MINISTRY OF HEALTH

ZANZIBAR

ZANZIBAR INTEGRATED HIV, TB AND LEPROSY PROGRAMME

ANNUAL REPORT

2015

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ACRONYMS

ACSM	Advocacy Communication and Social Mobilization
AFB	Acid Fast Bacilli
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retro Viral
BCC	Behavioural Change Communication
CDC	Center for Disease Control and Prevention
CHBC	Community Home Based Care
CITC	Client Initiated Testing and Counselling
CMS	Central Medical Stores
CPT	Cotrimoxazole Preventive Therapy
CTC	Care and Treatment Clinic
DHIS2	District Health Information System 2
DHMT	District Health Management Team
DNA	Deoxyribose Nucleic Acid
DOT	Directly Observed Therapy
DSO	District Surveillance Officer
DTLC	District Tuberculosis and Leprosy Coordinator
EID	Early Infant Diagnosis
EQA	External Quality Assurance
FBO	Faith Based Organization
FBT	Full Blood Tests
HBC	Home Based Care
HBV	Hepatitis B Virus
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
HTS	HIV Testing Services
HUWANYU	Huduma za Wagonjwa Nyumbani
IBBSS	Integrated Bio-Behavioural Surveillance Survey
ICT	Information and Communication Technology

IEC	Information Education Communication
IPD	In-Patient Department
IPT	Isoniazid Preventive Therapy
IQC	Internal Quality Control
IRB	Institutional Review Board
IT	Information Technology
KPs	Key Populations
MARPs	Most At Risk Populations
MAT	Methadone Assisted Therapy
MB	Multi Bacillary
MDR	Multi Drug Resistant
MDT	Multi Drug Therapy
M&E	Monitoring and Evaluation
MOH	Ministry Of Health
MSD	Medical Stores Department
MSM	Men who have Sex with Men
MTB/RIF	Mycobacterium Tuberculosis/Rifampicin
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NTLP	National Tuberculosis and Leprosy Programme
OPD	Out-Patient Department
PB	Pauci Bacillary
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PWID	People Who Inject Drugs
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infection

RTLC	Regional Tuberculosis and Leprosy Coordinator
SI	Strategic Information
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infection
SWs	Sex Workers
TB	Tuberculosis
THPS	Tanzania Health Promotion Services
TWG	Technical Working Group
UNAIDS	United Nations programme on HIV and AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZAC	Zanzibar AIDS Commission
ZAMREC	Zanzibar Medical Research Ethical Committee
ZAPHA+	Zanzibar Association of People living with HIV and AIDS
ZAYEDESA	Zanzibar Youth Education Environment Development Support Association
ZIHTLP	Zanzibar Integrated HIV, TB and Leprosy Programme

EXECUTIVE SUMMARY

This 2015 annual report is the fifth report on the progress to the HIV, STI, TB and Leprosy response since 2011. This reporting round, describes not only the 2015 annual progress but also a glimpse of the trends towards 2016. This report has been prepared through analysis of service utilization reports from HIV care and treatment, Counselling and Testing for HIV infection, Prevention of Mother to Child Transmission of HIV infection (PMTCT), Home Based Care, Information, Education and Communication, TB and Leprosy, Key Population, STI/RTI, Strategic Information and surveillance of HIV and TB in the country.

The intensified HIV response in 2014 has resulted in increased uptake of HIV prevention, treatment and care services leading to continued reduction in number of new HIV infections among adults and children, and AIDS related deaths. Zanzibar is still classified as a HIV concentrated epidemic country with more HIV cases among Key Populations.

The numbers of TB cases notified are gradually increasing for the last four years. The increase in the notification is largest in the group of smear positive with age group 15-34 years being the most affected groups. The number of patients with multibacillary leprosy is still alarming (76% - 54%) which demonstrates increased risk of transmission in the community.

HIV Counseling and Testing Services: During 2015, the number of Counseling and Testing sites offering HIV Counseling and testing services were 98 including 23 VCT sites alone, 32 PITC alone and 43 both PITC and VCT. A total of 101,669 individuals from general population received counseling and testing services for HIV in 2015 compared with 123,456 clients in 2014. Among the clients tested, 48,601 (48%) were females and 53,068 (52%) were males.

Prevention of Mother to Child Transmission services: The programme is continuing implementing Prevention of Mother to Child Transmission services with treatment as prevention strategy. A total of 31,536 pregnant women were tested for HIV which is 49% of all estimated pregnant women, wherein 230 (74%) HIV positive pregnant women out of 385 estimated HIV positive pregnant women were initiated on ART. Number of infants born to

HIV positive mothers who received HIV antigen test (DNA PCR) within 2 months of birth were 180/230 (78%) and all were started on Cotrimoxazole within two months of birth.

Key Population services: As of December, 2015, about 1,895 of key population including 1,323 FSWs, 153 MSMs and about 419 PWIDs were reached with different services. A total of 174 (84% of the year one target) clients who inject/use drugs were enrolled at MAT. As of December 2015, number of clients who have been on MAT for six months and above were 159 (91%) of whom 36 (23%) are HIV positive clients who continue to receiving HIV care and treatment services at different CTCs.

STI/RTI Control and Prevention Programme: A total of 9,063 STI cases reported and managed which is a decrease from 9,596 episodes reported in 2015. There was slight increase in STI cases diagnosed (8,862 in 2014 to 9,063 in 2015). Of these episodes, 8,576 were syndromic and 487 were etiological. Number of male condoms distributed through various condom outlets in Zanzibar has declined from 84,502 in the year 2014 to 15,860 in the year 2015. This decline was due to frequent stock out of male condom

Care and Treatment services for PLHIV: The care, support and treatment programme provides comprehensive services for PLHIV which include free ART, psychosocial support, prevention and treatment of Opportunistic Infections including Tuberculosis. By 2015, a total of twelve ART clinics were provide care and treatment services with 8,536 patients ever been enrolled in CTCs of whom 6,079 (71%) are ever started on ARVs at these facilities. About 79.3% of patients initiated on ART are still alive and known to be on treatment 12 months after initiation of treatment. Percentage of patients screened for TB has remained the same at 99%. Among 5,013 patients who were screened for TB 88 were diagnosed with TB and were started on anti TB.

Home Bases Care services: During 2015, a total of 2,694 patients received HBC services which is an increase from 3,725 clients reported in 2014. Among those received services 1,629 were people living with HIV (1,073 females and 556 males) and 1,065 were chronically ill patients (589 females and 476 males). Children below 15 years of age were 267.

Tuberculosis and Leprosy control services: For TB services, a total number of all registered TB cases were 855, where number of new smear positive TB cases was 479. TB success rate was 91% which was the same as the cure rate i.e. 91%. For TB/HIV

collaborative activities, 795 TB patients tested for HIV and 109 (14%) were positive for HIV. Eighty six percent (86%) of the co-infected patients started ART through under one roof service. The number of new leprosy cases registered in 2015 was 176 cases of whom 56.4% were MB cases. The number of patients with multibacillary leprosy is still alarming which demonstrates increased risk of transmission in the community. Among the registered, 16% were children, 5.8% had disability grade 2.

Laboratory Services: A total of 37,534 clinical tests were performed in 2015 in 6 laboratories. Samples for Early Infant Diagnosis diagnosis of HIV in exposed infants and children less than 18 months of age were collected from PMTCT sites and transported to Muhimbili National Hospital, Dar es Salaam. A total of 259 HIV exposed infants and children less than 18 months of age have been tested by DNA-PCR. For TB diagnosis, in 2015, diagnostic performance increased from 5,392 with 410 positives (2014) to 5,934 (2015) with 518 positives. Mnazi Mmoja laboratory examined 1,517 samples using Gene expert.

Information, Education and Communication/ Behaviour Change Communication: The focus of IEC activities has been on promoting safe behaviour, reducing HIV and TB stigma and discrimination, demand generation for HIV/ AIDS services and condom promotion. In 2015, the programme conducted training on pathway to behaviour change for key population. Sensitization meeting and health education for community, religious leaders and in sober houses for TB and leprosy. Also IEC/BCC The programme also involves religious leaders (FBO) in abstinence and being faithful (AB) campaign therefore, spiritual, social and psychological counselling. Also IEC/BCC different IEC/BCC materials on HIV and TB were developed, printed and distributed.

Strategic Information Management: Some of the key achievements during 2015 are roll-out of Integrated Biological & Behavioural Surveillance (IBBS) for fishermen. Protocol for conducting formative assessment to determine methods that can be used to conduct next round of IBBSS including size estimation for KPs has been prepared and submitted to ZAMREC and CDC IRB for ethical clearance. Capacity building activities including supportive supervision, mentorship have been conducted.

CHAPTER 1: GENERAL INSTITUTIONAL BACKGROUND INFORMATION

1.1 Introduction

Zanzibar Integrated HIV, TB and Leprosy Programme (ZIHTLP) is under the Directorate of Preventive Services and Health Education of the Ministry of Health (MOH) Zanzibar. It is a result of two combined programs, namely Zanzibar AIDS Control Programme and Zanzibar TB and Leprosy Control Programme. The two programmes were officially joined in February 2012 in order to maximize provision of services for two interrelated diseases and efficiently utilize resources.

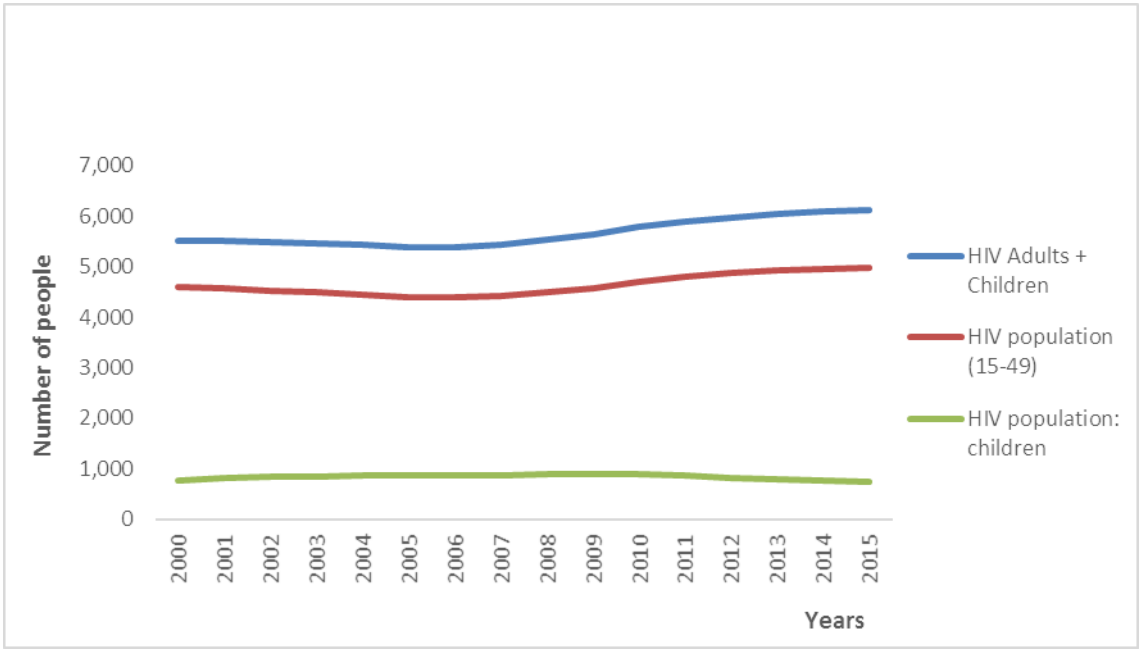
1.2 The burden of diseases (HIV, TB and Leprosy)

1.2.1 HIV situation

The first three AIDS cases were diagnosed in 1986. Since then the HIV epidemic has remained low (below 1%) in the general population. However, Zanzibar is typically characterized with concentrated HIV epidemic with high HIV prevalence among sex workers (SWs), people who inject drugs (PWIDs) and men who have sex with men (MSM). The prevalence is 19.3%, 11.3% and 2.4% among SWs, PWID and MSM, respectively. This is according to the Integrated Bio-Behavioural Surveillance Survey (IBBSS) conducted in 2012.

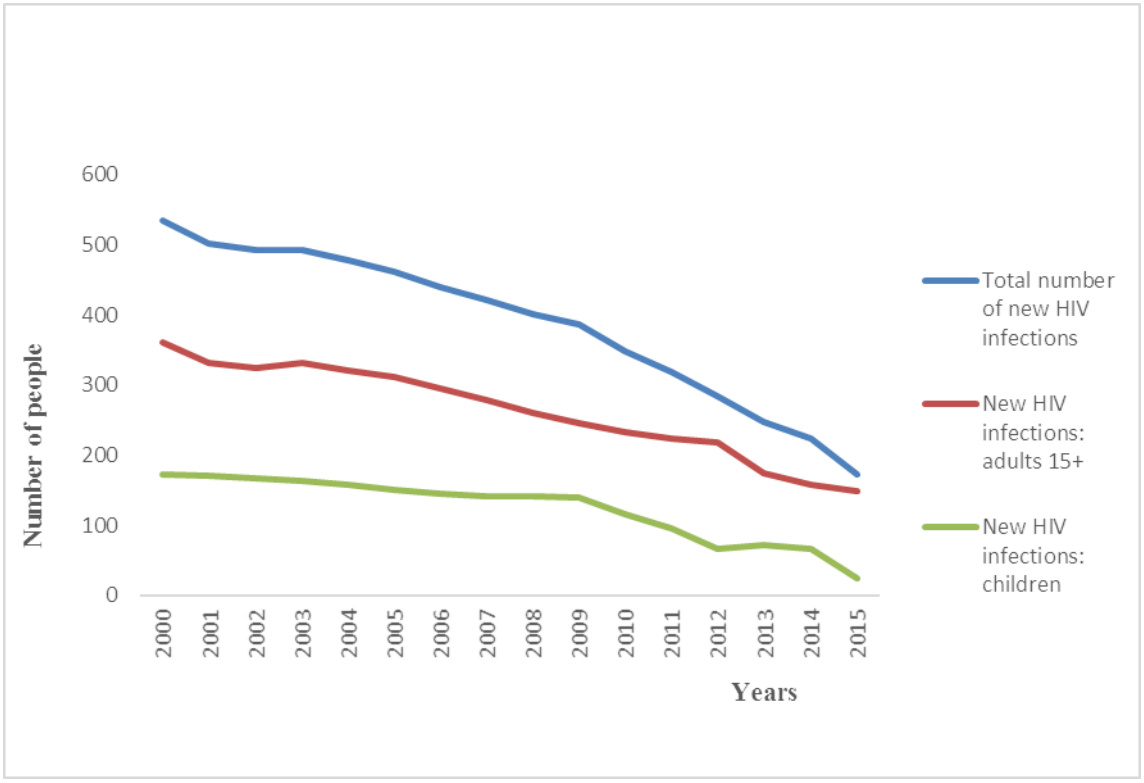
Based on the spectrum data, it is estimated that an average of 6,129 people including adults and children will be living with HIV in 2015. Among them 81% (4,979) will be people in age group of 15-49 years and 12% (740) are children less than 15 years of age. The population of people living with HIV (PLHIV) has been steady from 2000 to 2008. A slight increase of this population has been noted from 2008 through 2015 as illustrated in figure 1.1 below. This can be explained by the establishment of care and treatment services in 2005 and access to ART that improved health outcome of PLHIV.

Figure 1.1: Population estimates of people living with HIV, 2000 – 2015, Zanzibar



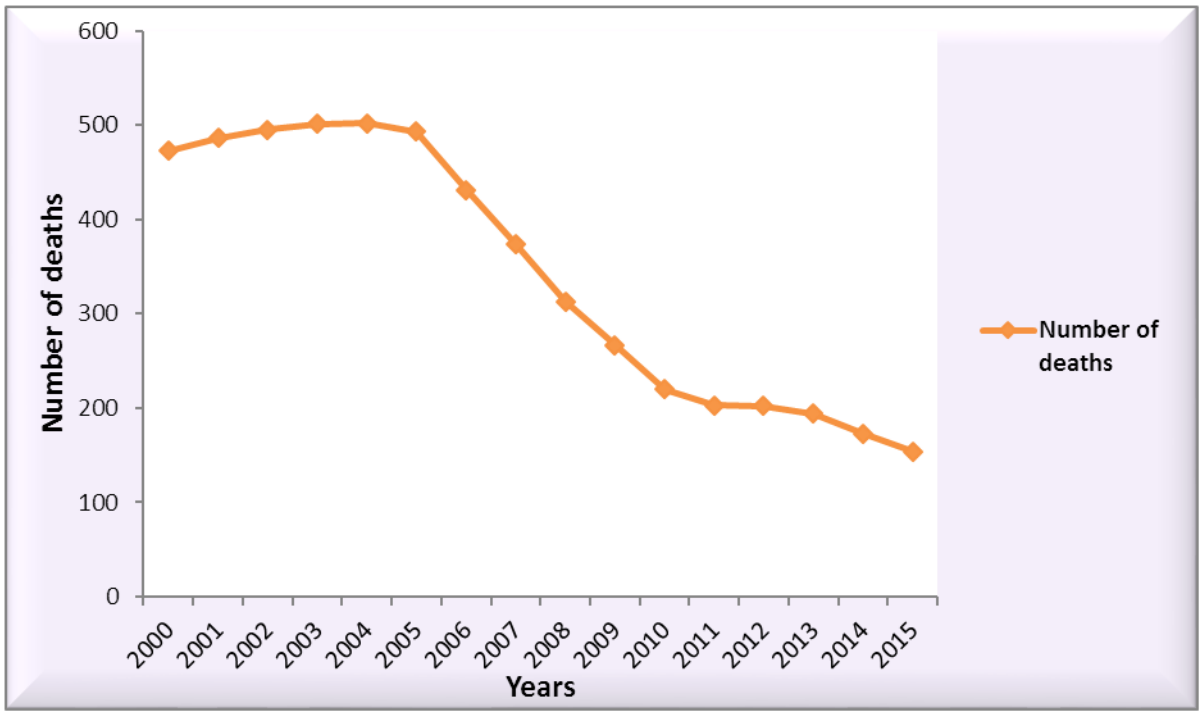
The number of new HIV infections from 2005 shows a downward trend across all age groups (figure 1.2). In this year, 173 new cases are estimated whereby 14% (24) are children less than 15 years. The decline of new HIV cases indicates that HIV prevention and treatment interventions are bearing fruits.

Figure 1.2: Trend of new HIV infection from 2000 – 2015, Zanzibar



Moreover, the number of deaths among PLHIV has decreased tremendously for the last 10 years (figure 1.3). The decline is remarkable from 2005 which reflects the time period when care and treatment program with access to ARVs was established.

Figure 1.3 Total deaths to HIV population from 2000 to 2015 in Zanzibar

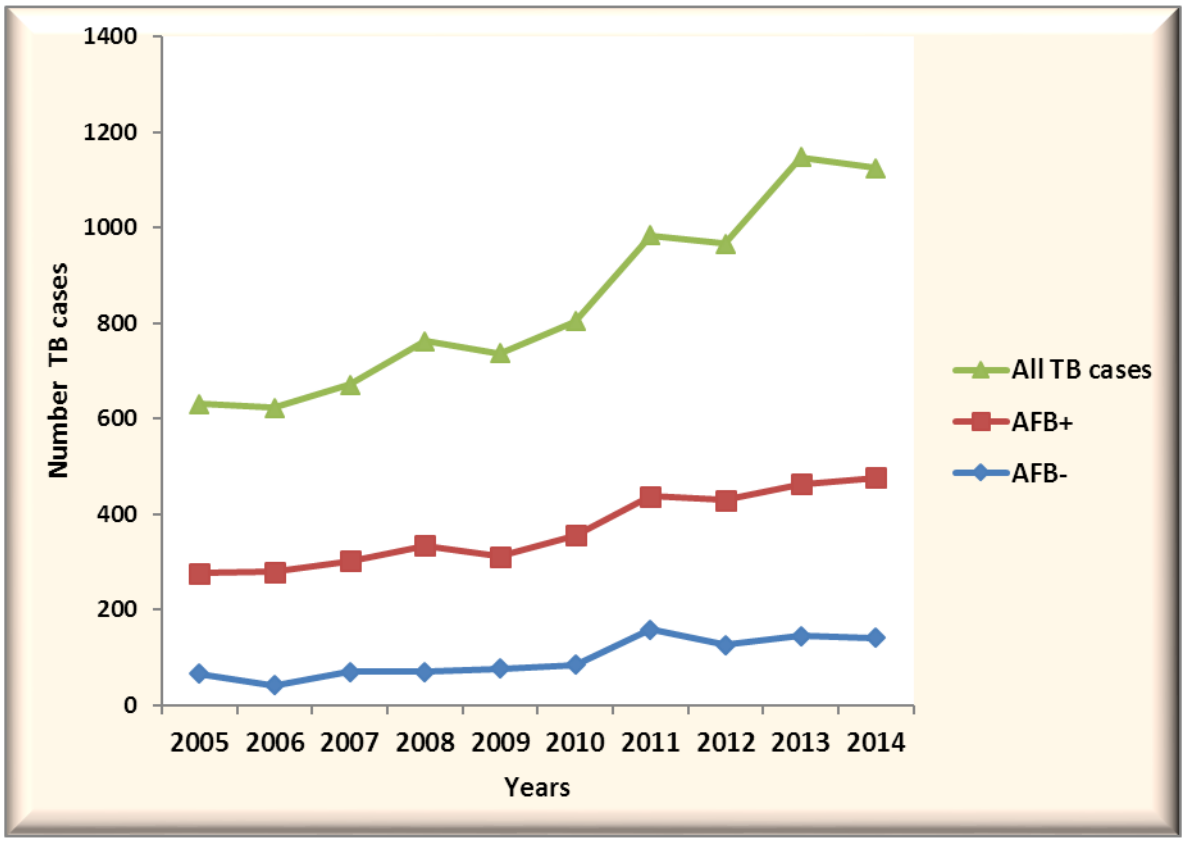


1.2.2 TB situation

Tuberculosis (TB) continues to be among the major public health problems in the country. The number of TB cases notified in Zanzibar has steadily increased from 350 in 2000 to 648 in 2014. The increase in the notification is largest in the group of smear negative and extra-pulmonary (figure 1.4). Considering the age group specific notification, we observe that the group 15-24 and 25-34 years are the most affected groups.

