprosy patients registered in 2011, about 92.7% completed their treatment, 5.5% were out of control and 1.8% transferred out. The treatment completion rate is below the WHO target which is 95%. The treatment completion for this year is also lower compared to 2012 which was 98%.

11.4 Challenges

- Low involvement of private facilities in TB and leprosy management.
- Low suspicious rate of both TB and Leprosy within the health care facilities
- In adequate follow up of patients on Home based DOT system

11.5 Proposed way forward

- Strengthen Public Private Partnership through PPM assessment and sensitization of private facilities' owners on importance of integrating TB services in their facilities
- Enhance capacity of health facilities staff with knowledge and skills for detection of TB and leprosy through training and mentorship
- Conduct survey for home based DOT and integrate home based DOT with community home based care services

11.6 Achievements

- Increased TB case notification
- Scale up of TB diagnostic centers from 40 to 46

11.7 Plans for 2014

- Conduct assessment on TB IPC in health facilities and implement its recommendations
- Conduct assessment on TB laboratory EQA and develop norms and SOPs that will enhance EQA system
- Engage private health facilities in provision of TB services

12. Strategic Information

12.1 Background

Strategic Information Unit has a mandate to monitor the trend of HIV epidemic and distribution of other STIs through conducting:

- Antenatal clinic (ANC) sentinel surveillance to monitor prevalence of HIV infection among pregnant women as a proxy to the general population,
- Integrated Biological and Behavioural Surveillance Surveys (IBBSS) among key populations at risk of HIV
- Other surveys based on needs from other surveillance findings.

In collaboration with the Health Management Information System (HMIS) Unit of MOH, Strategic Information Unit also monitors HIV, STI, TB and Leprosy interventions through:

- Developing services monitoring tools;
- Building capacity of health care workers on the use of the monitoring tools;
- Coordinating data management for the interventions;
- Conducting regular supportive supervision to ensure availability of high quality data and use at all levels; and
- Producing and disseminating programme's implementation reports.

The unit also provides leadership in conducting evaluations on various interventions as well as designing and conducting relevant operational researches to inform programming.

12.2 Goal

The goal of the Strategic Information Unit is to provide information for tracking of progress and informing decision making in implementation of HIV, STI, TB and Leprosy interventions.

12.3 Objectives and Activities Implemented in 2013

Objectives 1: To ensure accurate, complete and timely, monitoring data collected and reported from the district level

Activities implemented

1.1 Provide supportive supervision on HIV/STI data management to district health management teams (DHMTs)

Supervision of DHMT in all the 10 districts of Zanzibar was conducted once in both Unguja and Pemba. The objective of the supervision was to monitor how HIV data is handled at district level from availability of monthly monitoring tools, storing of data, collection and completeness of the reports from sites, data entry, analysis and use at district level. During the supervisions some successes were noted including District Surveillance Officers' (DSOs) commitment in HIV/STI

data handling at district level because they know all sites providing HIV/STI services; they collect HIV/STI services data from all sites and enter the data in District Health Information System 2 (DHIS2). However some challenges were observed including:

- Repeated mistakes in monthly report forms
- Unreliable internet connection at district level forces DSOs to enter data at HMIS unit which causes a delay in data entry and accessibility at district
- Inadequate data cleaning to identify minor or major errors for correction
- Inadequate analysis and use of HIV/STI data at district level

All the above challenges were discussed with DSOs and way forward agreed upon including checking of reports before collection from health facilities, and regular cleaning and analysis of data at district level. However, the problem of internet at DHMT level still remains unresolved and is waiting a solution at Ministerial level.

1.2 Conduct HIV/STI data verification at health facility level

HIV/STI data verification was conducted once in each health facility to a total of **133** health facilities in Unguja and **74** health facilities in Pemba, which is equivalent to **90%** (133/147) and **93%** (74/80) of all sites providing HIV/STI services in Unguja and Pemba respectively. The objective of this data verification was to assess data accuracy, completeness, consistency, availability, and timeliness to determine the overall reliability of data collected. The methodology used was to cross check reported data from the sources at sites including registers for the period of 6 months prior to the day of data verification.

The key challenges from this activity were:

- Most of the reports (67%) are being submitted to DHMT instead of DHMT member collecting the report from the facility. Because of this data checking and verification before collection is not done
- Most of the service indicators were not 100% accurate, i.e. there was either under-reporting or over-reporting but the discrepancies were higher for STI, HBC and PMTCT data.

During the data verification exercise, all the reports verified in the visited sites were corrected. In addition all issues noted were shared with staff on site and strategies for improving their reporting agreed upon based on the issue observed.

Objective 2: To monitor trends in HIV epidemic and assess risk factors for transmission among general population and KPs groups

Activities implemented

2.1 Disseminate findings of IBBSS among KPs (PWID, MSM, SWs) 2011/2012

A one day dissemination meeting of the findings for the IBBSS among key populations (PWID, MSM, SWs), 2011-2012 was conducted. The objective of the meeting was to present the final results of the IBBSS for both Unguja and Pemba to key stakeholders and discuss the findings. A total of 65 people participated in the meeting including 26 from Ministry of Health, 9 from other government ministries, 17 from non-governmental organizations and 13 from development partners.

Among the major findings from this study that were presented at this meeting are:

- Significant increase between 2007 and 2011/2012 in HIV prevalence among SWs, decrease among MSM while the prevalence among PWID has remained stable (Figure 12.1)
- High condom use among SWs but low among MSM and PWID (Figure 12.2)
- High HIV testing by all three KPs groups (Figure 12.3)

Figure 12.1: HIV prevalence among MSM, SW and PWID, Unguja, IBBSS 2007 and 2011/12

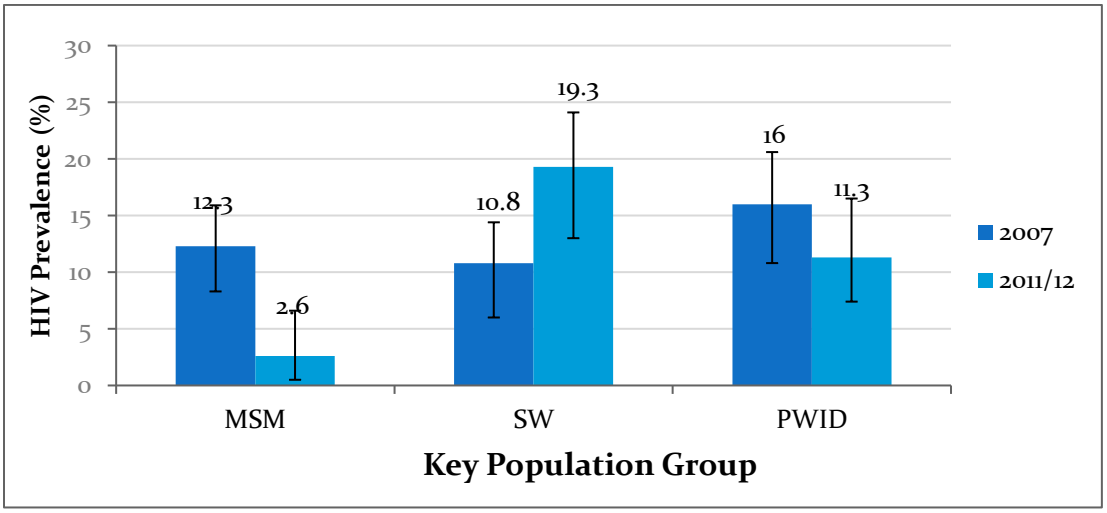


Figure 12.2: Condom use among MSM, SW and PWID, Unguja, IBBSS 2011-2012

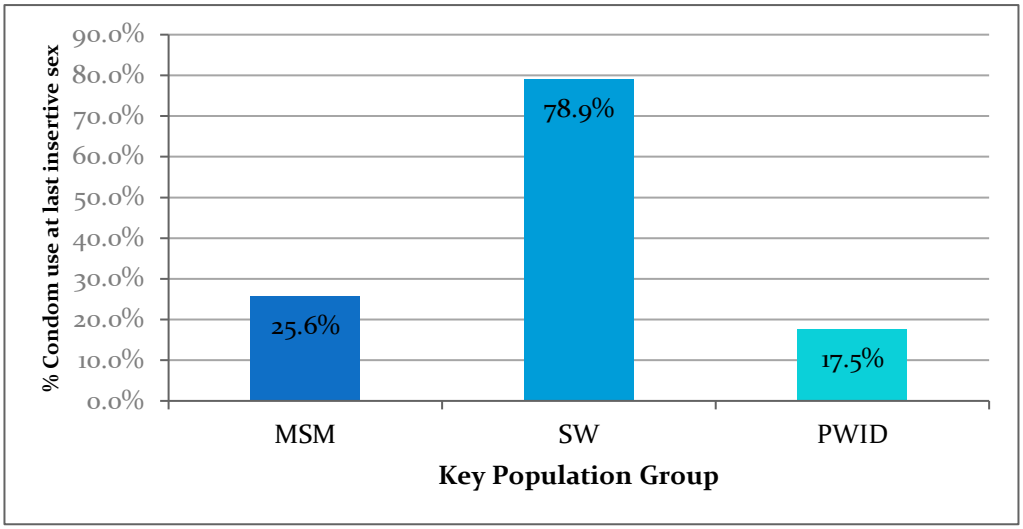
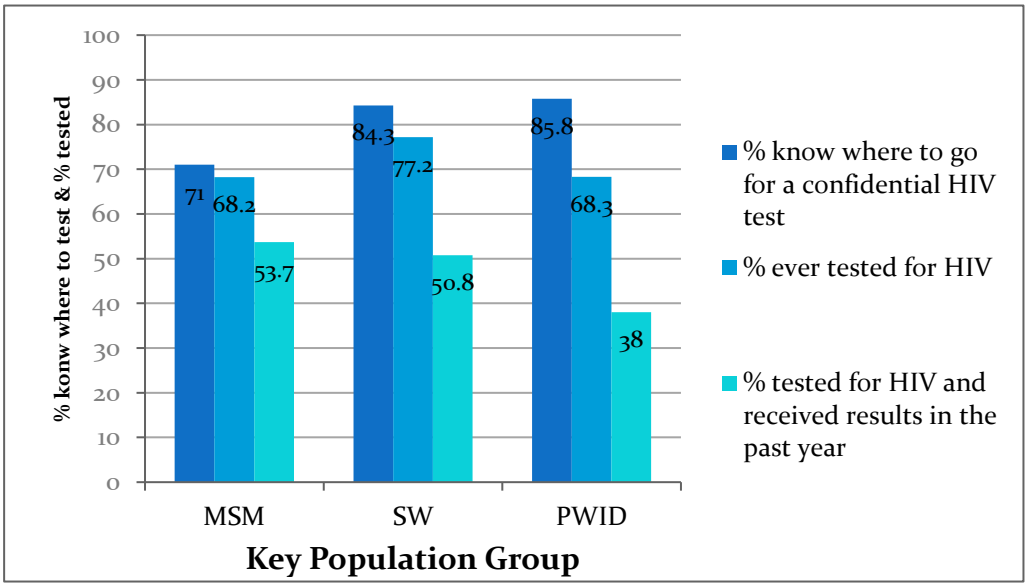