Though the programme has shown an increasing trend in notification of all forms of TB in the past 10 years (figure 1.4), it is still below the estimated number of the existing TB cases. According to TB prevalence survey of 2013, it is estimated that there are 124 TB cases per 100,000 populations which is equivalent to 1,612 cases per year. This indicates that the TB case detection is far below the expected cases.

Figure 1.4: Number of TB cases by smear identification from 2004-2014, Zanzibar



In 2014 a total of 648 patients were diagnosed of whom 617 (95%) were new patients. Out of 617 new patients 335 (54%) were smear positive, 141 (23%) smear negative and 141 (21%) were extra pulmonary TB patients. A total of 22 re-treatment patients registered during 2014, among them 12 (55%) were relapse, 6 (27%) were failure and 4 (18%) were return to control.

MDR-TB cases remain low in Zanzibar. The Drug Resistant Survey (DRS) done in Tanzania in 2007 indicated that the MDR-TB burden in Zanzibar was 1.1% among new cases and 3.9% among retreated cases. The first case of MDR-TB in Zanzibar was diagnosed in 2009 in Pemba. Since then between 1 to 2 MDR-TB patients are diagnosed annually. The introduction of Gene X-pert (MTB/RIF) in early 2014 has resulted in three cases notified in 2014.

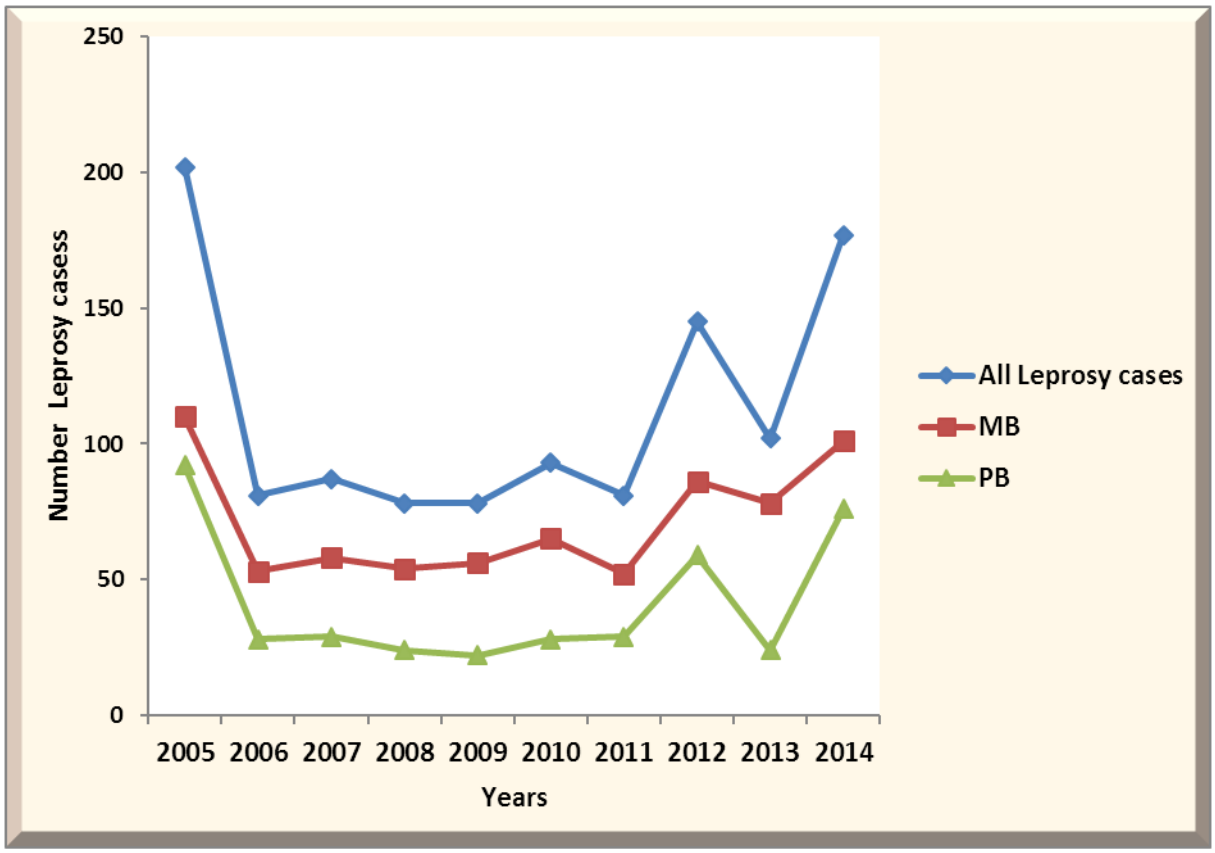
1.2.3 Leprosy situation

The main objective of Leprosy control is prevention of disability from the disease through early detection and treatment of all Leprosy patients. Although Multi Drug Therapy (MDT) results are fairly good in Zanzibar, the number of newly detected Leprosy patients with disabilities has not significantly declined. According to Annual Report of 2014, the total number of Leprosy cases registered was 177, being an increase of 77 cases over 2013. The case detection rate was slightly less than 1 per 100,000 populations.

The trend of registered new Leprosy cases has been fluctuating in the last 10 years (figure 1.5) with prevalence rate of around 1 case per 10,000 populations similar to the WHO

elimination target. Tanzania as a country was declared to have reached the Leprosy elimination targets in 2006. However, Zanzibar still has some districts with high prevalence of Leprosy above WHO targets including South, Central, West and Micheweni administrative districts. Thus, Zanzibar remains a high Leprosy-burden country in the Africa Region.

Figure 1.5: Number of cases by type of Leprosy from 2005-2014 in Zanzibar



1.3 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.

1.4 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, TB and Leprosy services for general and most at risk population.

1.5 The 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.

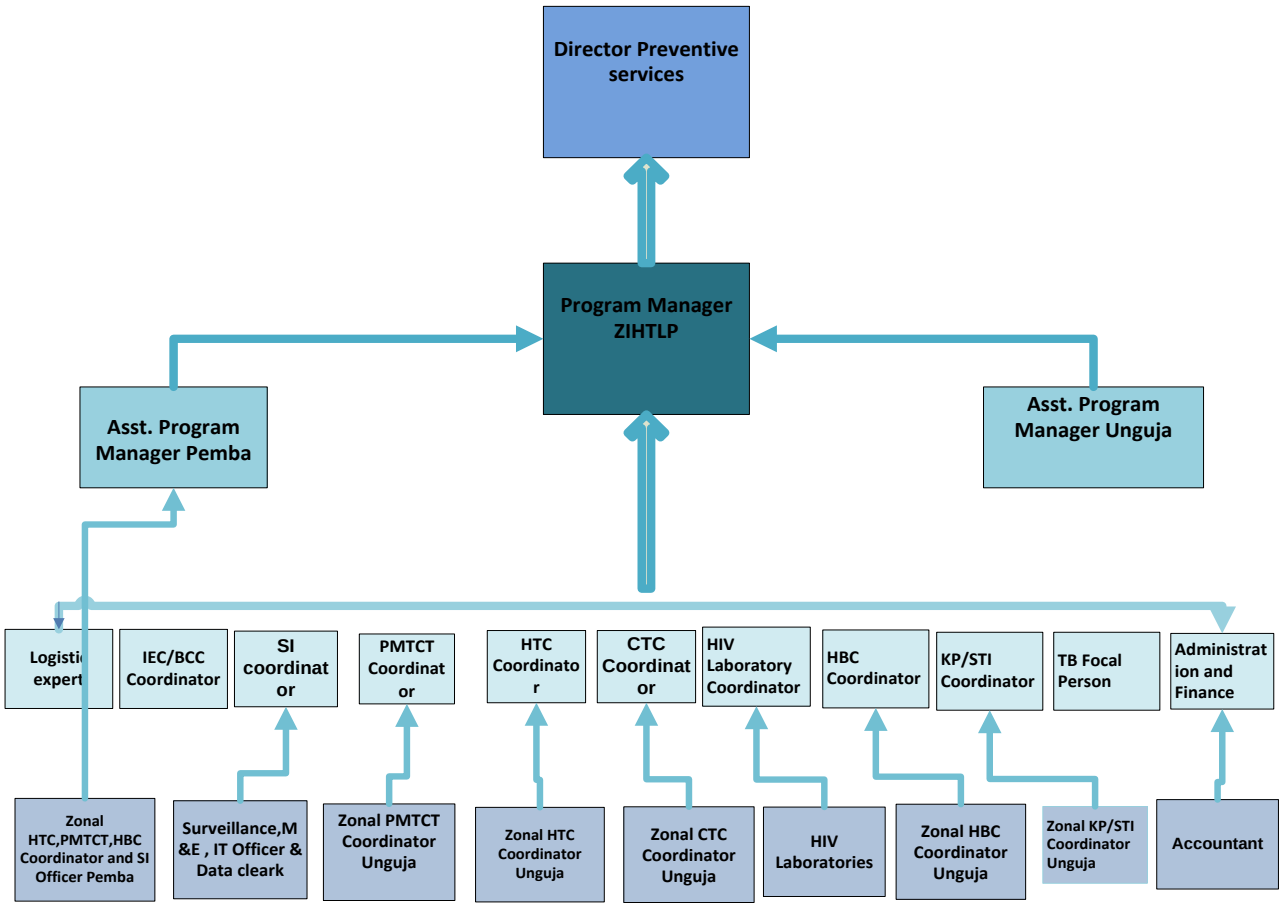
1.6 Program's Core Functions

The ZIHTLP coordinates all activities pertaining HIV, TB and Leprosy control in the country. It is also responsible for advising and guiding the MOH on health issues related to HIV, TB and Leprosy, building capacity of health care workers (HCWs) 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.

1.7 Organizational Structure

This is an area of authority, responsibility and accountability. ZIHTLP contains ten (10) technical units, each unit led by a 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, HIV Care and Treatment, TB and Leprosy, Information Education Communication/Behavioral Change Communication, Key Populations & Sexually Transmitted Infections, Home Based Care, HIV Laboratory, Strategic Information and Program Administration and Finance. The following is the Organizational Chart of the program:

Figure 1.6 Organizational chart of the Zanzibar Integrated HIV, TB and Leprosy Programme



1.8 Implementation status of previous year (2014) recommendations

Recommendation	Implementation status
Financial unit in Pemba should be operationalized and functional	Accountant has been seconded from the Ministry headquarters to the program, financial software has been installed, financial unit staff have been capacitated and the unit has started to be functional
ZIHTLP should operationalize staff performance review based on their performance plan	This is partly implemented; some key program staff have developed and submitted to the management their performance plans. More follow up is needed to ensure performance plans are developed at least by coordinators and review is conducted.
Increase coverage of clients receiving PITC services	One among program strategies is to ensure that all patients/clients attending OPD, IPD and Clinics are tested for HIV through PITC services as a routine due to many positive cases being identified through PITC services. Shortage of HIV test kits and transfer of trained service providers without replacement was experienced during this reporting period, hence this hampered HTS including our ambition to increase number of clients receiving PITC services.
Conduct PITC training for new providers in existing sites to increase provision of services	In 2015 one PITC training was conducted to 30 HCWs from Unguja and Pemba from new and existing sites (Mnazi Mmoja hospital, PHCCs and PHCUs). Although this training took place, it seems not enough to cover all providers who need this kind of training hence, provide quality HTS services.
Strengthen linkage of HTC clients to CTCs	In collaboration with CTC unit, escorted referral was promoted by providing incentives to providers who escorted positive clients to CTC. In addition a report form mechanism of recording clients' unique CTC identity number in HTS register was designed to ensure that all newly identified positive cases successfully referred to CTC are documented.
All diagnosed patients should be attached	Internal collaboration meetings between CTC

with HBC providers and once enrolled in CTC, their HUWANYU number should be entered in CTC1 and CTC2 cards	staff and HBC providers were conducted. Through the meetings a list of CTC patient receiving HBC services was generated and updating of this information (CTC HUWANYU number) in CTC2 data base was done.
ART refilling centers should be established in the districts	In collaboration with respective DHMTs three ARV refilling sites were established. The sites are Muyuni, Mahonda and Uzini health facilities located in South, North B and Central districts, respectively. By the end of 2015 number of patients who were receiving their ARVs from these refilling sites were 14.
Increase sensitization of male involvement in the community	A sensitization meeting was conducted that involved community leaders such as Shehas, religious leaders and members of HIV Shehia committees. Several reasons were shared why male involvement is still low such as cultural reason that men are occupied with multiple activities, that culturally unaccepted for a man to accompany his wife to clinic, always women are considered to be responsible for pregnant so they should take care of the pregnancy and children themselves. Nevertheless, strategic interventions were recommended with close follow up to monitor the changes.
Scale up CTC services in PMTCT sites	Care and Treatment clinics have not been established in PMTCT clinics for various reasons including inadequate human resource and infrastructure. However, staff in some PMTCT sites were trained on basic ART that facilitate provision of ARV to pregnant mothers and monitoring their treatment adherence.
All HIV patients who are TB suspects should be tested for TB using Gene X-pert	Collaboration meeting has been conducted between TB and CTC staff. TB focal person was identified in Unguja CTCs to ensure that sputum samples for PLHIV who are TB suspects were transported to X-pert MTB/RIF site for examination. By the end of 2015, 391 samples from PLHIV were tested by X-pert MTB/RIF whereby 12 people

	found with Tuberculosis.
Formative assessment should be done to determine methods that can be used to estimate number of KPs in Zanzibar	Protocol for conducting formative assessment to determine methods that can be used to conduct next round of IBBSS including size estimation for KPs has been prepared and submitted to ZAMREC and CDC IRB for ethical clearance. Once it is cleared, the formative assessment will be conducted in 2016.
Data verification should be conducted on regular basis so as to ensure quality of data and reports generated	Data verification for HIV, STI, TB and Leprosy has been conducted in 2015 to determine the overall reliability of data collected. However, it was only conducted to selected facilities i.e. 34% (83/245) due to unavailability of adequate funds to conduct data verification in all sites.
Establish mobile health technology for people living with HIV	Mobile health technology has not yet been established. However, technical discussions have been going on with CDC and NACP.

1.9 Structure of the report

The ZIHTLP annual report provides details on the progress of HIV, TB and Leprosy Program for the period of January – December 2015. The report is divided into nine chapters, which provide overview of implementation of program activities and the progress performance of each program unit.

The report used data generated from routine services and reflects services provided through health facilities and community groups. It also covers information collected from different disease surveys/studies and assessment reports. It highlights performance and challenges encountered during the implementation of HIV, TB and Leprosy interventions. It also provides recommendations to overcome the identified challenges.

CHAPTER 2: HIV PREVENTION

2.1 HIV TESTING SERVICES

2.1.1 Background

HIV Testing Services (HTS) were established in Zanzibar in 1988. This unit has the responsibility of coordinating the testing activities through three main approaches:

- Client Initiated Counselling and Testing (CITC)/Voluntary Counselling and Testing (VCT)
- Provider Initiated Testing and Counselling (PITC)
- Mobile HIV Testing and Counselling

The HTS have been established in **98** sites which are located in all **10** districts of Zanzibar. These sites include Government facilities, NGOs, FBOs as well as Private hospitals and clinics; among them, **23** sites provide VCT services alone, **32** provide PITC services alone and **43** provide both PITC and VCT services.

2.1.2 Goal

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

2.1.3 Objectives

1. To promote HIV testing services
2. To improve quality of HIV testing services delivery
3. To increase access of HIV testing services
4. To strengthen HIV testing services

2.1.4 Program Implementation

2.1.4.1 Capacity Building

Following the development of comprehensive HTS guidelines, refresher training on VCT service for counsellors was conducted. A total of **30** counsellors from Unguja and Pemba participated in the training. The objectives were to update VCT providers on new developed comprehensive HTS guideline as well as enhance their capacity on how to deliver HTS comprehensive services. Furthermore, a five days mentorship was conducted to **8** sites (2 PHCCs and 6 PHCUs). The objective of the mentorship was to assist HCWs to improve their working performance in implementing HTS services.

2.1.4.2 Service Monitoring

The HTS unit conducted four supportive supervisions to 98 sites (government facilities, NGOs, Private hospitals and FBOs) which provide VCT and PITC services from both Unguja and Pemba. The objectives of supervision were to monitor the progress of the delivered HTS and support service providers to increase their performance in providing quality care.

Moreover, the HTS unit conducted four feedback meetings (two days each) to **143** HCWs (**98** in Unguja and **45** in Pemba) providing VCT services and **206** HCWs who are providing PITC services (**141** in Unguja and **65** in Pemba). The objectives of these meetings were to give feedback, share experience between HCWs and discuss success and challenges while implementing HTS.

2.1.5 HIV Testing Services indicators and trend from 2013 to 2015

Indicator		Year		
		2013	**2014**	**2015**
1	Number of health facilities and sites offering HTS	**97 HTS sites** **(**43 VCT alone, 27 PITC alone and 27 both VCT and PITC)	**97 HTS sites** (37 VCT alone, 31 PITC alone, and 29 both VCT and PITC)	**98 HTS sites** **(**23 VCT alone, 32 PITC alone and 43 both PITC and VCT)
2	Number of individuals who received testing and counselling services for HIV and received their results	**115,565**	**123,456**	**101,669**
	• Individuals identified as HIV positive	**1,423**	**1,381**	**1,172**

1. Number of sites offering HTS

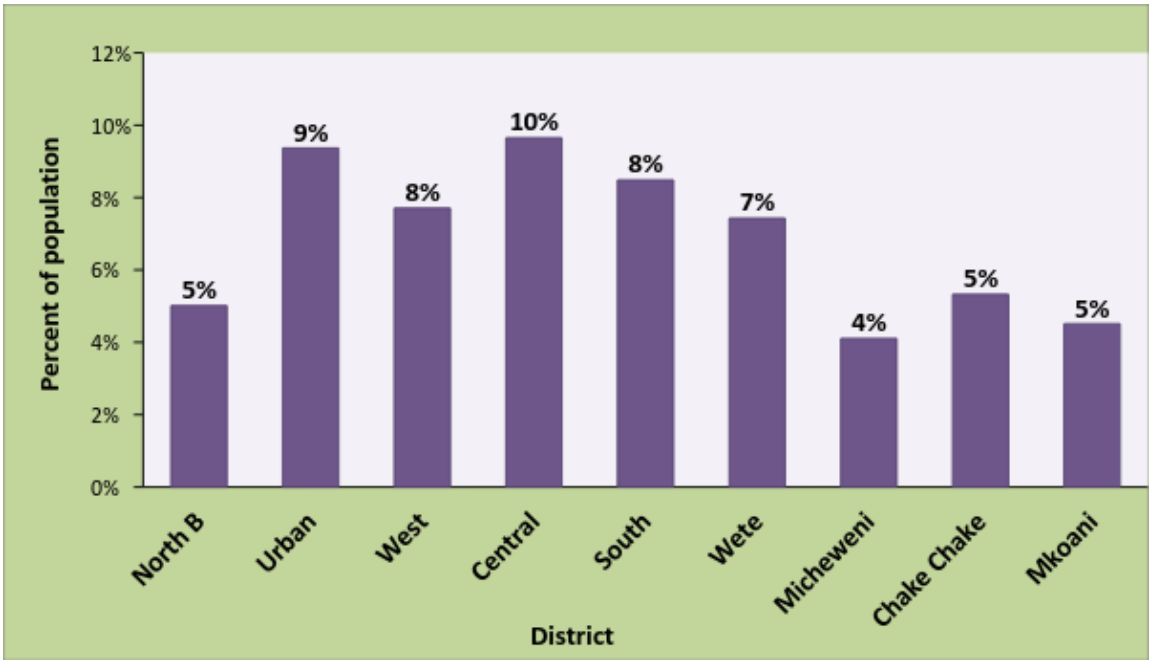
The number of sites that provide both VCT and PITC services has increased from 29 in 2014 to 43 in 2015 due to integration of PITC services in existing VCT sites.