Figure 12.3: HIV testing knowledge and behaviour among MSM, SW and PWID, Unguja, IBBSS 2011-2012



2.2 Conduct workshop on HIV epidemiological profile including HIV modes of transmission (MOT) for Zanzibar

A four days workshop was conducted for 15 ZIHTLP staff from Unguja and Pemba with the overall objective of developing an HIV epidemiological profile including HIV MOT for Zanzibar. The specific objectives of the workshop were to:

- Familiarize participants with excel-based data storage format

- Generate outputs (tables, charts, maps) for use in the epidemiological profile
- Familiarize participants with Epi Info 3.5.3 mapping module
- Prepare the HIV epidemiological profile for Zanzibar
- Model HIV MOT using available surveillance data

At the end of the workshop, a draft of the HIV epidemiological profile including MOT for Zanzibar was in place. However, by the end of 2013 the document has not been finalized as it is awaiting a Zanzibar specific HIV incidence estimate to be put in HIV modes of transmission model.

Objective 3: Enhance human capacity in SI among facility-level, district health management team, and ZIHTLP staff

Activities implemented

3.1 Conduct training on MS Access for ZIHTLP staff

Five days training on MS Access was conducted for **30** ZIHTLP staff (27 from Unguja and 3 from Pemba). The objective of the training was to orient staff on the importance and uses of database and to provide appropriate knowledge and skills to the staff about MS Access database for data management. At the end of the training, the participants are expected to use this knowledge in their everyday work related to data management.

3.2 Conduct training on STATA for ZIHTLP staff

A three days training was organized and conducted for **9** ZIHTLP staff, 1 staff from IRCH programme and 1 staff from ZAC on STATA data analysis software. The objectives of the training were to:

- Familiarize participants with STATA 12
- Teach participants how to import, manipulate, clean, manage, and analyze data using STATA 12
- Teach how to apply basic biostatistics concepts using STATA (e.g. hypothesis testing, adjusting for confounders, and regression).

As a result of this training, participants are expected to use the skills gained to do basic data management and analysis in routine service monitoring as well as in any surveys conducted.

3.4 Training of HCWs on HIV services monitoring tools

3.4.1 Conduct training on revised HIV counseling and testing monitoring tools for health care workers

One day training on revised HIV counseling and testing (HCT) registers and report forms was conducted in 6 sessions in Unguja and 4 sessions in Pemba. The training involved a total of **333** health care workers (198 in Unguja and 135 in Pemba).

The objective of the training was to orient the staff from private and public health facilities, NGOs and FBOs providing HCT services on the changes which have occurred in the registers and report forms following revision of HCT guidelines in the year 2012 e.g. inclusion of a variable on type of attendance i.e. first test or retest, inclusion of type of counseling i.e. individual, couple or parent and child e.t.c. Following this training, the HCT service providers were expected to fill the revised HCT registers and monthly report forms accurately.

3.4.2 Conduct training on Post Exposure Prophylaxis monitoring tools for HCWs

Two days training on Post Exposure Prophylaxis (PEP) registers and report forms was conducted in 2 sessions in Unguja and 1 session in Pemba. The training involved a total of **94** HCWs (62 in Unguja and 32 in Pemba) from both private and public health facilities which are providing PEP services either on site or by referral.

The objective of the training was to build the capacity of the staff on filling of the newly developed PEP registers and report forms. The training also gave a chance to service providers to provide their inputs on the monitoring tools before printing. It is expected that following this training, the providers will start to use the new registers as they provide PEP services and compile a report monthly using the report form.

3.4.3 Conduct training on HIV care and treatment CTC2 database for ZIHTLP and CTC staff

A three days training on the CTC2 database for ZIHTLP staff and staff from all the 10 CTCs in Unguja and Pemba was conducted. A total of **30** staff participated in the training.

The objectives of the training were:

- To update participants on the changes which have occurred in CTC2 database as a result of changes in new ART initiation criteria as outlined in the newly developed Zanzibar National Guidelines for the Management of HIV and AIDS
- To orient new data clerks on the CTC2 database

Following the training, the new CTC2 database was installed in all CTCs and CTC data clerks have started to use it.

3.4.5 Conduct training on HBC monitoring tools for Community HBC providers in Unguja

One day training on HBC registration and follow up forms for a total of **258** Community HBC providers was conducted in 6 sessions in Unguja. The objective of the training was to re-orient the staff providing HBC services in the community on the registration and follow up forms. This is because a lot of challenges on the filling of these forms have been observed during supervision and data verification conducted this year. The training also gave a chance to service providers to clear any doubts they had on the filling of these monitoring tools. As a result of this training, the community HBC providers were expected to fill the HBC registration and follow up forms accurately. A similar training will be conducted for Pemba Community HBC providers in the coming year.

3.5 Participation of ZIHTLP SI staff in regional/international trainings and conferences

3.5.1 Participate in HIV incidence testing training

Strategic Information Coordinator participated in a 4 days course on Limiting Antigen Avidity (LAg) Enzyme Immuno Assay (EIA) and its application for Estimating HIV-1 Incidence conducted in Johannesburg, South Africa by the African Centre for Integrated Laboratory Training. The objective of the course was to provide the participants with skills on how to conduct the assay i.e. LAg EIA and how to use the results to estimate HIV-1 incidence for surveillance purposes.

Lesson learnt from the training was that to estimate HIV incidence, large sample sizes are needed in order to be able to detect new HIV infections and it might be practically impossible for Zanzibar to conduct an incidence study of its own. Therefore for HIV incidence estimation, it was recommended that Zanzibar should use epidemiological modeling. Follow up with technical partners has started to look into how the epidemiological modeling approach can be taken forward.

Objective 4: Develop and implement health sector HIV, TB and Leprosy Monitoring and Evaluation (M&E) Plan

Activities implemented

4.1 Conduct workshop to revise and update TB and Leprosy M&E plan

To strengthen M&E of TB and Leprosy services, a five days workshop was conducted to revise the existing TB and Leprosy M&E plan. The aim of the workshop was to update the plan, make it comprehensive and align it with TB and Leprosy Strategic Plan. A total of 19 participants from different departments of MOH and other implementing partners were involved in this workshop. The deliverable output was the comprehensive M&E plan for TB and Leprosy services.

4.2 Conduct workshop to update TB, TB/HIV and leprosy reporting tools

A three days workshop was conducted to review TB and TB/HIV reporting tools. The aim of this workshop was to update the tools so as to enable HMIS unit to capture TB and leprosy data and incorporate it in the Ministry of Health system for national use. The participants of the workshop were from different MOH departments that include HMIS staff, DSOs, RTLCs, DTLCs and ZIHTLP coordinators.

The following reporting tools were reviewed and updated during the workshop:

- TB and TB/HIV case notification and treatment outcome report form
- Leprosy notification and treatment outcome report forms

Following this workshop, the report forms are to be printed and training on the forms is to be conducted for HCWs.

4.3 Adapt and print data collection tools in all program areas

A review of all HIV/STI monthly report forms and some registers was conducted in collaboration with HMIS unit of MOH. The types and numbers of registers/patient forms and monthly report forms were then printed and distributed to sites for use:

Table 12.1: Types and numbers of monitoring tools printed and distributed in 2013

Monitoring tool	Type	Quantity
Registers/patient forms	HBC registration forms	2,000
	HBC follow up forms	800
	CTC2 cards	6,000
	PEP registers	230
	STI registers	100
Monthly report forms	STI	230
	HBC	140
	HCT	120
	RCH (PMTCT section included within this report)	170
	Maternity(PMTCT section included within this report)	60

4.4 Conduct assessment on HIV/STI data quality and design a Data Quality Assessment Guideline

In the process to improve quality of information used for decision making and in order to strengthen its M&E system, ZIHTLP contracted a consultant to conduct HIV/STI data quality assessment and to develop an HIV/STI Data Quality Assessment guideline. The objective of this assessment was to determine quality of HIV/STI data at health facility, district and national levels; identify gaps that affect its quality; as well as suggest measures to improve the quality. Following the assessment, the consultant was expected to develop an action plan to implement corrective measures for improving HIV/STI data quality and strengthening data management as well as designing an HIV/STI Data Quality Assurance system and guideline.

The preliminary findings from qualitative and quantitative assessment showed that the ZIHTLP M&E system was relative strong; in the quantitative section, 91% of all reports from health facilities were available in DHIS2, and 94% of the available reports were filled out completely. However, only 83% of the available reports were submitted timely. As of December 2013, the assessment report, follow up action plan and the developed HIV/STI Data Quality Assessment guideline were not yet finalized.

4.5 Prepare ZIHTLP 2012 annual report

A team of 18 ZIHTLP technical staff participated in two workshops, each of three days, to prepare annual report for the programme for the year 2012. By the end of the first workshop a first draft of the report was available and during the second workshop the annual report was reviewed and finalized. Thereafter 1,000 copies of the report were printed and distributed to stakeholders for use.

Strategic Information indicators and trend 2011 - 2013

Indicator		**2011**	**2012**	**2013**
1	Number and types of surveys conducted	1 (Rapid assessment among PWID, SWs and MSM in Pemba)	1 (IBBSS among PWID, SWs and MSM in Unguja)	**0**

2	Percent of facilities submitting complete, timely and accurate HIV reports* Completeness Timeliness		**87%** **40%**	**85%** **39%**

* Completeness and timeliness of HIV/STI data entered in DHIS2 has been used as a proxy for completeness and timeliness of reporting. Source of this information is MOH DHIS2 reporting rate summary report for the year 2012-2013.

1. Number and types of surveys conducted

There was no survey conducted by the programme in 2013 despite the fact that ANC sentinel surveillance survey among pregnant women had been planned. This was because there was a delay in getting ethical approval for conducting the survey from partner who is supporting the survey technically and financially. Hence, this survey will now be implemented in 2014.

2. Percent of facilities submitting complete, timely and accurate HIV reports

The delay in HIV data entry at district level has persisted between 2012 and 2013 whereby as seen in the table above, timeliness of entering reports into the DHIS2 database is below average. One contributing factor to this is lack of internet services at district level and hence district data managers are forced to travel to central level for data entry.

12.4 Challenges

- Holdup in getting ethical approval for ANC surveillance delayed the launch of the ANC surveillance by more than a year
- Inadequate filling of service registers and inaccuracy of reports still persists
- Late entry of reports at district level causing a delay in reporting at central level
- Inability to conduct HIV incidence survey for Zanzibar

12.5 Proposed way forward

- Conduct mentorship for HCWs coming from sites whose reports are inaccurate

- Conduct refresher training for HCWs on service monitoring tools found to have most inaccuracies during supervision and data verification e.g. HBC, PMTCT
- Engage technical partners to assist Zanzibar to conduct HIV incidence survey

12.6 Plans for 2014

- Finalize HIV epidemiological profile for Zanzibar
- Conduct ANC surveillance
- Conduct IBBSS among fishermen
- Finalize development of programme website

13. Programme Administration and Finance

13.1. Background

This unit is the hub of coordination of all activities implemented by the program. It oversees all administrative and financial management aspects of the program including human and financial resources. It is also responsible for procurements needs of the program and tracking of the procured goods and services. Program management is also responsible for preparing financial reports and, in collaboration with other units, compiling technical reports and submission of reports to the Ministry and stakeholders.