2. Number of individual who received HIV testing services and received their test results

In 2015, a total of 101,669 were counselled and tested for HIV. The number has decreased compared to 123,456 in 2014. This decline was attributed to frequent stock outs of HIV test kits and shortage of trained staff at testing sites.

The proportion of people testing for HIV is noted to be highest in Central district **(10%)** followed by Urban district in Unguja **(9%)** while Micheweni district in Pemba had the least (**4%**) as seen in Figure 2.1.1 below**.**

Figure 2.1.1: Percent of population received HTS by district, Zanzibar, 2015



The overall HIV proportion among tested was 1.2% (1,172/101,669). It was highest in Central district (**1.8%)** and least in Wete district (**0.3%).** Furthermore, it is also higher in Unguja (**1.3%)** as compared to Pemba (**0.5%)**

Table 2.1.1: HIV proportion among tested by district of residence, Zanzibar 2015

District	Number tested for HIV	Number HIV positive	Percent positive
North A	6,400	49	0.8%
North B	4,499	42	0.9%
Urban	23,637	307	1.3%
West	32,321	416	1.3%
Central	7,818	139	1.8%
South	3,533	52	1.5%
Unguja	**78,208**	**1,005**	**1.3%**
Wete	8,334	27	0.3%
Micheweni	4,432	27	0.6%
Chake Chake	5,349	35	0.7%
Mkoani	4,564	17	0.4%
Pemba	**22,679**	**106**	**0.5%**
Outside Zanzibar	**782**	**61**	**7.8%**

Total	**101,669**	**1,172**	**1.2%**

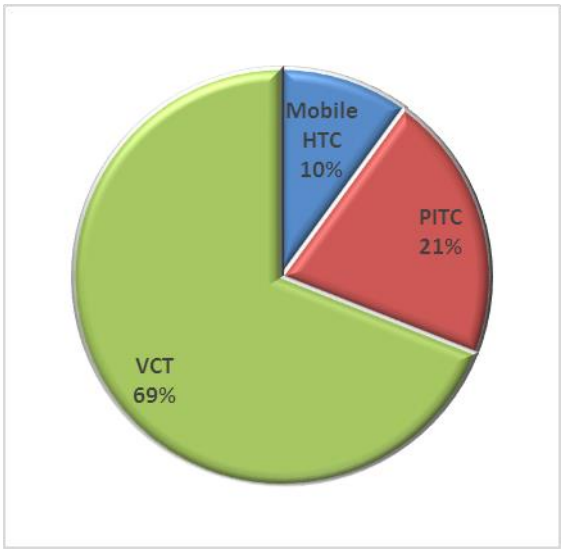
Out of all the **101,669** people tested within Zanzibar, **48,601** (**48%)** were females and **53,068** (**52%**) were males, with HIV proportion being almost two times higher among females (**1.5%)** than males (**0.8%).**

Table 2.1.2: HIV proportion among tested by age groups and sex, Zanzibar, 2015

Age Group (Year)	Female			Male			Total		
	Number tested for HIV	Number HIV positive	Percent positive	Number tested for HIV	Number HIV positive	Percent positive	Number tested for HIV	Number HIV positive	Percent positive
0-4	1,606	15	0.9%	1,773	12	0.7%	3,379	27	0.8%
5-14	894	7	0.8%	817	8	1.0%	1,711	15	0.9%
15-24	21,223	141	0.7%	13,805	29	0.2%	35,028	170	0.5%
25-34	16,163	306	1.9%	22,359	128	0.6%	38,522	434	1.1%
35-44	5,663	178	3.1%	8,881	127	1.4%	14,544	305	2.1%
45+	3,052	105	3.4%	5,433	116	2.1%	8,485	221	2.6%
Total	**48,601**	**752**	**1.5%**	**53,068**	**420**	**0.8%**	**101,669**	**1,172**	**1.2%**

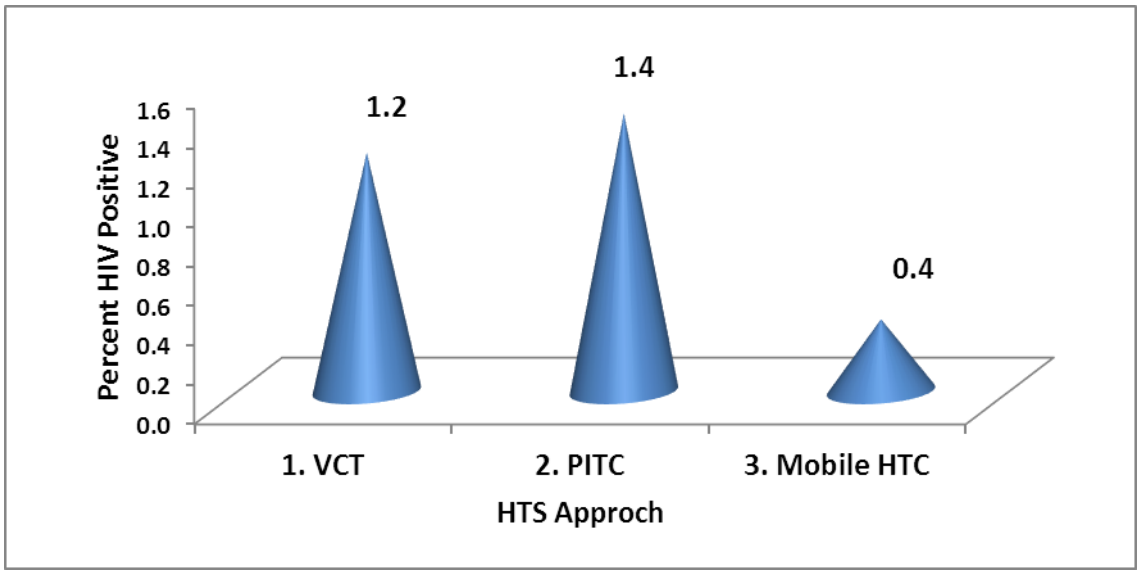
Among people tested for HIV, **69%** were reached through VCT approach, **21%** were reached through PITC approach and the remaining **10%** were reached through Mobile HTS.

Figure 2.1.2: HIV testing by HTS approach, Zanzibar, 2015



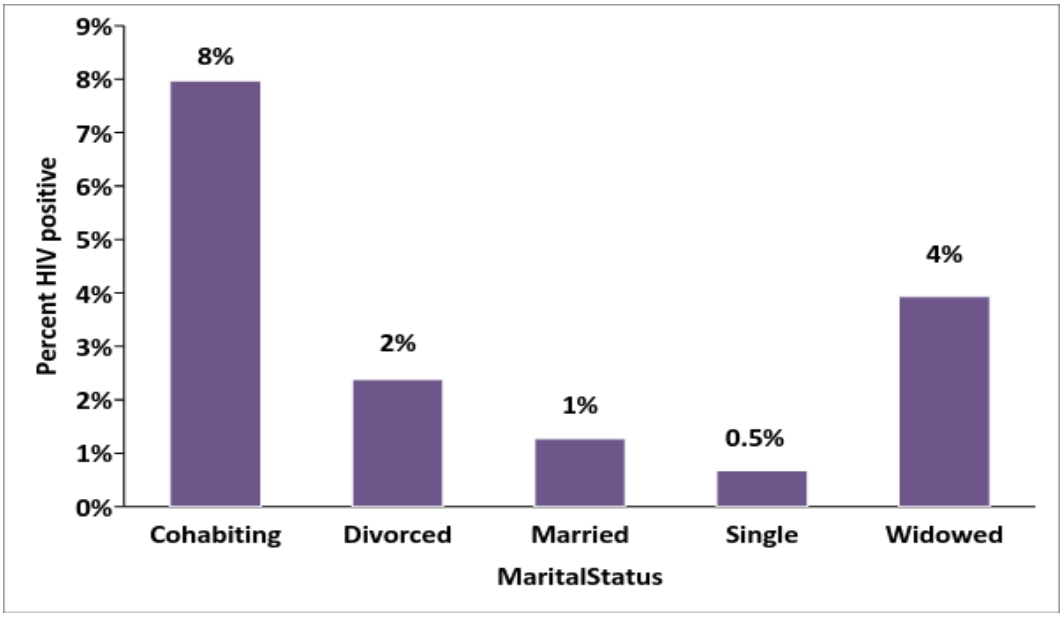
However, HIV proportion among those tested through PITC was higher (**1.4%**) than those who were tested through VCT **(1.2%).**

Figure 2.1.3: HIV proportion among tested by HTS approach, Zanzibar, 2015



HIV positivity among tested was highest for those who were cohabiting (**8%**) followed by those widowed (**4%**). The singles had the lowest positive results among the tested.

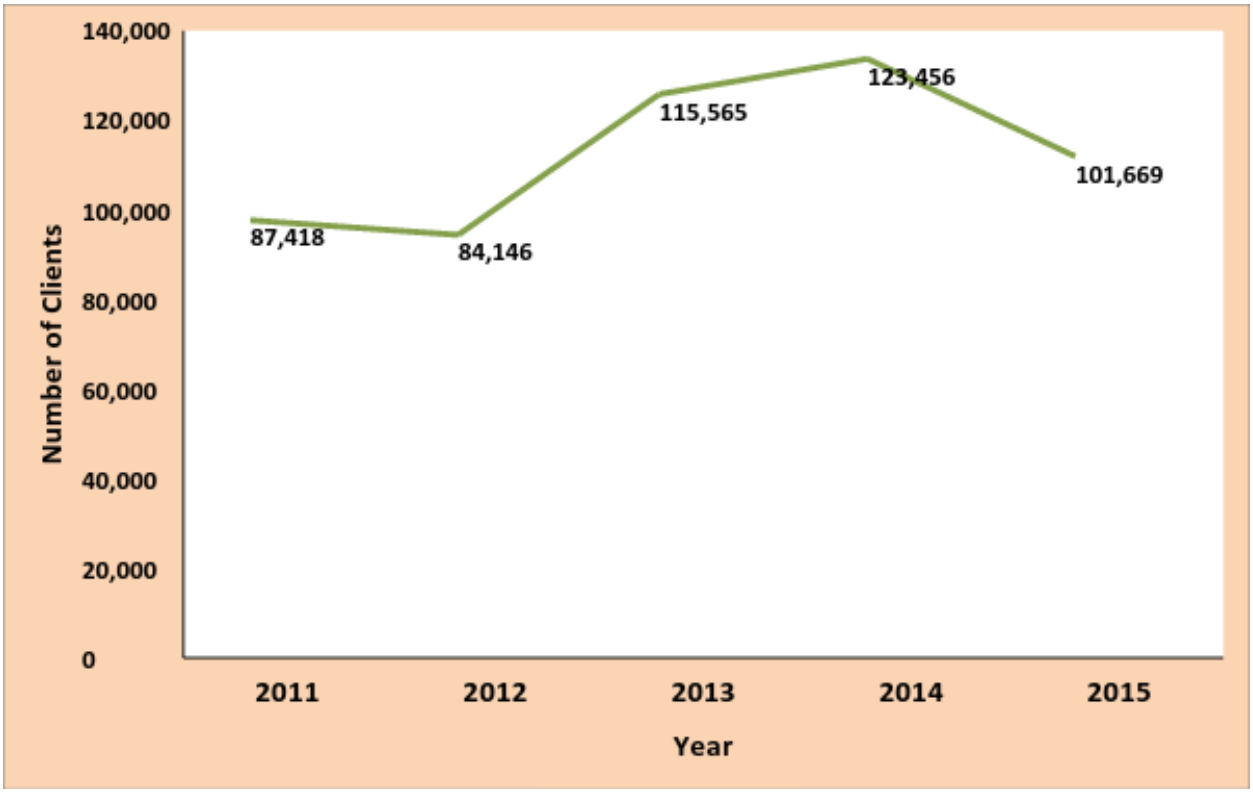
Figure 2.1.4: HIV proportion among tested by Marital Status, Zanzibar, 2015



2.1.6 Trend of number of individuals who received HIV testing services and received their results from 2011 to 2015

The number of individuals who tested for HIV has increased progressively from 2012 (**84,146**) to 2014 (**123,456**). However, there was a decrease in number people tested in 2015 (**101,699**) this was due to frequent stock out of HIV test kits.

Figure 2.1.5: Number of individuals who received HIV testing services and received their results, Zanzibar, 2011 – 2015



2.1.7 Challenges

- Transfer of trained service providers without replacement at VCT and PITC sites that hinder progress of HTS services
- Frequent stock outs of HIV test kits
- Low uptake of PITC services especially in children

2.2 PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV (PMTCT) SERVICES

2.2.1 Background

PMTCT services were first established in Zanzibar in 2005. To date the services exist in 159 sites which are located in all the ten districts of Zanzibar. After adaptation of Option B+, the goal of PMTCT program has changed from prevention of vertical transmission of HIV, to elimination of HIV transmission from mother to child and improving care for infected partners and their children.

2.2.2 Goal

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

2.2.3 Objectives

1. To reduce the transmission of HIV from a mother to her children during pregnancy, birth, and/or breast-feeding and ensure enrolment to care and treatment for the mother and HIV infected baby
2. To improve child survival among HIV exposed and infected children
3. To increase utilization of PMTCT services by couple (pregnant women and their partners)
4. To increase the percentage of HIV-positive pregnant/lactating women who receive anti-retroviral (ARVs)

2.2.4 Program Implementation

2.2.4.1 Capacity building

PMTCT Unit conducted two new PMTCT trainings for **70** providers from Pemba. The objective of the training was to build capacity of health care workers (HCWs) to provide quality PMTCT services to their clients. In addition Early Infant Diagnosis (EID) training was conducted for **77** HCWS (40 from Unguja and 37 Pemba). The objective of the training was to impart participants with knowledge and skills on EID and its interventions.

2.2.4.2 Service monitoring

During this year, 6 PMTCT supportive supervisions were conducted jointly with District Health Management Teams (DHMT) to **85** out of **159** sites implementing PMTCT Option B+ (**24** sites Pemba and **61** Unguja). The aim was to build their capacity and improve quality of services provision. Following supportive supervision five feedback meetings (1 Pemba and 4 Unguja) were conducted, the aim was to share findings, best practices, challenges and bottleneck towards improving provision of PMTCT services.

Follow up of HIV positive mothers and their infants was conducted in order to improve retention of identified HIV positive pregnant women, total of **74** PMTCT sites were visited. In this follow up, 50 mothers who were lost to follow up were returned back to services and

continued with the treatment. During the same visit **32** children were returned back for follow up and EID services.

Coordination meeting with PMTCT, CTC, HBC service providers and ZAPHA+ was conducted in Unguja. A total of **42** participants **35** from Unguja and **7** from Pemba participated in the meeting. The aim was to discuss identified issues, challenges and find the solution for the identified gaps focus to retain HIV positive pregnant mothers and their infants in care.

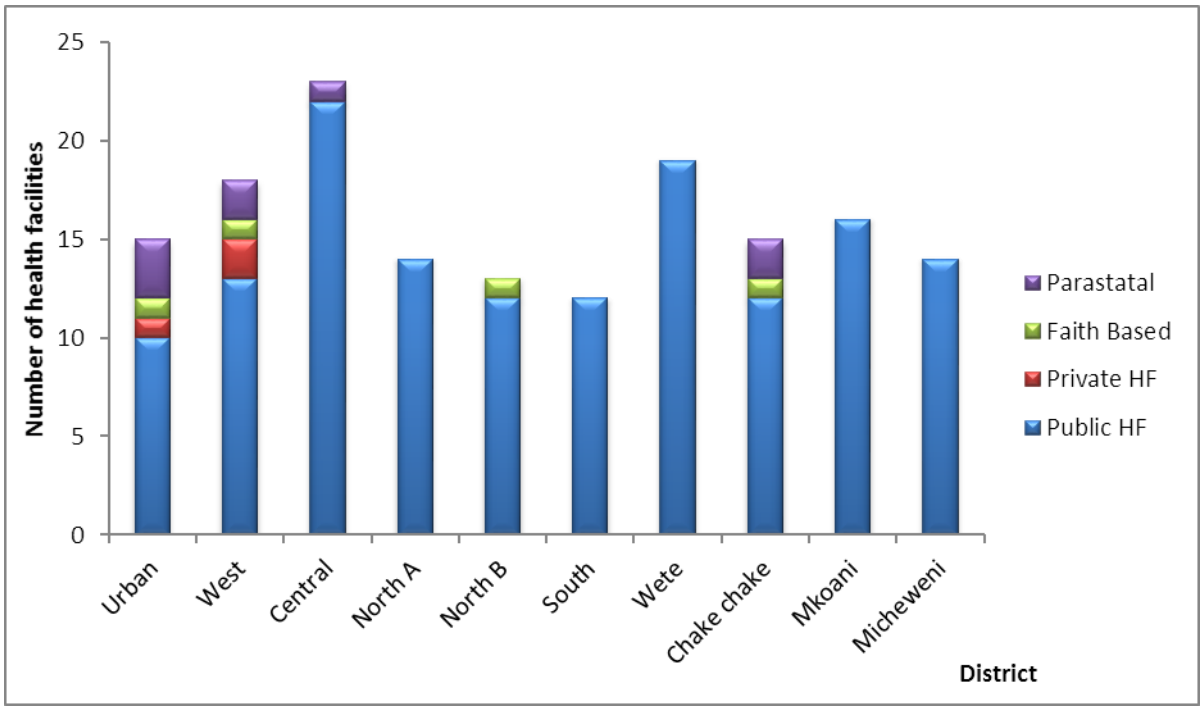
2.2.5 PMTCT services indicators and trend from 2013 to 2015

	Indicators	Year		
		2013	2014	2015
		n/N (%)	n/N (%)	n/N (%)
1	Number of health facilities providing RCH services that also provide both HIV testing and counselling and ARVs for PMTCT on the site	153/156 (98%)	156/164 (95%)	159/164 (97%)
2	Number and percent of pregnant women who were tested for HIV and know their results	56,343/58,661 (96%)	60,132/60,132 (100%)	31,536/64,085 (49%)
3	Number and percent of known positive pregnant women	347/352 (98%)	359/361 (99%)	230/385 (59.7%)
4	Percent of HIV positive pregnant women who receive ARVs to reduce the risk of mother to-child transmission of HIV	248/352 (70.5%)	287/361 (80%)	200/385 (51.9%)
5	Percent of HIV positive pregnant women delivering in health facilities	231/352 (66%)	291/361 (81%)	232/385 (60.2%)
6	Percent of male partners of pregnant women who are tested for HIV in last 12 months	1,804/58,661 (3%)	1,643/60,132 (3%)	1,059/64,085 (1.6%)
7	Percent of infants born to HIV positive pregnant women who are started on Cotrimoxazole within two months of birth	195/347 (56%)	194/359 (54%)	180/230 (78.2%)
8	Percent of infants born to HIV positive mothers who receive HIV antigen test (DNA PCR) within 2 months of birth	252/347 (73%)	270/359 (75%)	180/230 (78.2%)
9	Percent of HIV positive infants started on ART	15/18 (83.3)	9/7 (128%)	9/6 (150%)

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

Health facilities providing RCH services with HIV testing, counselling and ARVs for PMTCT has increased from 156 in 2014 to 159 in 2015. Among the facilities providing PMTCT services, 95 (60%) health facilities are in Unguja and 64 (40%) are in Pemba. These services are provided in different types of health facilities including public, private, parastatal and faith based health facilities. Majority (90%, n=144) of health facilities providing PMTCT services are public health facilities, 5% (n=8) are parastatal health facilities mostly military health facilities, 3% (n=4) are faith based health facilities and 2% (n=3) are private health facilities. **Appendix I** shows the list of health facilities by district and the figure below illustrates the number of health facilities by district. Central district represent highest number of health facilities and South district has lowest number of health facilities with PMTCT services.