13.2. Goal

The goal of programme management is to ensure proper execution of the program work plan and adequate availability of program resources (human and financial).

Role and Partnership

13.3. Planning and administration

13.3.1 Human Resource

The Zanzibar Integrated HIV, TB and Leprosy Programme have a total of 73 Staff (60 Government and 13 Programme direct employees). Government employees include all those employees on the programme that are under direct employment by the Ministry of Health and who have been assigned to work on the programme. They receive salary and all related benefits from the Government. Programme direct employees are employees on the programme whom are directly employed by the ZIHTLP with employment terms and conditions agreed.
During the reporting period eight new staff was recruited (one MD, three Clinicians, IPC officer, Procurement Officer, and one office Cleaner).

13.3.2 Travel, International and National meetings/Conferences

During the reporting period, the following ZHITLP technical staff managed to participate in country and International travel and meetings organized by different HIV and TB partners:

International Meetings/Conferences

- Delegation of two technical personal from Atlanta visited Zanzibar and had discussion with Program staff following HIV/HBV Pilot study carry on at Mnazi mmoja CTC Clinics
- The program manager and SI officer participated in the AIDS International Conference held in Kuala Lumpa, Malaysia where they presented poster abstract on “HIV/HBV/HCV

co-infection among PWIDs in Zanzibar" and "Successful initiation of Key Population HIV Services in Zanzibar"

National Meetings/conference

- Program staff attended implementing partners meeting, in Tanzania Mainland organized by CDC
- Annual working group meeting organized by TACAIDS and UN family
- Attended RTLC and DTLC meetings on TB organized by National TB and Leprosy program of Tanzania Mainland.

13.4. Consultancy and services

- Assessment to identify gaps that reduce quality of data at health facility, district and national level as well as design a quality assurance system
- Consultancy to develop strengthening Plan, Laboratory norms and SOP so as to strengthen Quality assurance system for TB smear microscopy in Zanzibar

13.5. Procurement

In the year 2013 the ZIHTLP procured the following health and non health equipments for Unguja and Pemba:

1. One refrigerator sent to Pemba Health laboratory - PHL for keeping and reservation of TB cultures samples
2. Eleven LED Microscopes procured to enhance diagnosis of TB
3. Two double cabin pickup to support outreach services for Key Populations
4. Four motorcycles procured, 2 for home based care and 2 for care and treatment services.

13.6 Intra Sectoral collaboration and support

ZIHTLP continue to collaborate with different stakeholders within and outside the country in controlling transmission of HIV, TB and Leprosy, improving quality of services, enhancing capacity of programme staff and technical assistants for efficient implementation of the programme interventions. Outlined below table are the partners working together and providing support to ZIHTLP during the year 2013:

NAME OF PARTNERS	TECHNICAL SUPPORT PROVIDED
Management Science for Health (MSH)	• Conduct assessment on establishment of financial and procurement operation system in sub office of Pemba, • Capacity building trainings on performance management system including development of job description of each program staff, • Conduct supportive supervision of implementation of SOPs designed to increase case detection for TB which were piloted in some facilities of Unguja and Pemba • Printing of 100 copies of the Zanzibar Health Sector HIV Strategic Plan.
2. PATH	• Monitoring and evaluation of TB and TB/HIV collaborative services • human resource strengthening and capacity building through training, • Supportive supervision and mentorship to strengthen knowledge and skills of HCWs on TB/HIV.
3.Pathfinder International	• Strengthening program's capacity in Behaviour Change Communication in HIV and other related diseases. • Supported IEC/BCC Coordinator to attend a two weeks course at Makerere University in Uganda to develop Social Behavior Change Communication (SBCC) materials
4.Francior Xavier Bagnoud (FXB)	• FXB assisted in the development of PMTCT job aids by conducting pre and post assessment of those materials.
5. Pangaea Global AIDS Foundation (PANGAEA)	• Developed a work plan to establish Methadone services in Zanzibar.

	• Review a road map towards establishment of methadone services, discuss on the requirements for the procurement and shipment of methadone • Visited the methandone clinic which was under renovation to provide technical inputs.
6. University of California, San Francisco (UCSF)	• Technical support on report writing and dissemination of the Intergrated Behavoiural and Biological Surveillance Survey among key populations. • Special training on STATA • Technical support in developing HIV epidemiological profile for Zanzibar

13.7 Finance

The program's major funding support comes from the Revolutionary Government of Zanzibar and the development partners namely: PEPFAR, Global Fund, United Nation Agencies(UNDP, WHO, UNICEF) through United Nations Development Assistance Plan (UNDAP), International Center for AIDS, care and Treatment Program (ICAP) and Germany Leprosy Relief Association (GLRA). In the year 2013 ZIHTLP received a total amount of **Tanzania Shillings 35,967,000.00** from the Government and **USD 3,125,685.40** from the development partners. During the reporting period, ZIHTLP observed funds increment in terms of income and expenditures in year 2013 compared to the year 2012 by 15% (income) and 17% (expenditure).