Figure 2.2.1: Health facilities providing PMTCT services by district, Zanzibar, 2015

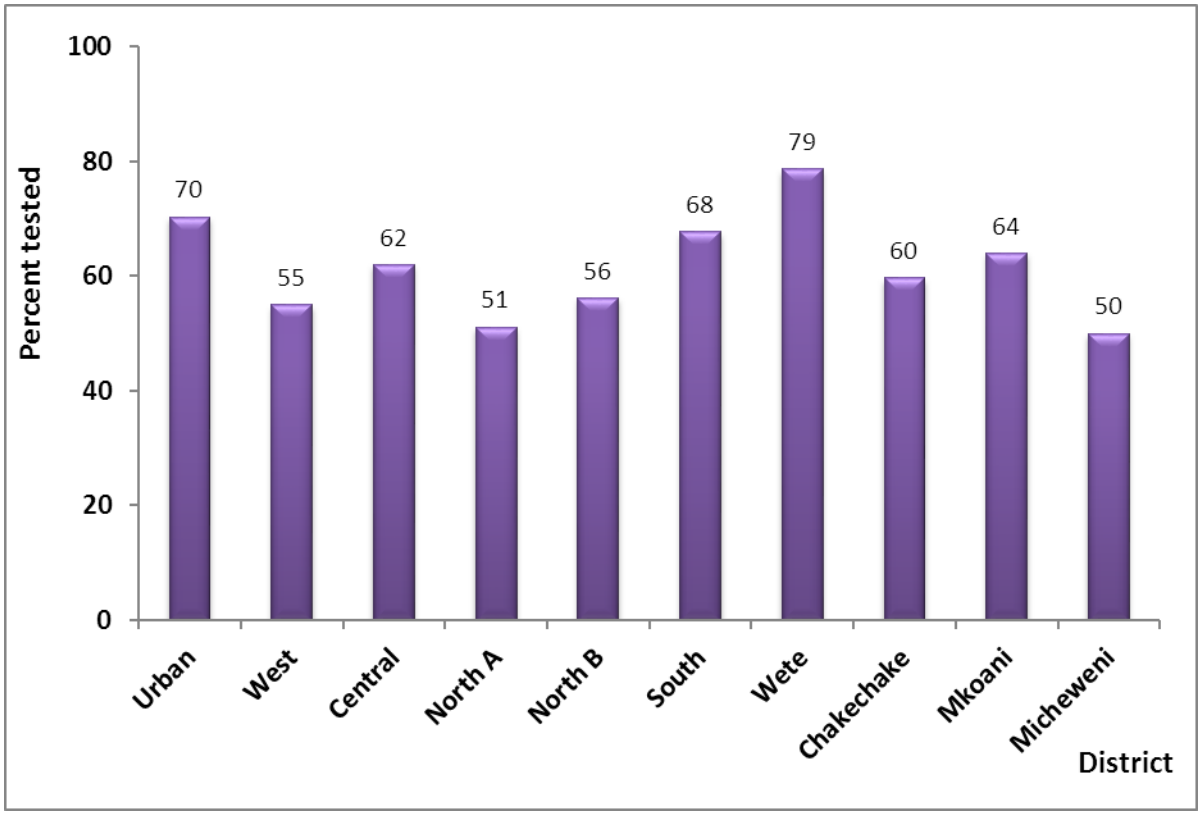


2. Number and percent of pregnant women who tested for HIV and know their results

In 2015, HIV testing has decreased compared to the number of pregnant women tested under PMTCT in previous years. Results showed downward trend from 100% (60,132/60,132) in 2014 dropped to 49% (31,536/64,085) in 2015. These have been attributed by shortage of staff as well as shortage of HIV test kits countrywide and change of HIV testing algorithm at the last quarter of this reporting year. This change was not part of the plan for this year and its implementation required building skills to HCWs on HIV testing algorithm using SD Bioline. By district, Wete had the highest percent (78%) ANC clients tested for HIV while Micheweni

had the least (50%) of ANC clients tested for HIV in the year 2015. Figure 2.2.2 below illustrate the percentage of ANC clients tested for HIV by district.

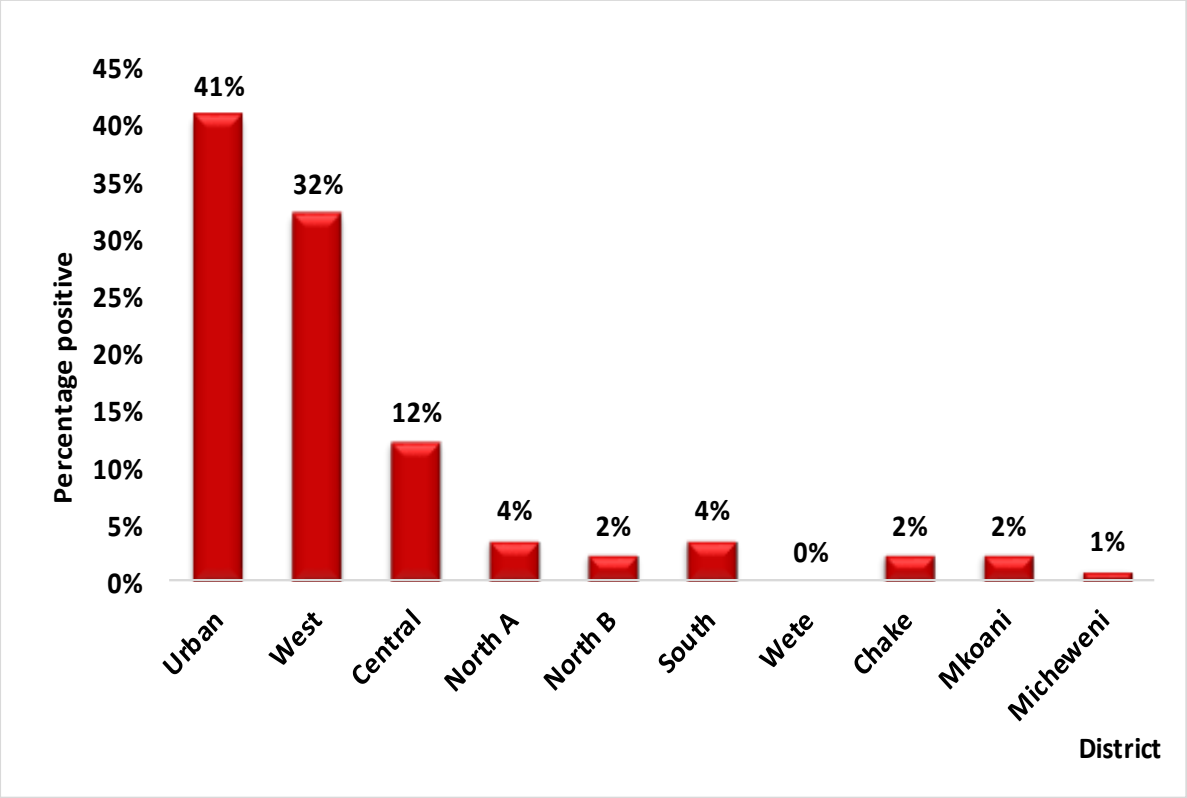
Figure 2.2.2: Proportion of ANC Clients tested for HIV by District, Zanzibar, 2015



3. Number and percent of known positive pregnant women

The proportion of known positive pregnant women has decreased from 99% (359/361) in 2014 to 59.7% (230/385) in 2015. The decreased proportion might be due to unavailability of HIV testing services and shortage of staff. Among the known positive pregnant women, 60% (140/230) were previously known and 40% were newly tested positive at ANC. Ninety five percent (95%) of all identified positive pregnant women were from Unguja, where Urban district reported 41% of the cases followed by West District 32%. Wete district reported no case during this reporting year as shown in the figure below.

Figure 2.2.3: Percentage of known HIV positive pregnant women identified by district, Zanzibar, 2015



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 out of estimated HIV positive pregnant women has decreased from 80% (287/361) in 2014 to 52% (200/385) in 2015. However out of all identified HIV positive pregnant women in 2015, 87% (200/230) were started on ART.

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

Proportion of HIV positive pregnant women delivering in health facilities out of estimated HIV positive pregnant women decreased from 81% (291/361) in 2014 to 60% (232/385) in 2015. Among contributing to this are self-stigma and low awareness of importance of delivering at hospital among HIV positive pregnant women.

6. Percent of male partners of pregnant women who are tested for HIV in last 12 months

There is decrease of male involvement in PMTCT services from 2.7% (1,643/60,132) in 2014 to 1.6% (1,059/64,085) in 2015. This may be contributed by culture; men are too much occupied with daily activities and women should take care of their pregnancies and children, and unconducive environment of RCH clinics. Hence, male user friendly RCH/PMTCT services need to be scaled up so as to allow more men to utilise services effectively.

7. Percent of infants born to HIV positive pregnant women who started on Cotrimoxazole prophylaxis within two months of birth

The proportion of exposed infants started on Cotrimoxazole prophylaxis within the first 2 months of birth increased from 54% (194/359) in 2014 to 77.5% (180 /232) in 2015.This was due to sensitization done during coordination meetings, feedback meetings and close follow up to assist HCWs on proper filling of registers and availability of the drug.

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 increased from 75% (252/359) in 2014 to 78.2% (180/230) in 2015. Among the infants tested, 48% were female. None of the infant tested within two months of birth was HIV positive. The following table shows the number of infants tested for HIV by DNA PCR machine within two months of birth by quarter and sex.

Table 2.2.1: Number of infants tested for HIV by DNA PCR machine within two months of birth by sex and quarter, Zanzibar, 2015

Quarter	Female	Male	Total
January – March	21	28	**49**
April – June	24	30	**54**
July – September	18	20	**38**
October – December	21	18	**39**
Total	**84**	**96**	**180**

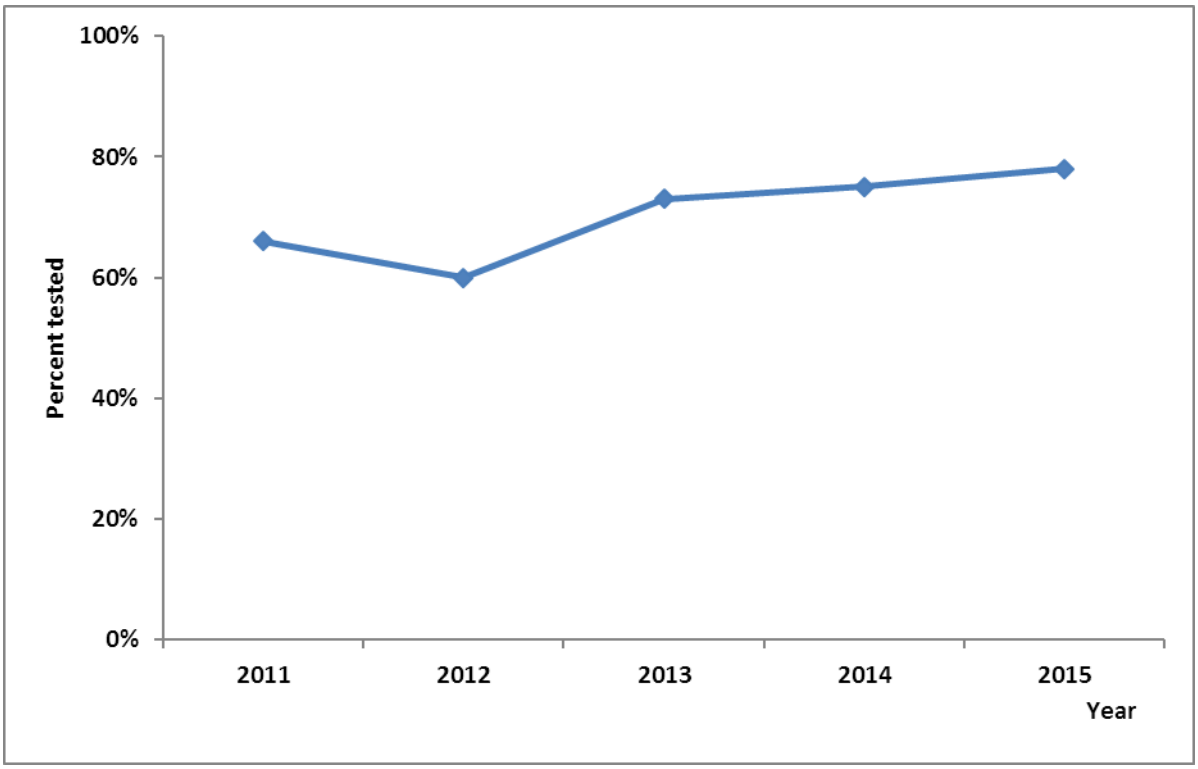
9. Percent of HIV positive infants started on ART

The percentage of infants enrolled on ART has increased from 128.5% (9/7) in 2014 to 150% (9/6) 2015. The high percentage of infants started on ART of more than 100% may be contributed by the infants diagnosed last year but were started on ART in 2015.

2.2.6 Trend of HIV exposed infants testing by HIV DNA PCR from 2011 to 2015

The figure 2.2.4 below shows trend of proportion of infants born to HIV positive mothers who receive first HIV antigen test (DNA PCR) within 2 months of birth. The proportion of children tested increased gradually from 60% in 2012 to 73% in 2013 to 78% in 2015. This increase was attributed to sensitization of HCWs and mothers on importance of early infant diagnosis, close follow up of lost mothers and infants, and regular supportive supervision and mentorship.

Figure 2.2.4: Percent of infants born to HIV positive mothers who receive HIV antigen test (DNA PCR) within 2 months of birth, Zanzibar, 2011-2015



2.2.7 Challenges

- Shortage of HIV test kits
- Shortage of staff at PMTCT sites
- Low number of pregnant women received ART
- Low male involvement in RCH/PMTCT services

2.3 KEY POPULATIONS SERVICES

2.3.1 Background

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

HIV related interventions for KPs started in 2003, whereby peer educators were involved in conducting home visit activities at community level to identify other KPs, provide HIV/STIs prevention education, distribute condoms as well as to refer identified HIV-positive clients to care and treatment and other related clinics.

To date there are three KPs-friendly service centers situated at Mnazi Mmoja Hospital, ZAYEDESA and Methadone Assisted Treatment (MAT) clinic at Kidongo Chekundu-Unguja. Currently, there is one National and various local NGOs, which in collaboration with other KPs stakeholders, continue to implement KPs intervention in Zanzibar.

2.3.2 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.

2.3.3 Objectives

1. To expand access and improve quality of HIV services for KPs.

2. To enhance staff capacity on KP interventions.

2.3.4 Programme Implementation

2.3.4.1 Capacity building

The KPs unit conducted five days training on Methadone Assisted Treatment (MAT) to **40** health care workers (HCWs) in Unguja. The aim of the training was to raise awareness and build capacity of HCWs on provision of quality MAT services to eligible clients.

2.3.4.2 Service monitoring

KPs unit conducted supportive supervision to NGOs and other health facilities that provide KPs services in Pemba. The main objective was to assess quality of HIV related services provided to KPs as well as to enable service providers to improve quality of services. In addition, the unit conducted one day KPs stakeholders' meeting, which involved **28** participants (25 in Unguja and 3 from Pemba). The aim of this meeting was to strengthen coordination and feedback mechanism among key implementers so as to improve the quality of KPs services.

The unit also conducted a five days (three days in Unguja and two in Pemba) sensitization meeting on MAT services to **90** (60 from Unguja and 30 from Pemba) key community leaders. During this year, the unit continued to provide user-friendly health services for KPs, whereby a total of **29** clients (10 KPs and 19 others) attended and received STIs services at Mnazi Mmoja Hospital and ZAYEDESA.

2.3.5 KP services indicators and trend from 2013 to 2015

	Indicators	Year		
		2013	2014	2015
1	**Number and percentage of MARPs (KPs) who received an HIV test in the past 12 months and who know their results**	**969**	**1,427**	**1,895**
	a) MSM	**121**	**146**	**153**
	b) SWs	**360**	**941**	**1,323**
	c) PWID	**488**	**340**	**419**
2	**Number of people who inject drugs on MAT**	**-**	**-**	**159**

1. Number and percent of MARPs (KPs) who received an HIV test in the past 12 months and who know their results

Number of KPs who received an HIV test in the past 12 months and who know their results has increased from 1,427 in 2014 to 1,895 in 2015; this was due to increased number of NGOs that implement KPs interventions in Zanzibar.

Table 2.3.1 indicates that there is significant difference in HIV positivity between KPs who tested through outreach services, compared to those who tested through VCT sites (0.04% and 0.17% respectively). It is possible that some of the clients who tested through outreach services might not be KPs.

Table 2.3.1:KPs who received HIV testing services by type of testing site, Zanzibar,2015

KPs category	Outreach services			VCT clinics		
	Tested	Positive	Percent	Tested	Positive	Percent
IDU	136	2	1%	283	29	10%
MSM	65	1	2%	88	3	3%
CSW	763	10	1%	560	23	4%
Total	**964**	**13**	**0.04**	**931**	**55**	**0.17**

2. Number of people who inject drugs on MAT

Comprehensive MAT services for heroin users in Zanzibar were established in February 2015. From February to December 2015, a total of 174 (84% of the year one target) clients were enrolled at MAT clinic in Unguja of whom 83% were male. As of December 2015, number of clients who had been on MAT for six months and above are 159 (91%), as indicated in table 2.3.2 below. Furthermore, it is noted that **36/159** (23%) of them are HIV positive clients and continued receiving HIV care and treatment services at different CTC sites in Unguja.

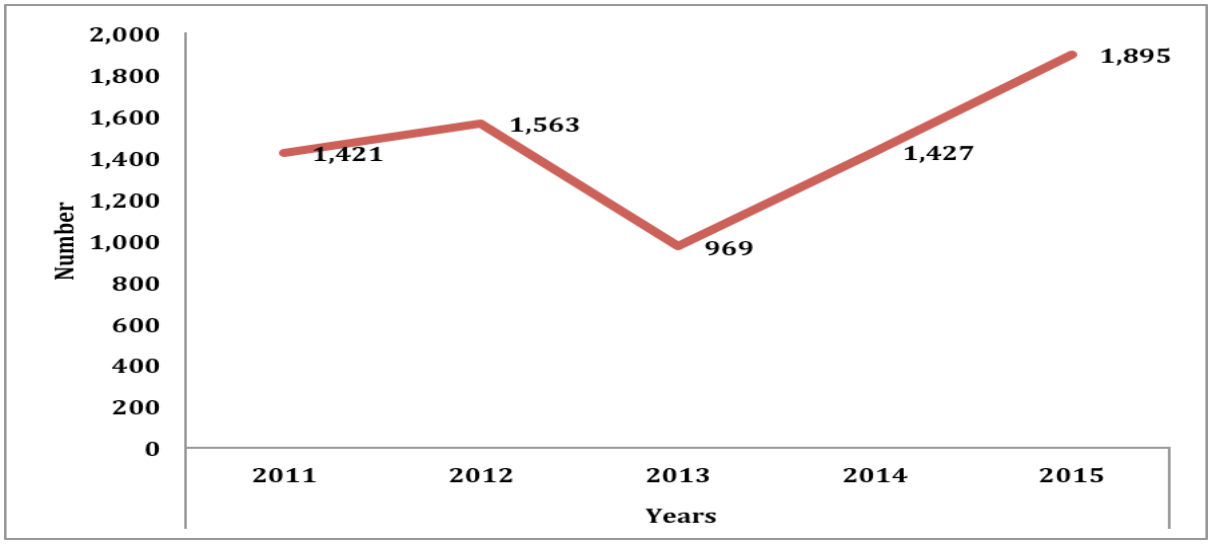
Table 2.3.2: Number of heroin users who were enrolled and received MAT services at Kidongo Chekundu MAT clinic in Unguja, Zanzibar, 2015

ITEM	MALE	FEMALE	TOTAL
Clients enrolled	144	30	**174**
Defaulters	8	4	**12**
Death	3	0	**3**
Current on MAT (≥ 6 months)	133	26	**159**
HIV positive	26	10	**36**
On ARVs	26	10	**36**
TB Suspect	20	6	**26**
Viral Hepatitis C positive	30	6	**36**
Viral Hepatitis B positive	18	5	**23**

2.3.6 Trend of HIV testing services among KPs from 2011 to 2015

There was an increase in number of KPs who received HIV testing services from 1,421 in 2011 to 1,563 in 2012, from 969 in 2013 to 1,427 in 2014 and from 1,427 in 2014 to 1,895 in 2015. Unfortunately there was a decline in number of KPs who received HTC services from 1,563 in 2012 to 969 in 2013 as indicated in figure number 2.3.1 below. This decline in number of KPs tested for HIV was due to low number of outreach interventions conducted by NGOs and inadequate financial support to some NGOs working with KPs.

Figure 2.3.1: Trend of HIV testing services among KPs from 2011 – 2015, Zanzibar



2.3.7 Challenges

- Low enrolment of MAT clients at MAT clinic
- Inadequate MAT supplies and reagents
- Lack of Viral Hepatitis reagents for screening and vaccination for Viral Hepatitis B
- Low turn up of KPs to attend KPs friendly clinics

2.4 SEXUALLY TRANSMITTED INFECTIONS SERVICES

2.4.1 Background

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

Early and appropriate treatment of STIs/RTIs is an important public health measure hence 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. Condom programming including promotion and distribution is another cornerstone of prevention of HIV and other STIs. STIs/RTIs services are provided in all **231** (**148** in Unguja and **83** in Pemba) health facilities in Zanzibar.

2.4.2 Goal

The goal of STIs/RTI services is to reduce new HIV and STIs and to provide care and treatment to all people in Zanzibar.

2.4.3 Objectives

i. To improve STIs services

ii. To reduce new sexually transmitted infections among Zanzibaris

2.4.4 Programme Implementation

2.4.4.1 Service monitoring

As of December 2015, the unit has managed to distribute a total of **16,214** pieces (**15,860** male and **354** female) condoms through various condom outlets as indicated in the table 2.4.1 below**.**

Table 2.4.1: Number of condoms distributed by different outlets, Zanzibar, 2015

Site /Facility	Number of condoms distributed		Total
	Male	Female	
Health Facility	8,948	354	9,302
NGOs	4,032	0	4,032
Army Force	2,880	0	2,880
Total	**15,860**	**354**	**16,214**

2.4.5 STI services indicators and trend from 2013 to 2015

	Indicators	Year		
		2013	2014	2015
1	Number of health facilities providing STIs care and treatment with staff trained in STIs care and treatment	85	85	85
2	Number of women and men with an STI presenting at health facilities who are diagnosed according to the national guidelines	9,596	8,862	9,063
3	Percentage of sexual partners of an individual with an STI treated at health facilities whose sexual partners are notified of their infections	10.7% (1,029/9,589)	9.8% (868/8,862)	11.5% (1,043/9,087)
4	Number of male condoms distributed	122,382	88,502	15,860

1. **Number of health facilities providing STIs/RTI care and treatment with staff trained in STIs care and treatment**

Number of health facilities that provide STI services with trained staff remained the same **(85)** for the past three years as indicated in table above. This is because there was no STI training conducted since 2013 due to the lack of funds.

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

In the year 2015 a total of **9,063** patients were diagnosed with STI. Among them, **1,932 (22.3%)** were males and **8,155 (89.7%)** were females. However, compared to 2014 data, there was slight increase in STI cases diagnosed (**8,862** in 2014 to **9,063** in 2015). This increase was due to the availability of STI drugs distributed in some of health facilities in quarter two of this year.

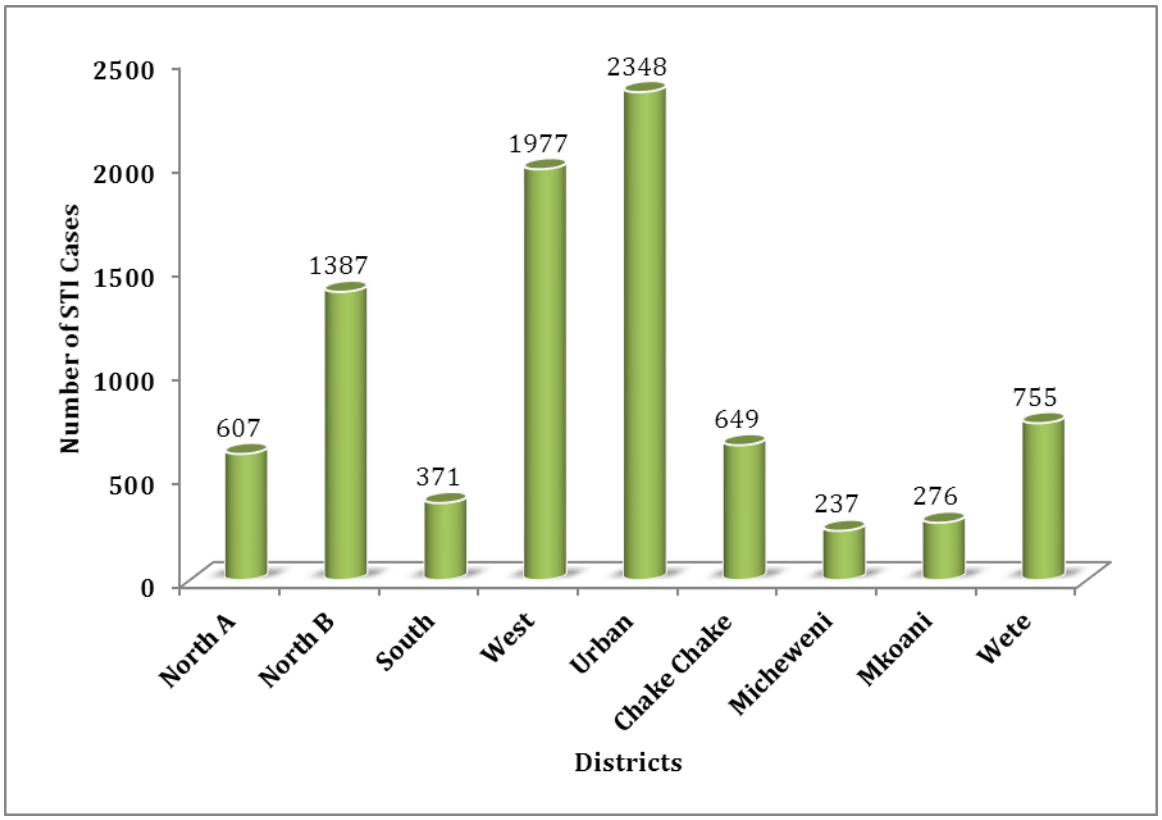
It is noted that the most diagnosed STI in 2015 was Vaginal Discharge Syndrome **(50%)** followed by Lower Abdominal Pain (**22**%) as indicated in table 2.4.2 below.

Table 2.4.2: Number of STI cases diagnosed by age and gender, Zanzibar 2015

Diagnosis	Age (years) & Gender						Total
	Male			Female			
	<15	15-24	25+	<15	15-24	25+	
Genital Ulcer	1	39	53	1	68	98	**260**
Inguinal Bubos	2	2	2	1	4	9	**20**
Lower Abdominal Pain				57	734	1,302	**2,093**
Vaginal Discharge				66	1,730	2,709	**4,505**
Urethral Discharge	10	362	1,117				**1,489**
Painful Scrotal Swelling	11	66	130				**207**
Neonatal Conjunctivitis (0-28 days)	2						**2**
Total Syndromic Diagnosis	**26**	**469**	**1,302**	**125**	**2,536**	**4,118**	**8,576**
Candidiasis	0	5	4	4	51	92	**156**
Chlamydia	0	1	6	1	12	14	**34**
Trichomonas Vaginalis	0	2	7	0	29	54	**92**
Gonorrhoea	1	29	61	4	21	56	**172**
Syphilis	0	3	8	0	9	12	**32**
Hepatitis B	0	0	0	1	0	0	**1**
Hepatitis C	0	0	0	0	0	0	**0**
Total Aetiologic Diagnosis	**1**	**40**	**86**	**10**	**122**	**228**	**487**
Total Syndromic & Aetiologic Diagnosis	**28**	**509**	**1,395**	**138**	**2,661**	**4,356**	**9,063**

Urban district was observed to report highest number of STI cases **2,350** (**25.9**%), followed by West and Central districts with **1,985** (**21.9**%) and **1,401** (**15.5**%) respectively; whereas South Unguja, Mkoani and Micheweni districts were observed to have few cases **371** (**4.1**%), **276** (**3.0**%), and **237** (**2.6**%) respectively as indicated in figure 2.4.1 below.

Figure 2.4.1: Number of STI/RTI cases by District, Zanzibar, 2015



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

Number of index cases whose sexual partners are notified of their infections has been increased from **868 (9.8%)** in 2014 to **1,043 (11.5%)** in 2015. However, the proportion of notified partners has not even reached half of index patients' number. This increase was due to the availability of STI drugs distributed in some of health facilities in quarter two in this year.

4. Number of male condoms distributed

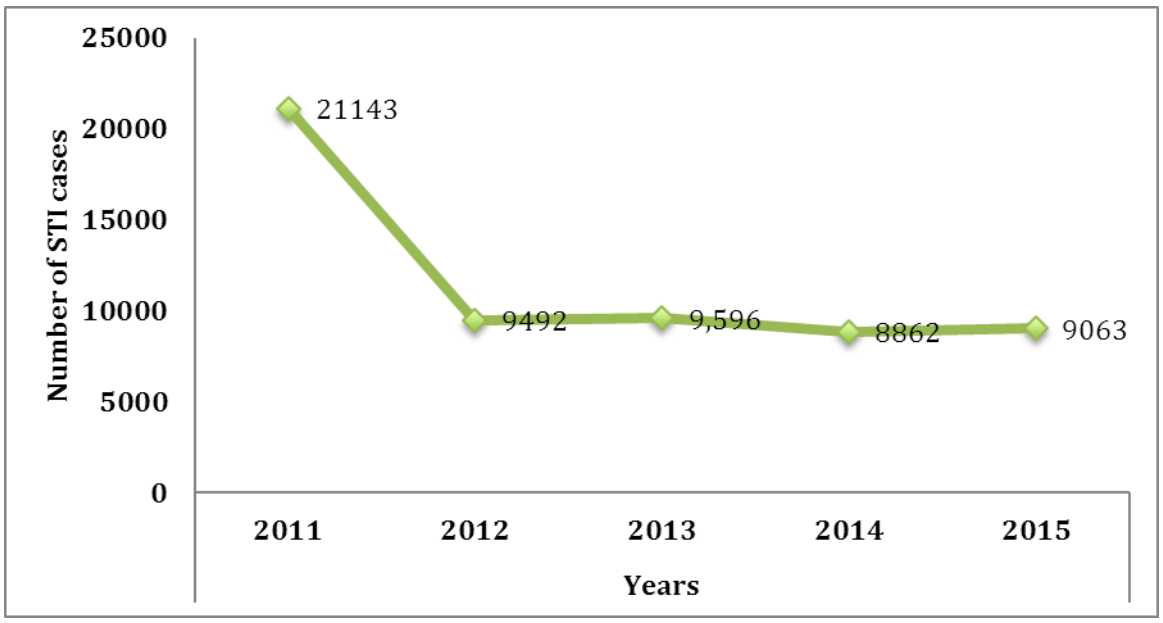
Number of male condoms distributed through various condom outlets in Zanzibar has declined from **84,502** in the year 2014 to **15,860** in the year 2015. This decline was due to frequent stock out of male condom in Zanzibar.

2.4.6 Trend of number of women and men with an STI presenting at health facilities who are diagnosed according to national guidelines, 2011 – 2015

Number of women and men with STI presenting at health facilities who are diagnosed according to the national guidelines has declined remarkably from 2011 to 2012 and slightly

from 2013 to 2014 as indicated in figure 2.4.2 below**.** This decline was due to frequent stock out of STI drugs that caused few numbers of health facilities receiving STI drugs.

Figure 2.4.2 Number of women and men with an STI presenting at health facilities who are diagnosed according to national guidelines, Zanzibar, 2011 – 2015



2.4.7 Challenges

- Lack of funds to procure STI drugs
- Shortage of trained STI providers
- Low number of sex partners who access management of STIs (partner tracing)
- Low cooperation from private hospitals in managing and reporting STI cases

CHAPTER 3: HIV CARE, TREATMENT AND SUPPORTING SERVICES

3.1 HIV CARE AND TREATMENT SERVICES

3.1.1 Background

HIV care and treatment (ART) services were established in 2005 at Mnazi Mmoja Hospital. Currently there are 12 care and treatment clinics (CTCs) in Zanzibar, 8 in Unguja and 4 in Pemba. Similarly, three ART refilling sites in Unguja were established. ART services are provided in public (10 clinics), private hospital (1) and Non-Governmental Organization (1).

3.1.2 Goal

The main goal is to reduce HIV/AIDS related morbidity and mortality.

3.1.3 Objectives

1. To increase access to care and treatment services
2. To strengthen existing ART services
3. To improve linkages between care and treatment unit and other related programs

3.1.4 Programme Implementation

3.1.4.1 Capacity building

Care and treatment unit has organized five days study visit to Mwananyamala Hospital to observe Isoniazid Preventive Therapy (IPT) implementation. Six staff from various level of service provision participated in this visit. The objective of study visit was to learn best practices, successes, challenges and other logistics on provision of IPT services. Lessons learnt from the study visit were to inform the program on necessary steps for scaling up IPT services at Mnazi Mmoja hospital.

3.1.4.2 Service monitoring

During this year, five supportive supervisions (3 in Pemba and 2 in Unguja) were conducted to all CTCs including under one roof TB/HIV clinics and three refilling sites. In addition, one day mentorship was conducted to all CTCs in Pemba, and three CTCs in Unguja. Furthermore, one day supportive meeting to care and treatment service providers were conducted in Unguja and Pemba following all supportive supervisions, to discuss and address some of the issues identified during supportive supervision. A total 103 care and treatment providers (63 Unguja and 40 Pemba) attended in each meeting.

In collaboration with peers and Community Home Based Care (CHBC) providers, CTC staff conducted home visit for 22 patients who are bed ridden and 503 who defaulted from the clinics. A total of 197 patients out of 503 were successfully returned back into care.

To improve care and treatment services, the following meetings were conducted:

- One coordination meeting between ZIHTLP and Central Medical Store and Procurement Unit of MoH staff to improve procurement and distribution of supplies
- Biannual collaboration meetings between CTC and TB clinic staffs in Unguja and Pemba, to improve management and care for co-infected patients.
- Meetings between CTC staff and ZAPHA+ members (1 in Pemba and 1 in Unguja) to harmonize and suppress level of stigma and discrimination
- Biannual collaboration meetings between ZIHTLP units and other stake holders to improve collaboration and mutual relation

In order to scale up HIV care and treatment services, one new CTC has been established at Kidongo Chekundu Hospital within MAT clinic.

3.1.5 HIV care and treatment indicators and trend from 2013 to 2015

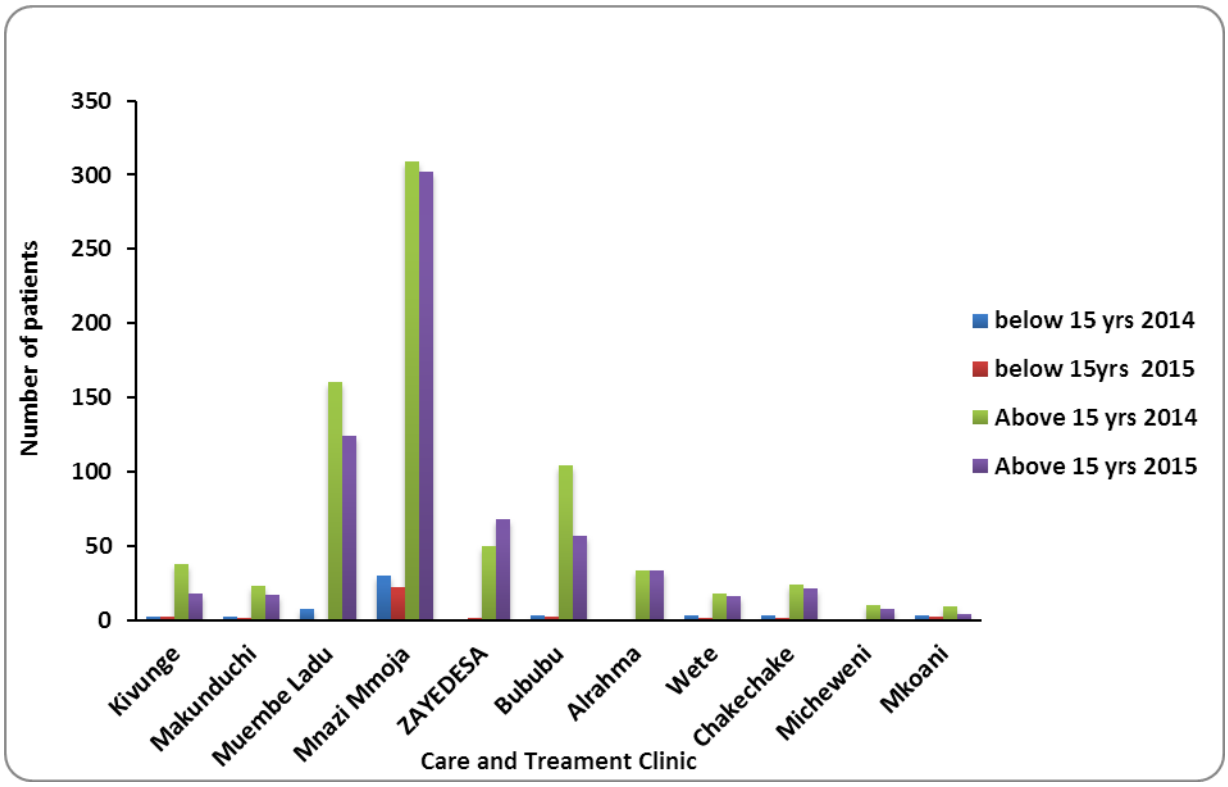
	Indicator	Year		
		2013	2014	2015
1	Number of comprehensive care and treatment clinics	10	11	12
2	Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	79.8	73.1	79.3
3	Number of PLHIV attending HIV treatment and care settings, who were screened for TB symptoms, in the preceding 12 months	4,390/4,396 (99%)	4,786/4,798 (99%)	5,013/5,051 (99%)
4	Number of adults and children with advanced HIV infection currently receiving ART	3,107	3,587	3,907
5	Number of health facilities providing comprehensive TB/HIV collaborative activities	2	2	2

1. Number of comprehensive care and treatment clinics

By 2015, twelve 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. It was observed during this reporting period a decrease in enrolment of 699 patients in 2015,

compared to 831 patients enrolled in 2014. There was a notable decrease in enrolment of adult patients in the majority (67%) of CTC clinics during 2015 (See figure 3.1.1). The remarkable decrease of more than 50% enrolment of HIV positive patients above15 years was noted in Kivunge and Muembeladu CTCs. However, there was an increased enrolment of the same age group at ZAYEDESA CTC in 2015 compared to 2014. These clinics enrol patients referred from various entry points that include PITC, VCT, and PMTCT etc.

Figure 3.1.1: Patients enrolment at CTC by age group and facility 2014 versus 2015, Zanzibar

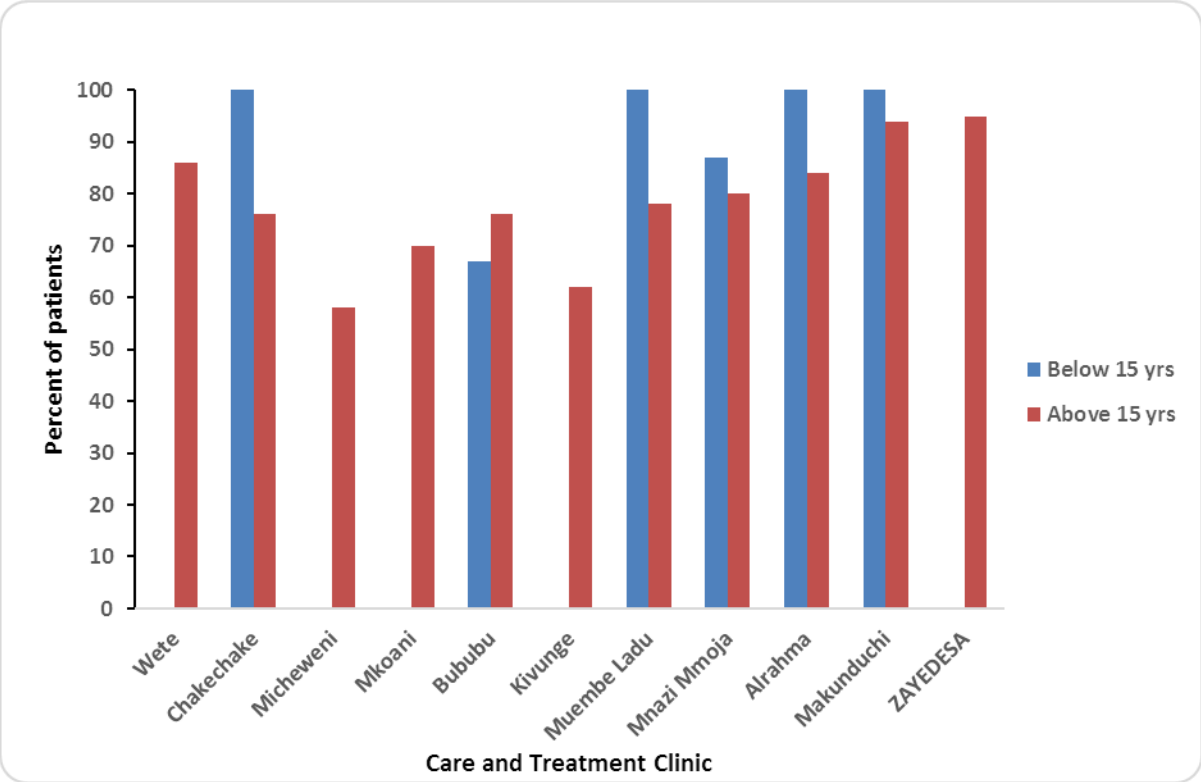


2. Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy

Overall percentage of patients who are still alive and known to be on treatment 12 months after initiation of antiretroviral therapy has increased from 73.1% in 2014 to 79.3% in 2015. It has been observed that children below fifteen years have overall high retention rate compared to adult in all care and treatment centers. ZAYEDESA CTC had highest retention rate of 94% and Micheweni had the lowest retention rate (58%).