Table no. 13.1 show source of funds from the Government and development partners during the year 2013

No	Name of Partners	Project Title/Name	Area of Intervention Support
1.	President Emergency Plan for AIDS Relief (PEPFAR)	Enhance HIV prevention, care and treatment services in Zanzibar	• HIV Counseling and Testing • Prevention of Mother To Child Transmission of HIV • Access to HIV Care and Treatment • Enhancement of laboratory capacity and services • Home Based Care services • Services for Sexual Transmitted Infections & Key Population, • Faith Based Collaborations in promoting Abstinence and Being faithful • Information Education Communication and Behaviors Change (IEC/BCC) • Strengthening Strategic Information System and • Program management
2.	Global Fund R10 for Tuberculosis	Zanzibar Scaling up Detection and Control of Tuberculosis Services	• to pursue high quality DOTS expansion and enhancement • strengthen collaborative TB/HIV activities • Prevent TB transmission in health facilities and other high risk congregate settings • Engage all care providers in TB control and empower people and communities in TB control.
3.	Columbia University-ICAP	Endeleza	• Strengthening of HIV Care and Treatment services to 7 sites (Mnazi Mmoja, Kivunge Cottage, Mwembeladu, Micheweni, Al Rahma, Chake Chake, and Wete Hospitals). • supports Early Infant Diagnosis (EID); t • TB/HIV integrated services and Provider Initiated Testing and Counseling (PITC)

4.	United National Development Program – Tanzania (UNDP)		• provide bridge support on HIV health sector interventions including M&E and surveillance activities
5.	GLRA (German Leprosy Relief Association)		• monthly supervision to the sites providing Leprosy services • contact tracing for Multibacillary Leprosy patients, • health education on leprosy to the community, • training on prevention of disability committees • reconstructive surgery for leprosy patients • establishment of self care group at Kivunge Hospital and follow up of existing self care groups
	GOVERMENTOF ZANZIBAR (SMZ)	Developing Program	• support HIV,TB and leprosy programme activities

13.8 Challenge

- Despite of having different HIV, TB and Leprosy partners support yet the program failed to determine the financial gaps required on each area of interventions due to the lack of Health Sector HIV strategic cost work plan.

- Insufficient funds to support TB and HIV activities from Central Government

13.9 Way forward

- To facilitate technical support to review and costing of Health Sector HIV and AIDs Strategic Plan
- Pursue Central Government to increase allocation of co-funding to HIV,TB and Leprosy interventions

13.10 Planned activities for next year 2014

- To conduct midterm review and costing of Health Sector HIV and AIDs Strategic Plan

Appendix I: List of HTC sites by district, Zanzibar, 2013

Unguja Urban District

	Facility	Ownership	VCT	PITC
1	Mnazi Mmoja Hospital	Public	√	√
2	Al Rahma Hospital	Private	√	
3	Rahaleo PHCU	Public	√	√
4	Mafunzo PHCU	Public	√	
5	Marie Stopes Hospital	Private	√	
6	ZAYEDESA Miembeni	NGO	√	
7	Al Tabib Dispensary	Private	√	
8	Makao Makuu JKU PHCU	Public	√	√
9	Chumbuni PHCU	Public	√	
10	ZANGOC Mpendae	NGO	√	
11	DSAPR Kidongo Chekundu	Public	√	
12	Ziwani Polisi PHCU	Public	√	√
13	ZAPHA+	NGO	√	
14	Mwembeladu RCH	Public		√
15	Kwamtipura PHCU	Public		√
16	Sebleni PHCU	Public	√	√
17	Mpendae PHCU	Public	√	
18	Matarumbeta PHCU	Public		√

West District

	Facility	Ownership	VCT	PITC
1	KMKM Kibweni PHCU	Public	√	√
2	Bububu Millitary Hospital	Public	√	√
3	ZANGOC Mwanakwerekwe	NGO	√	
4	SOS Medical Center	Private	√	
5	Fuoni PHCU	Public	√	√
6	Kiembe Samaki PHCU	Public	√	√
7	Kizimbani PHCU	Public	√	√
8	Chukwani PHCU	Public	√	√
9	Selem PHCU	Public	√	
10	Akbar	Private	√	

Central District

	Facility	Ownership	VCT	PITC
1	Unguja Ukuu PHCU	Public	√	
2	St Lukes Machui	FBO	√	
3	Uroa PHCU	Public	√	
4	Dunga PHCU	Public	√	√
5	Kidimni Dispensary	Private	√	
6	ZANGOC Binguni	NGO	√	
7	Ubago Millitary Camp PHCU	Public	√	

8	Mwera PHCU	Public		√
9	Kiboje PHCU	Public		√
10	Michamvi PHCU	Public		√
11	Miwani PHCU	Public	√	
12	Uzini PHCU	Public	√	
13	Chwaka PHCU	Public	√	
14	Jendele PHCU	Public	√	
15	Ukongoroni PHCU	Public		√

South District

	Facility	Ownership	VCT	PITC
1	Makunduchi PHCC	Public	√	√
2	Jambiani PHCU	Public	√	
3	Muyuni PHCU	Public	√	
4	ZAYEDESA Paje	NGO	√	
5	Kizimkazi Mkunguni	Public		√
6	Mtende PHCU	Public		√
7	Paje PHCU	Public		√

North A District

	Facility	Ownership	VCT	PITC
1	Kivunge PHCC	Public	√	√
2	ZAYEDESA Nungwi	NGO	√	
3	Matemwe PHCU	Public	√	√
4	Nungwi PHCU	Public		√
5	Tumbatu Jongowe	Public	√	√
6	Chaani Masingini PHCU	Public		√
7	Mkokotoni PHCU	Public		√

North B District

	Facility	Ownership	VCT	PITC
1	Mahonda PHCU	Public	√	
2	Kitope Mission Hospital	FBO	√	
3	Upenja PHCU	Public	√	
4	Kitope PHCU	Public		√
5	ZANGOC Mahonda	NGO	√	
6	Kiwengwa PHCU	Public		√
7	Bubumbini Misufini PHCU	Public	√	√

Pemba Chake Chake District

	Facility	Ownership	VCT	PITC
1	Chake Chake Hospital	Public	√	√
2	WAMATA	NGO	√	
3	Vitongoji PHCC	Public	√	√
4	Vitongoji Millitary Camp PHCU	Public	√	√
5	ZAPHA+	NGO	√	
6	Wesha PHCU	Public		√
7	Tundauwa PHCU	Public		√
8	Gomban PHCU	Public		√