In some care and treatment clinics (Wete, Micheweni, Mkoani, Kivunge and ZAYEDESA) there was no children below 15 years who were started on ART in 2014, hence there was no retention of the children below 15 years (See figure 3.1.2).

Figure 3.1.2: Percentage of adults and children still alive and on ARVs by age group and facility, Zanzibar, 2015*

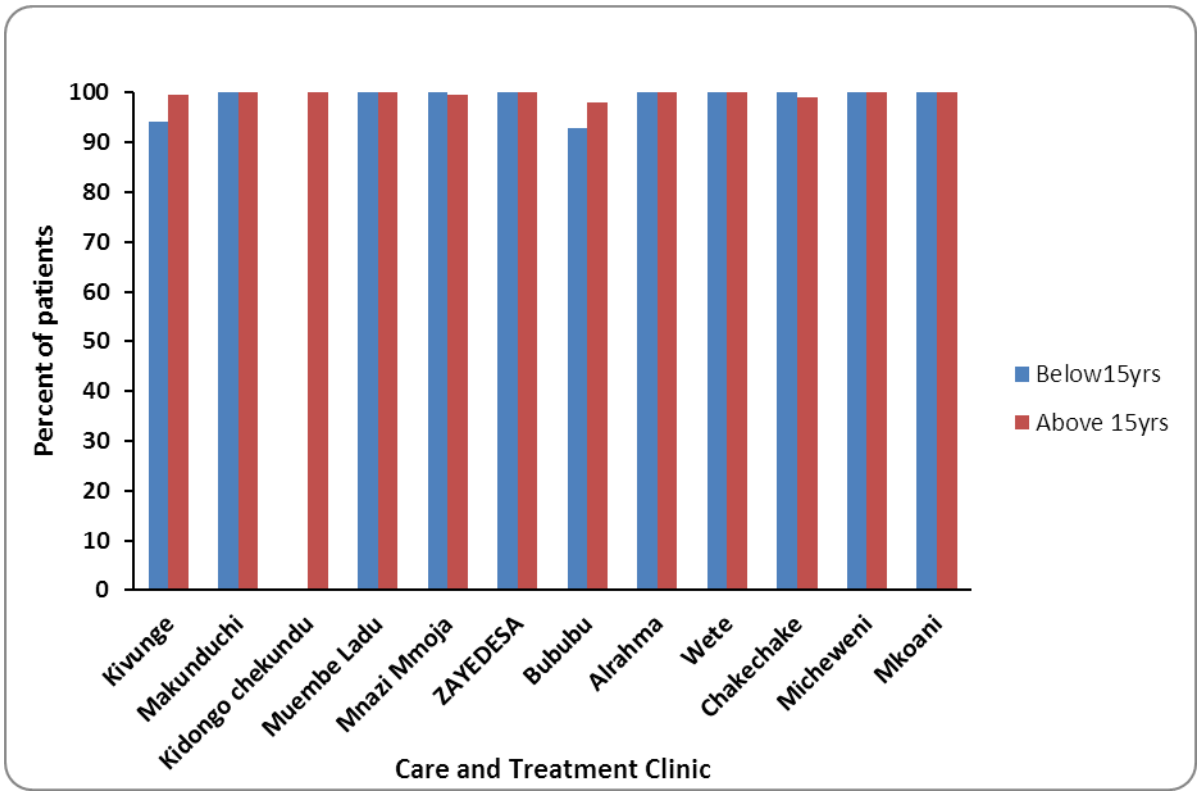


***Cohorts of January to December 2014, reported in 2015**

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

All HIV infected clients attending care and treatment services are required to be screened for TB at each visit, with the exception of those on TB therapy. Percentage of patients screened for TB has remained the same at 99% in 2014 and 2015. The figure below shows the number of HIV patients who were screened for TB out of those who received care during the period. Among 5,013 patients who were screened for TB 88 were diagnosed with TB and were started on ant TB.

Figure 3.1.3: Percentage of HIV patients screened for TB among those who received care by facility and age group Zanzibar, 2015.



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

As of December 2015, a total of **8,536** patients have ever been enrolled in CTCs of whom **6,079 (71%)** are ever started on ARVs at these facilities. However, patients who are currently on ARVs including transfer in are **3,907,** which is **75% (3,907/5,176)** of patients estimated to be in need of treatment according to spectrum 2015. Number of patients currently receiving ART has increased from 3,587 in 2014 to 3,907 in 2015.

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

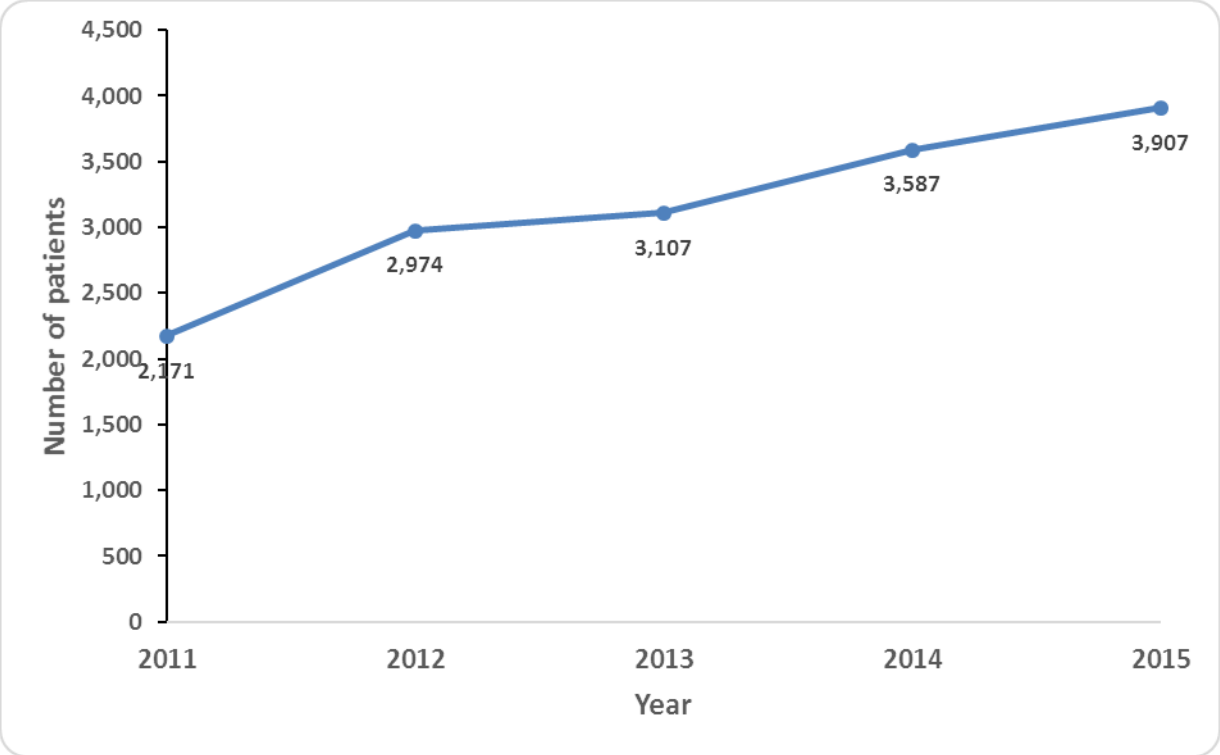
Currently there are two sites providing comprehensive TB/HIV services (Mnazi Mmoja and Chake Chake hospitals). TB patients who are diagnosed as HIV positive are treated at TB clinic and receive ARV drugs there until they finish TB treatment when they are referred to CTC.

3.1.6 Trend of PLHIV currently on ART from 2011 to 2015

The figure below shows patients currently on ART have increased progressively from 2,171 patients in 2011 to 3,907 patients by December 2015. The increase was remarkable from year

2013 onwards. This was contributed by 2013 revised treatment guidelines which had expanded ART initiation criteria.

Figure 3.1.4: Number of PLHIV currently receiving ART 2011-2015, Zanzibar



3.1.7 Challenges

- Low enrolment of patients into care and treatment clinics
- Low retention of enrolled clients

3.2 HOME BASED CARE SERVICES

3.2.1 Background

Home Based Care (HBC) services in Zanzibar were established in 1988 in 3 districts Unguja and 2 in Pemba to cater for AIDS patients only. To date, HBC services have been scaled up to 144 health facilities in all 10 districts of Zanzibar. The community-based HBC volunteers are pivotal in the provision of these services at the community. HBC volunteers are working under supervision of facility-based HBC providers. Each health facility has a contact person (facility supervisor) who is accountable for all HBC services at facility level.

3.2.2 Goal

The goal of Home Based Care is to provide comprehensive home based care services to HIV/AIDS patients and those patients with other chronic illnesses in Zanzibar.

3.2.3 Objectives

1. To improve quality of HBC services.

2. To enhance capacity of HBC implementers at all levels of service provision.

3.2.4 Program Implementation

3.2.4.1 Services monitoring

During this year HBC unit has conducted supportive supervision to facility-based HBC providers at 149 health facilities (82 in Unguja and 67 in Pemba). Also, the unit conducted community-based supportive supervision for 78 patients (50 in Unguja and 28 in Pemba), out of whom 40 were HIV patients and 38 were patients with chronic illnesses. The objective of supportive supervision was to improve performance of HBC providers to deliver quality and comprehensive HBC services, including appropriate documentation.

In addition, a total of 12 feedback meetings were conducted for district supervisors and facility-based HBC providers in 6 districts in Unguja (35 participants per session) and 4 meetings were conducted in 4 districts in Pemba (25 participants per session). Furthermore, 6 feedback meetings were conducted for 210 community-based HBC volunteers in Unguja (35 participants per district) and 4 meetings in Pemba (27 participants per district). The objective of the meetings was to provide feedback aimed at addressing challenges encountered, as well as to provide opportunity for sharing experiences and best practices.

HBC unit has also finalized and disseminated revised HBC guidelines for implementation of integrated community based health care at all levels of service provision.

3.2.5 HBC services indicators and trend from 2013-2015

Indicator	Year		
	2013	2014	2015
1. Number of skilled facility-based HBC providers	204	187	167
2. Number of skilled community-based HBC providers	290	412	409
3. Number of adults and children provided with HBC	3,019	3,725	2,694

1. Number of skilled facility-based HBC providers

The number of skilled facility-based HBC providers decreased from 187 in 2014 to 167 in 2015. The decrease is attributed to retirement of 20 providers from services (17 in 2014 and 3 in 2015), without replacement and hence the quality of HBC services is compromised.

The table below shows that the 167 skilled service providers (106 in Unguja and Pemba 61) implement HBC services in 144 sites (53 in Pemba and 91 Unguja).

Table 3.2.1: Number of health facilities with active HBC providers implementing HBC services by district, Zanzibar, 2015

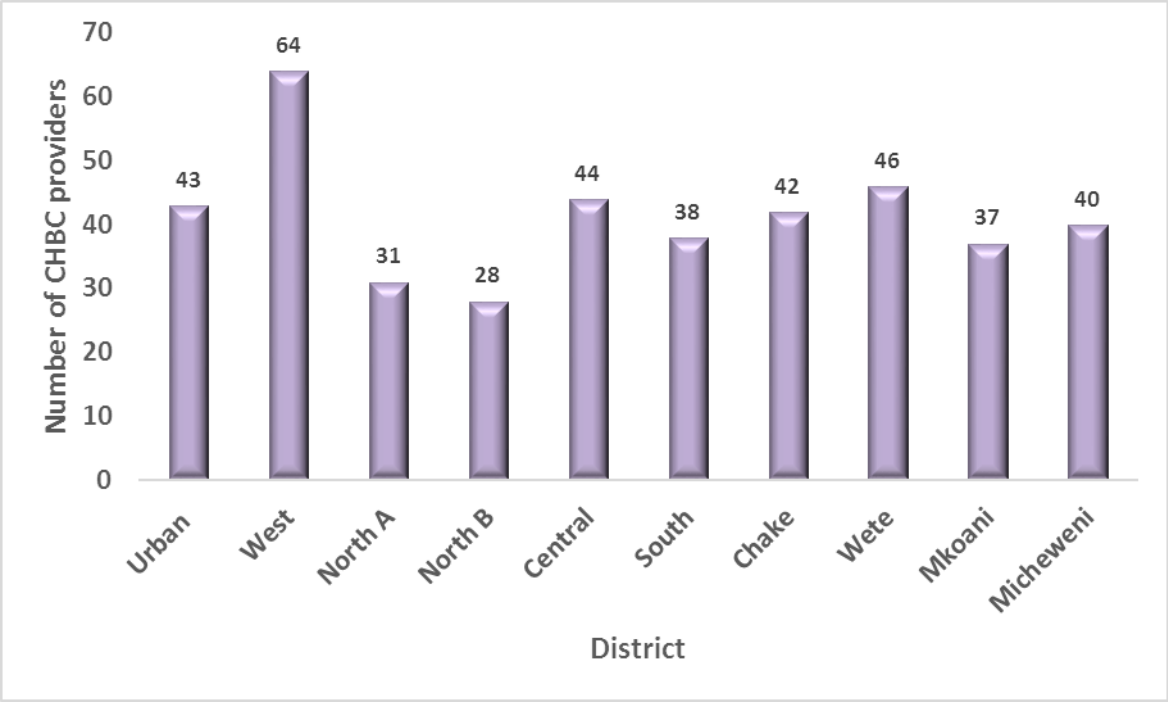
District	Number of HBC sites	Number of HBC providers active in field
Urban	15	18
West	18	20
South	12	16
Central	20	23
North A	14	16
North B	12	13
Chake Chake	13	14
Wete	16	18
Mkoani	13	16
Micheweni	11	13
Total	**144**	**167**

2. Number of skilled community-based HBC providers

Number of skilled community-based HBC providers has dropped from 412 in 2014 to 409 in 2015 (**244** in Unguja and **165** in Pemba) because 1 service provider dropped out and 2 have

died, without replacement. The number is not adequate to cover all the catchment areas for currently existing clients.

Figure 3.2.1: Number of CHBC providers by district, Zanzibar, 2015



3. Number of adults and children provided with HBC services

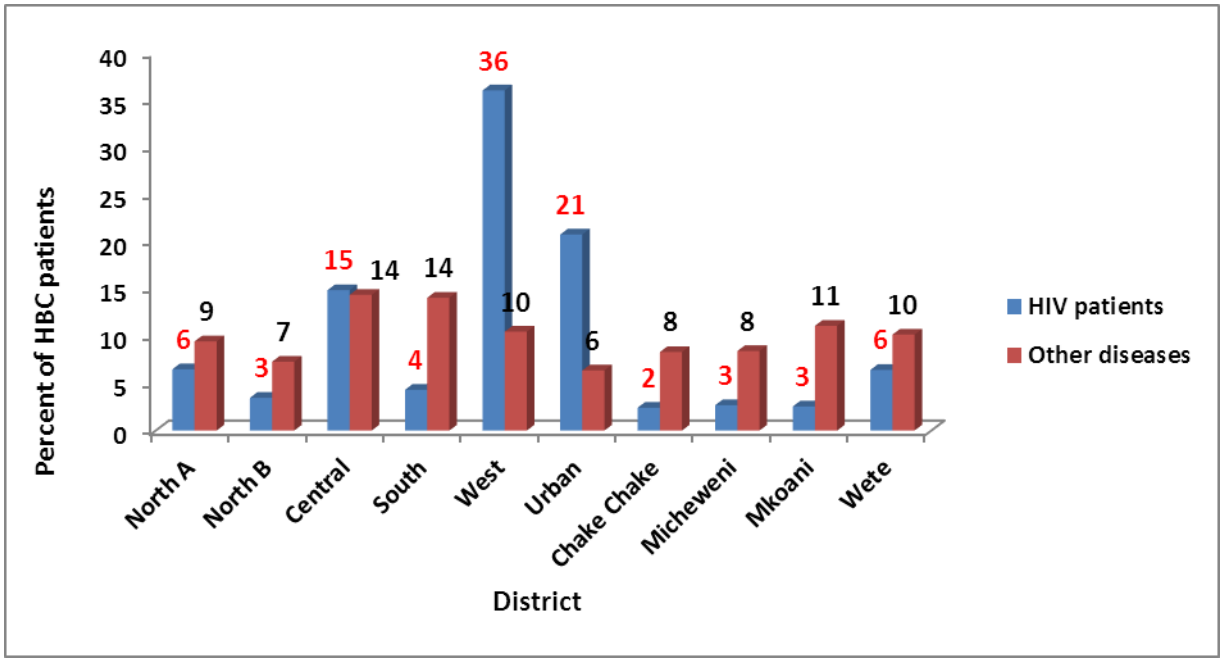
During this year, a total of 2,694 patients received HBC services, out of whom 1,629 were people living with HIV (1,073 females and 556 males) and 1,065 were chronically ill patients (589 females and 476 males) as seen in table 3.2.2 below. It is observed that, female patients receive more services than male patients. In comparison, more patients were provided with HBC services in 2014 (3,725) than 2015 (2,694) due to lack of support for HBC service providers.

Table 3.2.2: Number of clients who received HBC services by disease, sex and age group, Zanzibar, 2015

Age (years)	HIV patients		Other chronic diseases		Total
	M	F	M	F	
0 – 4	17	11	6	6	**40**
5 – 14	75	78	37	37	**227**
≥ 15	464	984	433	546	**2,427**
Total	**556**	**1,073**	**476**	**589**	**2,694**

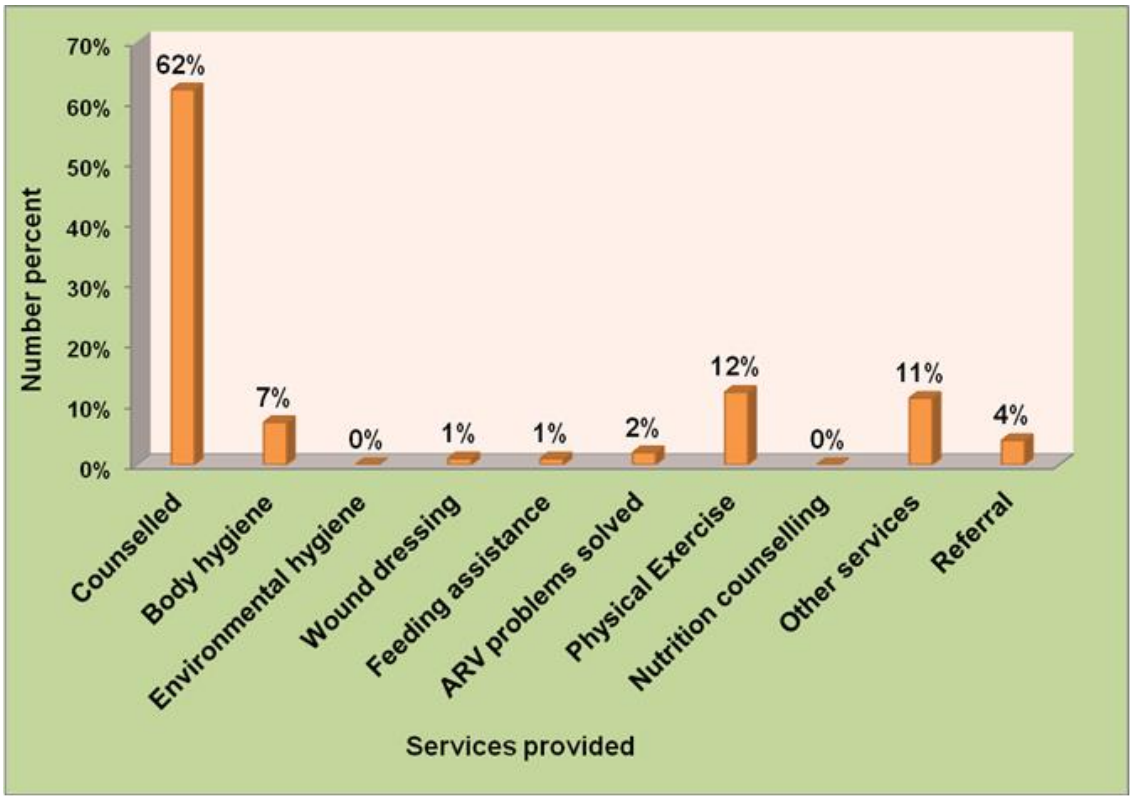
Patients who have diseases other than HIV are served more by HBC services in majority of districts (70%). In Central district the patients are equal in numbers, while in West and Urban districts, patients with HIV received HBC services more than those with other diseases (See Figure 3.2.2)

Figure 3.2.2: Number of clients who received HBC services by district, Zanzibar, 2015



HBC providers offer various services to patients, including basic nursing care, health and hygiene education, psychosocial and spiritual support, assistance with household duties, monitoring drug compliance as well as referral to health centers, NGOs and CBOs. The most frequently provided service is counselling as shown in the figure below.