Mkoani District

	Facility	Ownership	VCT	PITC
1	ZAYEDESA Mkoani	NGO	√	
2	Abdalla Mzee Hospital	Public	√	√
3	Bogoa PHCU	Public	√	√
4	Mtambile PHCU	Public	√	√
5	Kiwani PHCU	Public		√
6	Kangani PHCU	Public		√
7	Kengeja PHCU	Public		√
8	Wambaa PHCU	Public		√

Wete District

	Facility	Ownership	VCT	PITC
1	Wete Hospital	Public	√	√
2	Pandani PHCU	Public	√	√
3	ZANGOC Mshelisheli Kibutu	NGO	√	
4	Kambini PHCU	Public	√	√
5	Jadida PHCU	Public		√
6	Chwale PHCU	Public	√	
7	Kiuyu Miningwini PHCU	Public		√

Micheweni District

	Facility	Ownership	VCT	PITC
1	Micheweni PHCC	Public	√	√
2	Wingwi PHCU	Public	√	√
3	Konde PHCU	Public	√	√
4	ZANGOC Micheweni	NGO	√	
5	Tumbe PHCU	Public		√
6	Kiuyu Maziwa ngombe	Public		√
7	Kiuyu Mbuyuni	Public		√
8	Shumba Viamboni PHCU	Public	√	
9	Msuka PHCU	Public	√	
10	Mkangale PHCU	Public	√	√

Appendix II: HTC service indicators by month, January – December 2013

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of individual who Received Testing and Counseling (T&C) services for HIV and received their test results.	7398	7791	7469	10877	10704	11017	6555	8810	11081	12509	11301	10053
Those tested positive	105	100	119	142	122	134	108	93	115	149	120	116

Appendix III PMTCT Sites in Unguja

PMTCT Sites in Unguja			
s/n	**Facility**	**s/n**	**Facility**
Mjini District		**Kati District**	
1	Chumbuni PHCU	1	Bambi PHCU
2	Makao Makuu JKU PHCU	2	Chwaka PHCU
3	Kwamtipura PHCU	3	Dunga PHCU
4	Marie Stopes Hospital	4	Kiboje PHCU
5	Mnazi Mmoja Refferal	5	Michamvi PHCU
6	Mwembeladu Maternity	6	Mwera PHCU
7	Rahaleo PHCU	7	Tunguu PHCU
8	Sebleni PHCU	8	Unguja Ukuu PHCU
9	Seventh Day Adventist RCH	9	Uroa PHCU
10	Shaurimoyo PHCU	10	Uzi PHCU
11	Mafunzo PHCU	11	Marumbi PHCU
12	Jangombe Matarumbeta PHCU	12	Pongwe PHCU
13	Mpendae PHCU	13	Jendele PHCU
14	Ottu RCH	14	Ndijani kwabaniani PHCU
Maghribi District		15	ndijani Mseweni PHCU
1	Bwefum PHCU	16	Uzini PHCU
2	Chukwani Maternity Home	17	Mwera Pongwe PHCU

3	Fuoni PHCU	18	Machui PHCU
4	Fuoni Kibondeni PHCU	19	Mchangani PHCU
5	Kibweni KMKM RCH	20	Ukongoroni PHCU
6	Kiembe Samaki PHCU	21	Miwani PHCU
7	Kizimbani PHCU	22	Charawe PHCU
8	Kombeni PHCU	**Kaskazini A District**	
9	Magogoni PHCU	1	Chaani Kubwa PHCU
10	Selem (Mfenesini) PHCU	2	Chaani Masingini PHCU
11	Shakani PHCU	3	Gamba PHCU
12	SOS Medical Clinic	4	Kidoti PHCU
13	ST Camilus PHCU	5	Kivunge Cottage Hospital
14	M/Kwerekwe KKKT	6	Matemwe PHCU
15	SOS Medical Clinic	7	Nungwi PHCU
16	Kisauni PHCU	8	Tumbatu Gomani PHCU
17	Welezo Camp PHCU	9	tazari PHCU
Kaskazini B District		10	Pwanimchangani PHCU
1	Bumbwini Misufini PHCU	11	Tumbatu Jongowe PHCU
2	Donge Mchangani PHCU	12	Kijini PHCU
3	Donge Vijibweni PHCU	13	Kendwa PHCU
4	Fujoni PHCU	14	Mkokotoni PHCU
5	Kiomba Mvua PHCU	**Kusini District**	
6	Kitope PHCU	1	Jambiani PHCU
7	Kiwengwa PHCU	2	Kibuteni PHCU

8	Mahonda PHCU	3	Kizimkazi Dimbani PHCU
9	Bumbwini Makoba PHCU	4	Kizimkazi Mkunguni PHCU
10	Upenja PHCU	5	Makunduchi Cottage PHCU
11	Kitope RC	6	Mtende PHCU
12	Zingwe Zingwe PHCU	7	Muungoni PHCU
8	Muyuni PHCU		
9	Bwejuu PHCU		
10	Paje PHCU		

PMTCT Sites in Pemba

PMTCT Sites in Pemba			
s/n	**Facility**		
Wete District		**Chake Chake District**	
1	Wete HOSPT	1	Chake chake Hospital
2	chwale PHCU	2	Mvumoni PHCU
3	Junguni PHCU	3	Mgelema PHCU
6	Jadida PHCU	4	Shungi PHCU
7	fundo PHCU	5	Gombani PHCU
9	Kisiwani PHCU	6	Vitongoji Jeshini PHCU
10	Ole PHCU	7	Chonga PHCU
11	Pandani PHCU	8	Wesha PHCU
12	Uondwe PHCU	9	Vitongoji cottege PHCU

13	Kiungoni PHCU	10	JKU wawi PHCU
14	Vumba PHCU	11	Uwandani PHCU
15	Kambini PHCU	12	Mgelema PHCU
16	Mzambarauni PHCU	13	Pujini PHCU
17	Kiuyu Minungwini PHCU	14	ziwani PHCU
18	Ukujwi PHCU	**Mkoani District**	
19	Kagangani PHCU MKLO	1	Mkoani Hospital
20	Makoongeni PHCU	2	Mwambe PHCU
21	Kojani PHCU	3	Chambani PHCU
Micheweni District		4	Tundaua PHCU
1	Micheweni Hospital	5	wambaa PHCU
2	Wingwi PHCU	6	Kisiwa panza PHCU
3	Kiuyu mbuyuni PHCU	7	Makombeni PHCU
4	Makangale PHCU	8	Mtangani phcu
5	Konde PHCU	9	Makoongwe PHCU
6	Msuka PHCU	10	Kangani PHCU
7	Kiuyu maziwa ya ng"ombe	11	Shid PHCU
8	Tumbe PHCU	12	Mtambile PHCU
9	Shumba viamboni PHCU	13	Ukutini PHCU
10	Kiuyu kipangani PHCU	14	Kiwani PHCU
11	Sizini PHCU	15	Bogoa PHCU
12	Mkia wa ng'ombe PHCU	16	Kengeja PHCU
13	Finya PHCU	17	Shamiani PHCU
14	Kinyasini PHCU		

Appendix IV: Distribution of ZIHTLP Funds Received by Development Partners, Zanzibar from year 2011-2013

YEARS	Development Partner in USD $							
	PEPFAR(CDC)	COLUMBIA (ICAP)	UNDAP	TB GFR10	GLRA	GOVERNMENT	HIVR6	TOTAL
2011	2,081,135.06	112,453.00	118,818.40	0.00	0.00	7,897.00	885,866.00	3,206,169.46
2012	2,840,685.39	60,000.00	94,734.87	0.00	12,413.00	33,038.67	0.00	3,040,871.93
2013	2,539,365.00	45,301.51	15,545.87	924,511.00	16,793.62	23,978.00	0.00	3,565,495.00
TOTAL	**7,461,185.45**	**217,754.51**	**229,099.14**	**924,511.00**	**29,206.62**	**64,913.67**	**885,866.00**	**9,812,536.39**

Appendix V: Expenditures of ZIHTLP by Categories and Development Partner, Zanzibar-2013

Categories	Development Partner						
	PEPFAR(CDC)	COLUMBIA (ICAP)	UNDP	TB GFR10	GLRA	GOVERNMENT	TOTAL EXPENDITURE (US $)
Human Resource	769,066.72	14,367.33	0.00	30,337.01	1,200.00	0.00	814,971.06
Technical Assistance	1,280.00		0.00	10,149.44	0.00	0.00	11,429.44
Travel	217,020.94	1,530.33	0.00		0.00	13967.41	232,518.68
Equipment/Furniture	179,005.14		0.00	5,838.75	**0**.00	0.00	184,843.89
Supplies/Commodities, Testing, Packaging	1,025,611.52	11,947.80	0.00	66,592.82	0.00	3533.33	1,107,685.47
Subcontracts	117,633.00	0.00	0.00	0.00	0.00	0.00	117,633.00
Promotion & Advertising & IEC	53,521.06	0.00	0.00	0.00	0.00	0.00	
Monitoring & Evaluation	43,759.26	0.00	16,793.62	39,865.46	0.00	451.33	57,110.41
Training	297,686.30	0.00	0.00	0.00	0.00	0.00	
Indirect Costs/Overhead	139,985.21	17,456.04	0.00	41,691.77	14,345.87	2,100.67	636,339.80
Total	**2,853,569.15**	**45,301.51**	**16,793.62**	**194,475.25**	**15,545.87**	**20,053.00**	**3,145,738.39**

AppendixVI: Expenditures of ZIHTLP by Program Area and Development Partners, Zanzibar-2013

Program Area	Development Partner						
	PEPFAR (CDC)	COLUMBIA (ICAP)	UNDAP	TB GFR10	GLRA	GOVERNMENT	TOTAL EXPENDITURE (US $)
PMTCT	390,630.28	0.00	0.00	0.00	0.00	0.00	390,630.28
Abstinence/Be Faithful	34,046.83	0.00	0.00	0.00	0.00	0.00	34,646.83
Injection Drug Use & other MARR	322,864.40	0.00	0.00		0.00	0.00	322,864.40
Palliative Care: Basic Health Care and Support	178,125.50	0.00	0.00	0.00	0.00	0.00	178,125.00
Palliative Care: TB/HIV	43,137.23	0.00	0.00	373.13	0.00	0.00	43,510.36
TB and Leprosy		0.00	0.00	111,105.56	15,545.87	0.00	126,651.43
Counseling and Testing	395,414.71	0.00	0.00	0.00		3,533.33	398,948.04
ARV Services	661,086.66	45301.51	0.00	0.00	0.00	0.00	706,388.17
Laboratory Infrastructure	195,948	0.00	0.00	0.00	0.00	0.00	195,948.00
I EC/BCC and Other prevention	65,898.13	0.00	0.00	0.00	0.00		65,898.13
Strategic Information	327,058.49	0.00	16,793.6	30,234.17	0.00	13,967.41	388,053.69
Oversight & Management	239,358.91	0.00	0.00	52,762.39	0.00	2,552.00	294,673.30
Total	**2,853,569.14**	**45,301.51**	**16,793.6**	**194,475.25**	**15,545.87**	**20,053.00**	**3,145,738.39**