Figure 3.2.3: Frequency of provision of different types of HBC services, Zanzibar, 2015



3.2.6 Challenges

- Inadequate supportive supervision by facility-based HBC providers to community-based HBC providers due to shortage of staff
- Lack of formal HBC training for newly-joining HBC providers
- Lack of HBC kits

CHAPTER 4: TUBERCULOSIS AND LEPROSY SERVICES

4.1 Back ground

The Ministry of Health launched the Zanzibar Tuberculosis and Leprosy Programme in 1987 as a single combined programme. The programme is responsible for facilitating early diagnosis, treatment and cure of Tuberculosis (TB) and Leprosy patients so as to reduce the incidence and prevalence of the disease. In 2012, the programme was integrated with Zanzibar AIDS Control Programme. Currently, all public health facilities and some private facilities are providing TB Directly Observed Therapy (DOT) and Leprosy services depending on presence of patient in the respective facilities; also 52 TB diagnostic centres do smear examination (19 Pemba and 33 in Unguja).

4.2 Goal

The goal of Tuberculosis and Leprosy Program is to control the occurrence of Tuberculosis and Leprosy until they are no longer public health problems.

4.3 Objectives

1. Pursue high quality DOTS expansion and enhancement
2. Strengthen collaborative TB/HIV activities
3. Prevent TB transmission in health facilities and other high risk congregate settings
4. Engage all care providers in TB control
5. Empower people and communities in TB control.

4.4 Programme Implementation

4.4.1 Capacity building

In 2015, TB and Leprosy unit conducted the following trainings to health care workers (HCWs) of different carder in Unguja and Pemba:

- Five days training on TB management for 60 HCWs, (30 in Unguja and 30 Pemba). The aim of the training was to provide knowledge and skills on TB and TB/HIV management to HCWs.
- Five days training on TB management to 40 District Health Management Team (DHMT) members (18 from Pemba and 22 Unguja). The objective of the training was to provide them with knowledge and skills on TB management so that they can supervise TB interventions in their respective districts.
- Five days training on pediatric TB to 60 clinicians (30 in Unguja and 30 Pemba). The aim of the training was to build their capacity to diagnose and manage pediatric TB.
- Three days training on X-ray interpretation to 60 clinicians (30 in Unguja and 30 in Pemba) with the objective of enhancing clinicians' capacity to read and interpret chest X-ray films so as to diagnose TB accurately among TB suspects.
- Mentorship to HCWs providing TB and Leprosy services in 42 health facilities (28 in Unguja and 14 Pemba). The aim was to address gaps identified and build capacity of

HCWs so as to provide quality TB, TB/HIV and Leprosy services. The HCWs were mentored on proper screening and TB diagnosis, updating of TB/Leprosy registers, treatment cards as well as how to prepare a quarterly HMIS TB and Leprosy reports.

4.4.2 Service Monitoring

For the year 2015 the unit conducted supportive supervision to health care facilities at all levels to monitor the implementation of TB and leprosy activities. The supervision involved program officers from central level, Regional TB and Leprosy Coordinators (RTLCs) and District TB and Leprosy Coordinators (DTLCs). The aim of the supervisions were to assess the performance of RTLCs, DTLCs and other HCWs working in TB, TB/HIV and Leprosy within health care facilities. Moreover, program conducted several meetings to discuss the progress of program implementation. These include quarterly coordination meeting to program implementers, feedback meeting to HCWs and sensitization meeting with HCWs and prisoners' authority. During these meeting participants got an opportunity to share the progress of program interventions, challenges and planned way forward.

During this reporting period, the program also facilitated the provision of self-care services among Leprosy patients within the community. The aim was to motivate people affected by Leprosy to provide proper care of their affected areas (eyes, hands, and feet) so as to prevent further worsening of the existing disabilities. Furthermore the unit organized reconstructive surgery for 4 leprosy patients with disability grade 2 (3 male and 1 female). Contact tracing for Multi-bacillary (MB) Leprosy patients was conducted, with the aim of identifying, diagnosing and providing early treatment and hence prevent spread of the disease to their families and general community. Seventy five (75) MB Leprosy patients (60 in Unguja and 15 in Pemba) were visited and 24 suspects were identified. Among them 2 were diagnosed with Leprosy disease and all of them started treatment.

The unit also facilitated the collection of sputum from facilities with no diagnostic services to diagnostic centre, and for PLHIV the sputum was transported to X-pert MTB/RIF site. Through sputum collection exercise, 195 TB cases were detected. In addition, contact tracing was performed for smear positive TB patients so as to increase TB case detection and prevent further infection. Eighteen (18) TB patients were identified and initiated anti TB treatment and 136 under-five children of smear positive TB patients were given Isoniazid Preventive Therapy.

4.5 Tuberculosis service indicators and trend from 2013 to 2015

Indicators		Year		
		2013	2014	2015
1.	Number of all registered TB cases	685	648	855
2.	Number of new smear positive TB cases	318	335	479
3	TB cure rate	87%	90%	91%
4	TB treatment success rate	87%	90%	91%
5	Number of TB patient tested for HIV	659	618	795
6	Number of HIV positive TB patients	115	113	109
7	Percent of HIV positive TB patient on ART	86	80%	86%
8	Percent of HIV positive TB patient on CPT	75	97.4	98%

1. **Number of all registered TB cases**

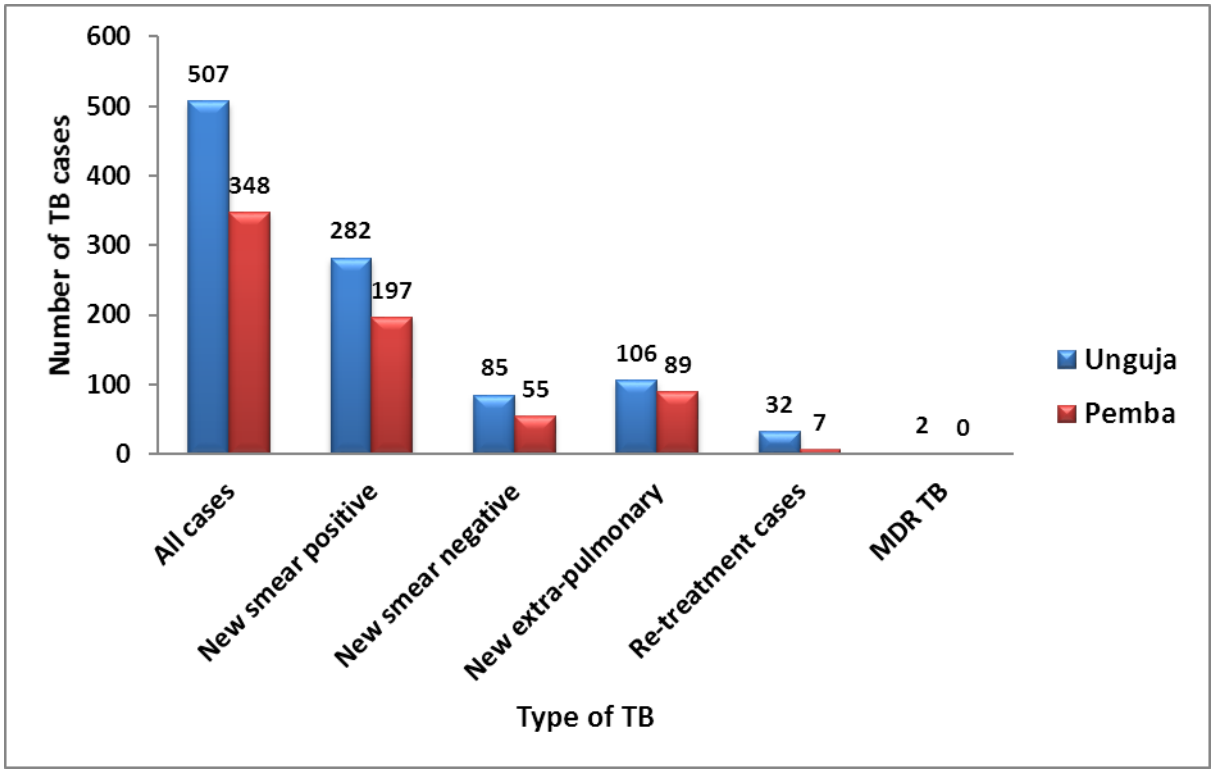
In 2015, a total of 855 cases of all forms of TB cases were notified and registered from public and private health facilities with 3% being children below 15 years. The number of notified cases has increased from 648 in 2014 to 855 in 2015 as a result of strengthened sputum collection system from peripheral facilities to diagnostic centre and availability of X-pert MTB/RIF. Among the notified cases 479(56%) were smear positive cases including 2 MDR-TB cases as shown in the table 4.1 below:

Table 4.1: TB cases notified by type of patient and category, Zanzibar, 2015

Type of patients	AFB+	AFB-	Extra Pulmonary	Total
New	479	140	195	814
Relapse	19			19
Failure	4			4
Return to control	6			6
Others	0	10	0	10
MDR TB	2	0	0	2
Total	**510**	**150**	**195**	**855**

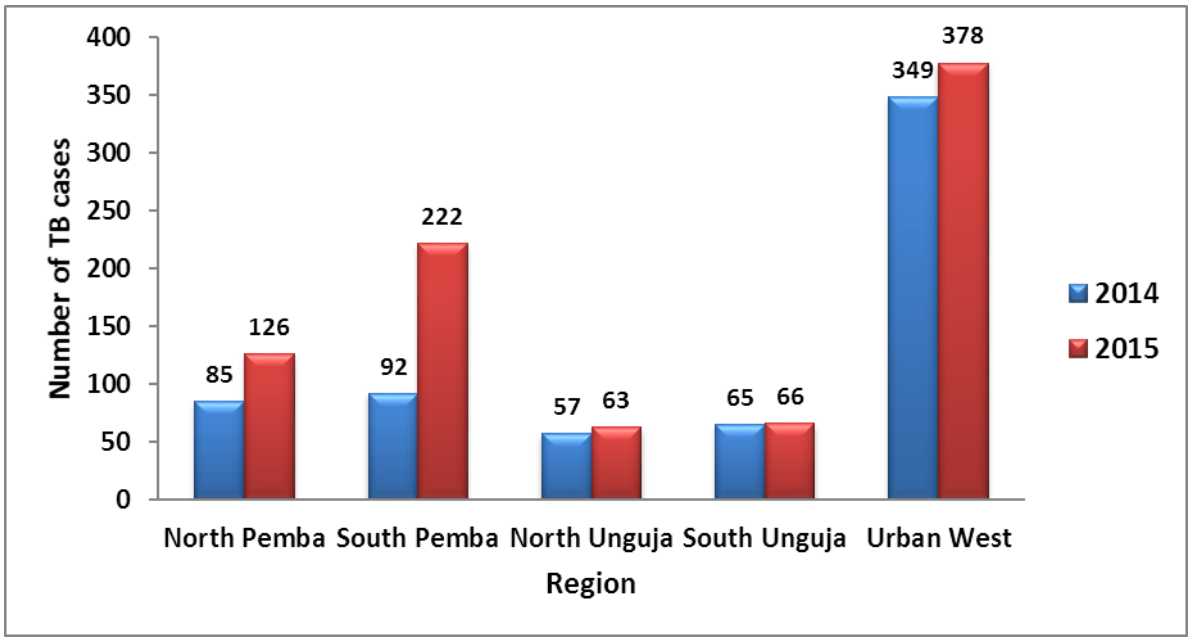
Among 855 patients notified in 2015, 506 (59.2%) patients were in Unguja and 349 (41%) in Pemba as seen in figure 4.1 below.

Figure 4.1: TB case notification by type of patient and Island, Zanzibar, 2015



The number of notified TB patients is highest in Urban West region in the past two years. South region of Pemba has shown a remarkable increase in case notification from 92 in 2014 to 222 in 2015. North and South regions of Unguja notified the least number of TB cases in both 2014 and 2015 as shown in the figure below.

Figure 4.2: TB case notification by region, Zanzibar, 2014-2015



2. **Number of new smear positive TB cases**

There is an increase in number of new smear positive TB cases by 43% compared to the previous year (335 in 2014 vs 479 in 2015). This indicates that there is high TB infection in the general community. The most affected group are young adults between 25 to 34 years. Men were more affected than women as shown in table 4.2 below.

Table 4.2: Number of smear positive cases by age and gender, Zanzibar 2015

Age Category	Male	Female	Total
0-14	16	15	**31**
15-24	43	44	**87**
25-34	59	54	**113**
35-44	54	35	**89**
45-54	51	27	**78**
55-64	27	16	**43**
65+	22	16	**38**
Total	**272**	**207**	**479**

3. **TB cure and treatment success rate**

A total of 335 new smear positive patients were registered in 2014. Among them 305 (91%) were cured, 1 (0.3%) completed treatment, 4 (12.2%) were failure, 10 (3%) died, 6 (1.8%) were out of control and 10 (3%) were transferred out. Therefore in 2015 TB cure rate is 91% which is in line with WHO recommendation whereby the program is required to reach the cure rate of at least 90%. This increase has been contributed by successful implementation of home based DOT whereby 98% of registered patients opted for home based DOT.

Table 4.3: Treatment outcome for all TB patients registered, Zanzibar, 2015

Type	Notified	Cured	Treatment completed	Failure	Died	Defaulted	Transfer Out	Total
Smear positive	335	305	1	4	10	6	10	335
Smear negative	141		133		6	0	2	141
Extra pulmonary	141		132		6	0	3	141
Relapse	12	9	0	0	0	3	0	12
Failure	6	6	0	0	0	0	0	6
Return	4	3	0	0	1	0	0	4
Others	6		5		1	0	0	6

4. **Number of TB patient tested for HIV**

Among the 855 TB patients enrolled in 2015,795 (93%) patients were tested for HIV. The proportion of TB patient tested for HIV has decreased compared to 2014 (95%). This might be contributed by shortage of HIV test kits. The program needs to take special effort to reach WHO target which is 100%.

5. **Number of HIV positive TB patients**

Among the 795 TB patients tested for HIV, 109 (14%) tested positive. There is a decrease in percentage of patients who were diagnosed to be TB/HIV co-infected as compared to 2014 (18.2%).

Treatment outcome of TB/HIV patients reported in 2014 is as follows: In 2014, 113 TB/HIV patients were diagnosed, among them 43 were new smear positive and 70 were others. Of new smear positive 39 (90.7%) were cured, 3 (7%) died and 1(2.3%) was transferred out. Out of 70 others, 6 (8.6%) were cured, 55 (78.6%) completed treatment, 6 (8.6%) died and 3 (4.3%) were transferred out.

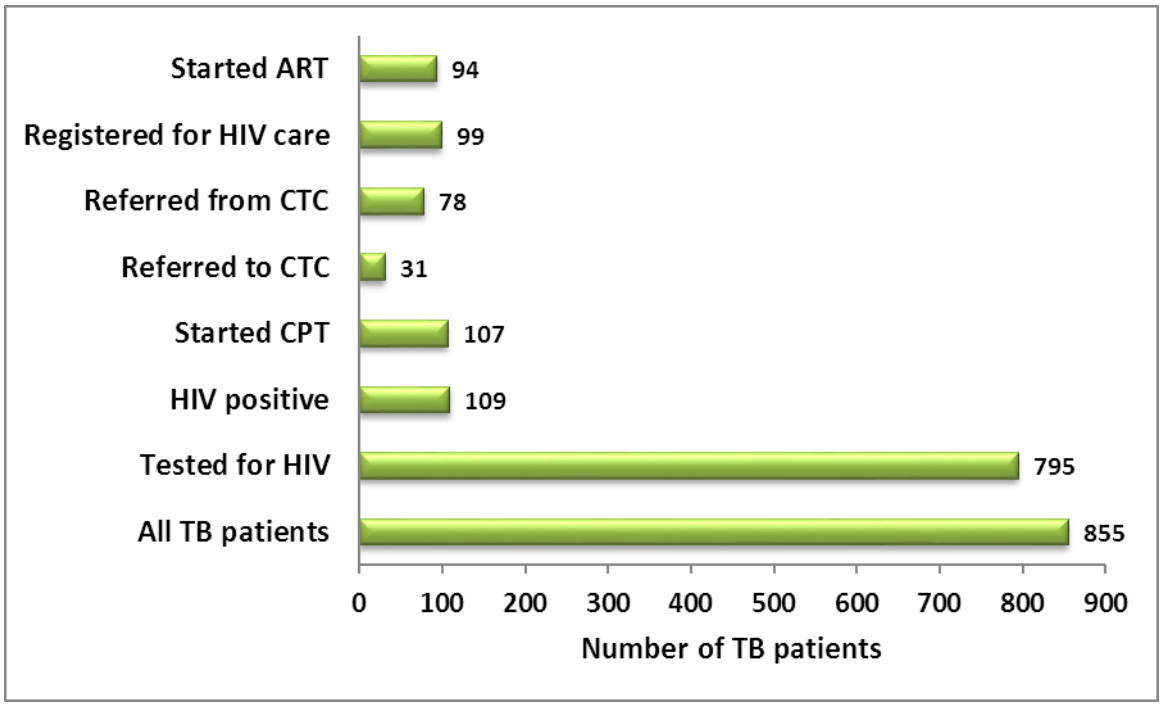
6. **Percent of HIV positive TB patients on ART**

Among 109 TB/HIV patients, 94 (86%) have started ART. This is an increase of 6% compare to the previous year. However more effort is needed to reach 100% as recommended by WHO.

7. **Percent of HIV positive TB patient on CPT**

The percentage of TB/HIV patient started CPT is 98% (107/109), the proportion of TB/HIV patient started CPT has slightly increased from 96.5% in 2014 to 98% in 2015. Nevertheless the required WHO target of 100% has not yet been reached.

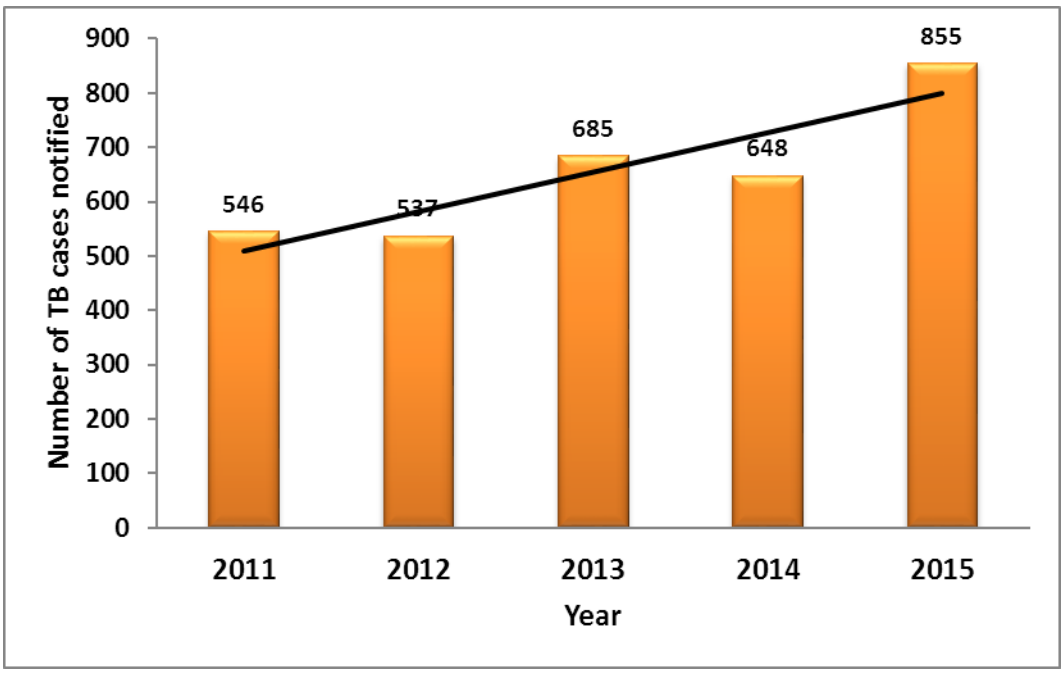
Figure 4.3: TB/HIV notification, Zanzibar, 2015



4.6 Trend of TB case notification from 2011 to 2015

For the last five years, the number of notified TB cases has gradually increased from 546 in 2011 to 855 cases in 2015.The increase in notification is remarkable in 2015. The increase is attributed by strengthened sputum collection system from peripheral facilities with no diagnostic services to diagnostic centre and the use of X-pert MTB/RIF.

Figure 4.4: Trend of TB case notification from 2011 to 2015, Zanzibar



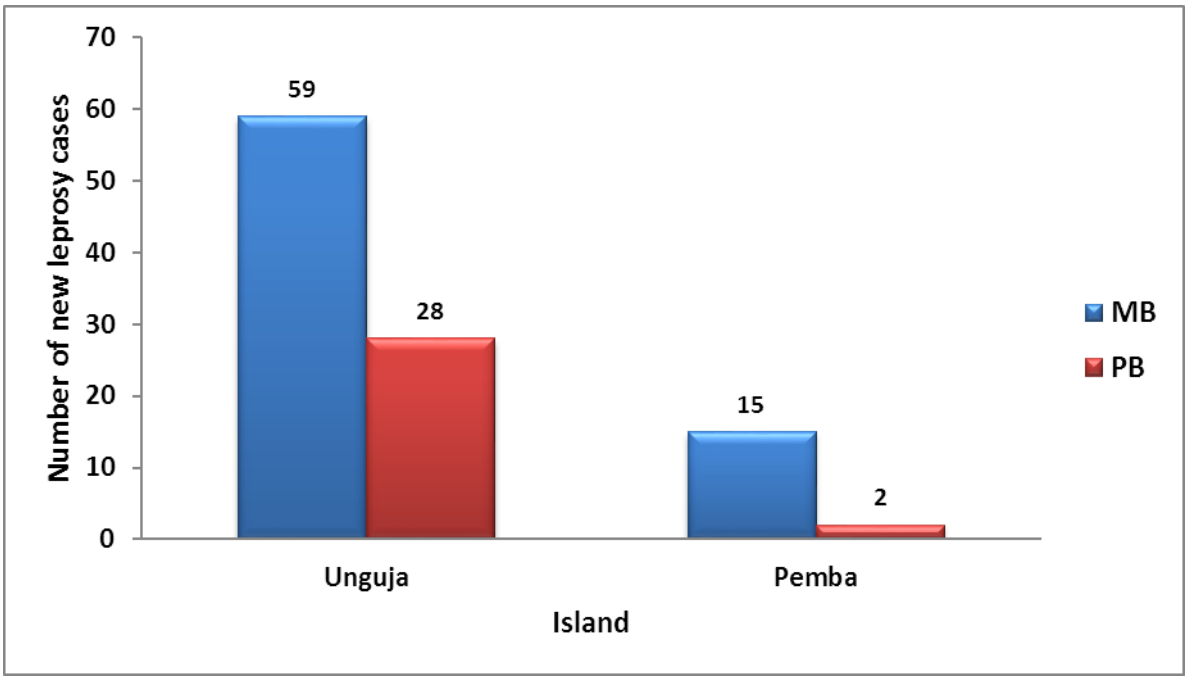
4.7 Leprosy services indicators and trend from 2013 to 2015

Indicators		Year		
		2013	2014	2015
1.	Number of all new registered Leprosy cases	100	177	104
2.	Percent of MB cases among all new cases	76	56	71
3.	Percent of children among new cases	18	19	16
4.	Percent of WHO disability grade 2 among new	12	3	5.8
5.	Percent of female patients among new cases	38	36	22
6	Percent of MB Leprosy patients completing 12 month of MDT amongst those expected to complete their MDT (calculated for 1 year cohort intake)	92.7	96.5	97

1. **Number of all new registered Leprosy cases**

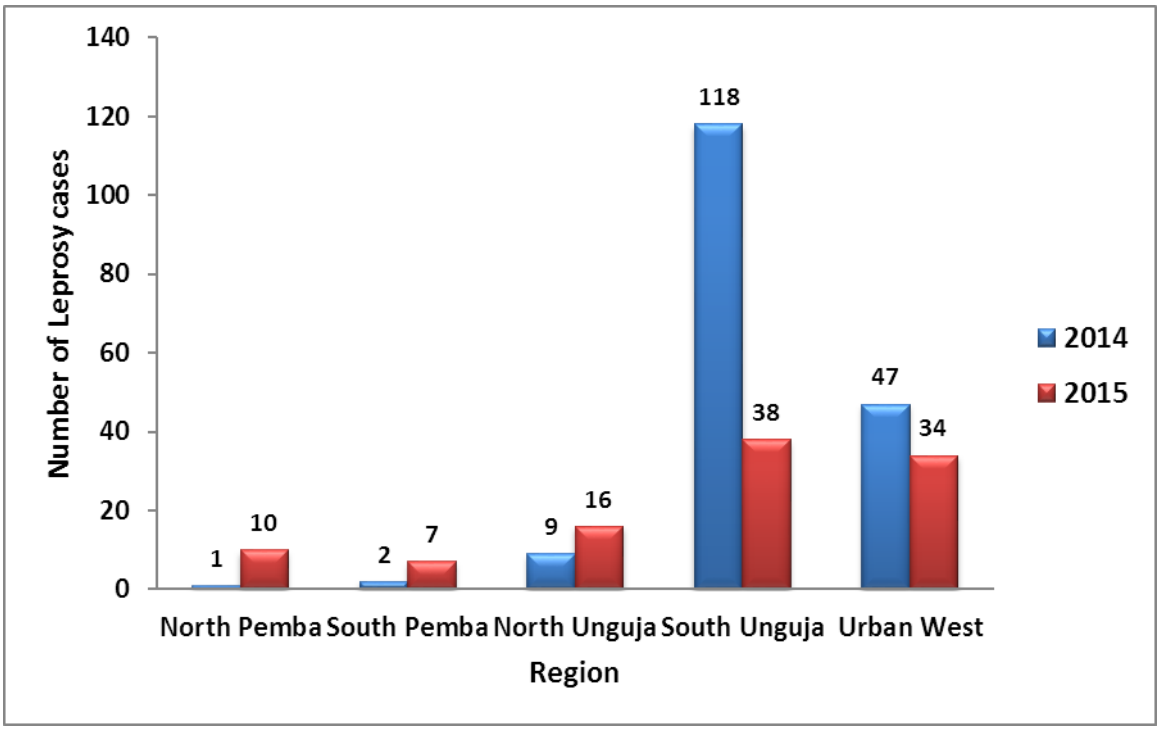
In 2015**,** Leprosy passive case finding was carried out in different health facilities in Unguja and Pemba by HCWs under support of DTLCs in their respective districts. Number of all new leprosy patients registered has decreased from 177 in 2014 to 104 in 2015. The decrease might have been contributed by the fact that house to house active case finding which was conducted in South district Unguja in 2014 and was able to detect 41 cases, was not done in 2015. This underscores the importance of conducting active case finding to detect hidden Leprosy cases in the community. Among registered Leprosy patients 87 (83.6%) were diagnosed in Unguja and 17 (16.3%) were diagnosed in Pemba as shown in figure 4.5 below.

Figure 4.5: Number of all new registered Leprosy cases by type and Island, Zanzibar, 2015



In 2015, number of leprosy cases notification has decreased in South and Urban West regions Unguja. The decrease is more in South region Unguja. This has been contributed by lack of implementation of active case finding in 2015 as compared to 2014.

Figure 4.6: Leprosy notification by region, 2014-2015, Zanzibar



2. Percent of MB cases among all new cases

Among all new cases registered the percentage of MB patients, which is the source of Leprosy infection, has increased from 56% (101/177) in 2014 to 71% (74/104) in 2015. This shows that Leprosy transmission among the community members is still high hence alarming the program to increase efforts in fighting against Leprosy so as to eliminate the disease.

3. Percent of children among new cases

A total of **17** children were detected and registered in this reporting year which is equal to 16.3% of all new cases. This shows decrease in proportion of children from 19.2% in 2014 to 16.3% in 2015.

4. Percent of WHO disability grade 2 among new cases

Among the 104 new Leprosy cases diagnosed in 2015, thirty eight (38) patients had disability grade 1 and six (6) had grade 2. The percentage of Leprosy cases with disability grade 2 has increased from 3% in 2014 to 5.8% in 2015. Among factors contributing to this was delay in diagnosing of Leprosy among HCWs due to inadequate knowledge and patients delay in seeking health care services caused by low awareness on Leprosy.

Table 4.4: Disability grade for newly diagnosed Leprosy patients, Zanzibar, 2015

Disability Grade	Number of Leprosy cases	%
0	60	57.7
1	38	36.5
2	6	5.8
Total	**104**	**100**

5. Percentage of female patients among new cases

The percentage of female patient was 36.9% (17/46) in 2014 compared to 22% (23/104) in 2015 among the total Leprosy patients identified. This shows a decrease of female patients identified during this reporting year.

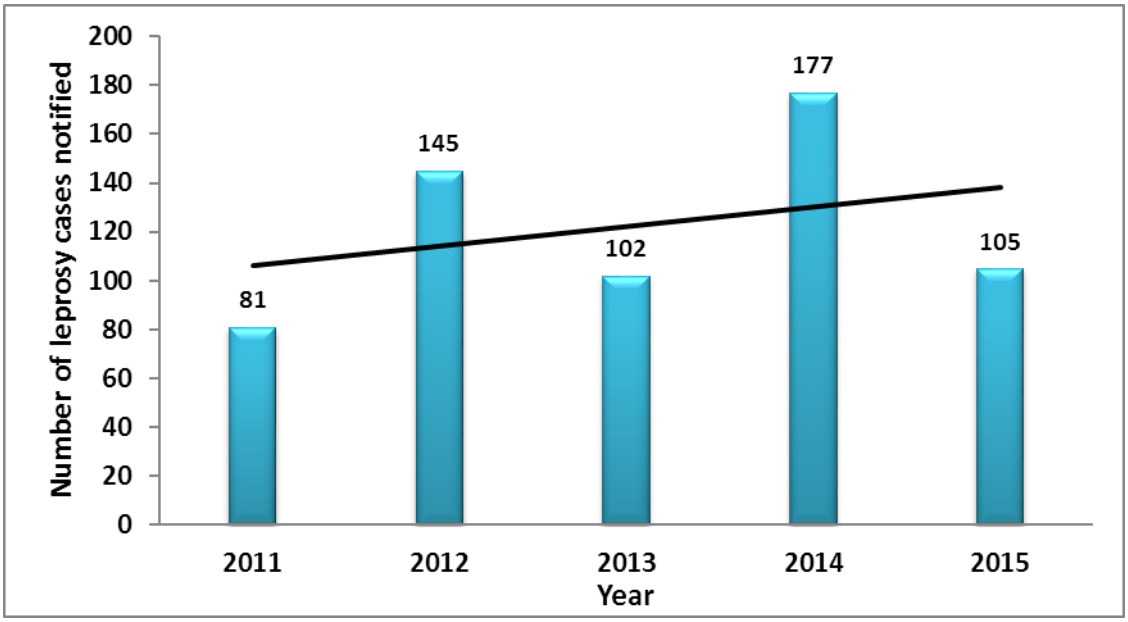
6. Percentage of MB leprosy patients completing 12 month of MDT amongst those expected to complete their MDT (calculated for 1 year cohort intake)

Among 76 MB leprosy patients diagnosed in year 2013, 73 (97%) completed their treatment and 3 (4%) were transferred out. This shows treatment completion rate has remained almost the same 96.5% in 2014 and 97% in 2015. However it is still within WHO target which is 95%.

4.8 Trend of Leprosy case notification from 2011 to 2015

Leprosy case notification seems to increase sporadically from 2011 to 2015; the increase is more in 2012 and 2014. This has been contributed by house to house active case finding conducted in South district as explained above.

Figure 4.6: Trend of Leprosy cases notification from 2011 to 2015, Zanzibar



4.9 Challenges

- Delay in receiving TB and leprosy commodities from Medical Stores Department
- Low MDR TB case detection
- Inadequate capacity to manage MDR TB patients
- Inadequate knowledge of HCWs to diagnose and manage Leprosy

CHAPTER 5: HIV AND TB LABORATORY SERVICES

5.1 Background

Laboratory unit of ZIHTLP is accountable on overseeing laboratories in HIV and TB services, to ensure that tests performed and results generated are reliable, reproducible, timely and accurate. The laboratory services are key component of quality health care services. Currently there are ten laboratories for HIV care and treatment services (6 Unguja & 4 Pemba), 98 HTS sites (53 Unguja & 45 Pemba), 156 PMTCT sites (92 Unguja & 64 Pemba) and 52 TB diagnostic sites in Zanzibar (33 Unguja &19 Pemba). Furthermore, ZIHTLP laboratory unit is an important segment of biomedical research activities. In addition, PHL laboratory in Pemba serve as reference laboratory for TB culture.

These laboratories are organized, according to capacity of the health facilities being served and the laboratory itself. This structure consists of Reference, District, Cottage hospital laboratories, TB and HIV diagnostic sites.

5.2 Goal

The goal is to oversee and strengthen National health laboratory services to support HIV, TB diagnosis, care and treatment services.

5.3 Objectives

1. To provide leadership in HIV/TB related laboratory services
2. To provide technical assistance in assuring operational testing systems
3. To strengthen quality systems integration, to support HIV/TB diagnosis, care and treatment in Zanzibar

5.4 Program Implementation

5.4.1 Capacity building

During this year HIV/TB laboratory unit conducted the following trainings:

- Five days training to 30 Laboratory Technicians and Technologists on Laboratory Quality System conducted in Pemba that aimed at familiarizing laboratory staff on quality system to improve laboratory services.
- Five days training on Biosafety and Biosecurity system was conducted to 60 laboratory staff (30 from Unguja and 30 Pemba). The objective was to build capacity of laboratory staff on the laboratory Biosafety and Biosecurity.
- Two days orientation training on HIV rapid test was conducted to 80 HCWs in Unguja, aimed at updating HCWs from testing sites on new HIV testing algorithm.
- Five days training on TB quality assurance (lot EQA) was conducted to 60 laboratory staff (30 Unguja & 30 Pemba), with the aim of imparting them with knowledge on performance of EQA using lot EQA approach.
- Five days training on sputum microscopic examination was conducted to 60 laboratory staff (30 Unguja & 30 Pemba) with the aim of increasing their skills on the diagnosis of AFB using microscope.

- Mentorship was conducted for staff from 14 (9 Unguja &5 Pemba) HIV diagnostic sites and 41 (27 Unguja &14 Pemba) TB diagnostic centers on HIV and TB related IQC and EQA on recording and feedback system.

5.4.2 Service monitoring

Proficiency testing is one among the methods for external quality assurance used to measure the quality of testing services at the site. It involves distribution of samples of known results to the providers aiming to assess performance of heath care providers for reproducible results.

Proficiency testing for HIV rapid test performance was conducted in 84 (47 Unguja &37 Pemba) testing sites and TB EQA was conducted in 41 (27 Unguja &14 Pemba) TB diagnostic site using lot EQA (rechecking). This was followed with one-day feedback meeting to 71 HCWs (36 Unguja & 35 Pemba) to discuss challenges encountered during the performance of the proficiency test.

5.5 Laboratory services indicators and trend from 2013 to 2015

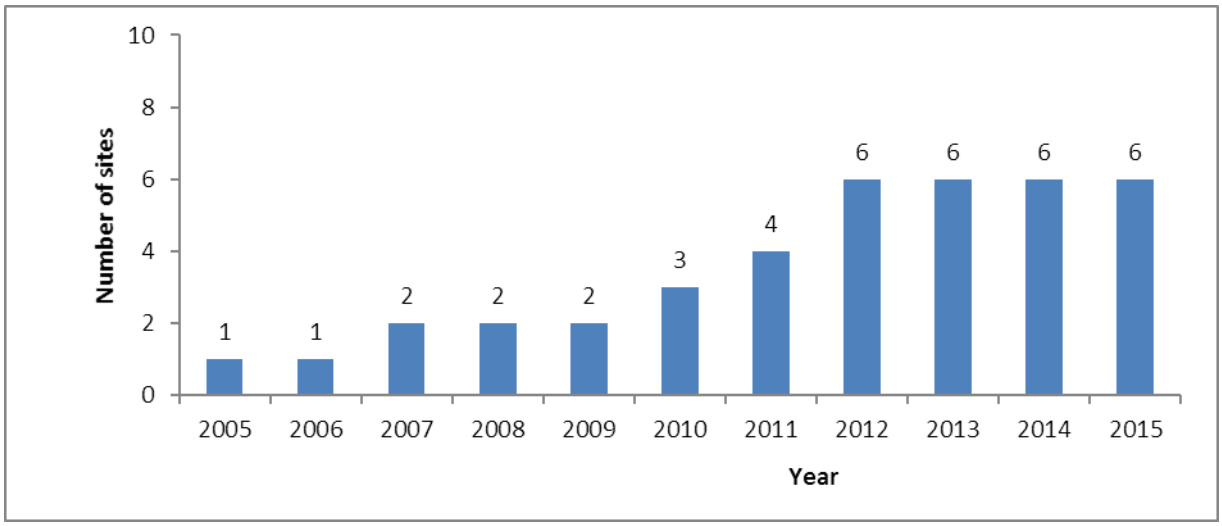
Indicator	Year		
	2013	2014	2015
1. Number of laboratories with capacity to perform clinical laboratory tests for HIV care and treatment services	**5** out of **10**	**6** out of **11**	**6** out of **12**
2. Number and percent of laboratories that implement three Laboratory Quality Management elements	**5**	**10**	**10**
3. Number of HIV testing sites participating in proficiency testing for HIV testing	**212** (**56** for HCT &**156** for PMTCT)	**0**	**84 (37** HTC & **47** PMTCT**)**
4. Number of TB diagnostic sites participating in proficiency testing for TB	**46**	**43**	**41**

diagnosis			
5. Number of TB diagnostic sites performing AFB examination	**46**	**43**	**41**

1. Number of laboratories with capacity to perform clinical laboratory tests for HIV care and treatment services

A total of 6 CTC laboratories provide HIV related tests which include CD4, Chemistry, and Hematology analysis, for monitoring the progress of HIV patients. The CTC laboratory services were gradually scaled up from 1 site in 2005 which was Mnazi Mmoja Hospital, followed by Chake Chake Hospital in 2007 and Wete Hospital in 2010. Installation of CD4 machine was done in Kivunge cottage hospital in 2011, and in 2012 services were scaled up in Mwembeladu Maternity Hospital and Bububu Military Hospital. Other 5 CTC laboratory have capacity to perform some of the clinical analysis but do not to include CD4. These sites have system for transportation of samples to nearby health facility for analysis. These sites include Micheweni and Mkoani Hospital for Pemba and Al-Rahma, Makunduchi, and ZAYEDESA in Unguja.

Figure 5.1: Number of sites with capacity to perform Clinical Laboratory Tests by year, Zanzibar, 2005-2015



The table 5.1 below shows the number of HIV clinical tests performed from 2011 to 2015 by site. The performance of testing was increasing with each subsequent years; this was due to increases in enrolment of clients in all CTCs. Each client is offered first CD4 test as a baseline on enrolment and is tested twice a year thereafter to monitor progression of the

disease. However, for other chemistry tests including ALT and AST, these are done every three months depending on the condition of the patient.

Table 5.1: Number of clinical tests performed disaggregated by site and year, Zanzibar, 2011-2015

Period (Year)	Number of Clinical Tests performed					
	Mnazi Mmoja	Mwembeladu	Kivunge	Bububu	Chake Chake	Wete
2011	10,038	776	234	430	1,386	1,134
2012	19,146	2,436	970	2,308	1,746	1,016
2013	18,382	2,186	834	3,008	1,301	819
2014	22,750	1,459	719	2,217	1,321	1,274
2015	31,744	1,352	1,087	1,472	978	901

Samples for early infant diagnosis (EID) were collected from PMTCT sites and transported to Muhimbili National Hospital, Dar es Salaam. The data show that there was a decrease of HIV positive infants from 7 infants (2.6%) in 2014 to 6 infants (2.3%) in 2015, the detailed data is as shown in the table below:

Table 5.2: Number of DBS samples for HIV DNA PCR testing by year, Zanzibar, 2011-2015

Period	Number of samples transported	Number of results received	HIV positive samples
2011	185	185	20 (10.8%)
2012	194	194	7 (3.6%)
2013	259	259	22 (8.4%)
2014	270	270	7 (2.6%)
2015	259	259	6 (2.3%)
Total	**1,167**	**1,167**	**62**

2. Number and percent of laboratories that implement three Laboratory Quality Management elements

There are 10 out of 33 (30.3%) laboratories which practice three laboratory quality management elements that include safety precautions, availability of SOPs and implement

proficiency tests. These laboratories are Mnazi Mmoja, Bububu, Mwembeladu, Kivunge, Makunduchi and KMKM for Unguja, and Chake Chake, Vitongoji, Micheweni and Wete for Pemba.

3. Number of HIV testing sites participating in proficiency testing for HIV testing

For the period of January - December 2015, a total of 84 sites (37 PMTCT & 47 HTS) participated in proficiency testing for HIV rapid test. In 2014 there was no site which participated in PT due to shortage of fund for preparation and distribution of samples. Among 84 HIV rapid testing sites that participated in proficiency testing 97% (82/84) achieved the acceptable performance of ≥98%.

4. Number of HIV testing sites participating in proficiency testing for TB diagnostic sites

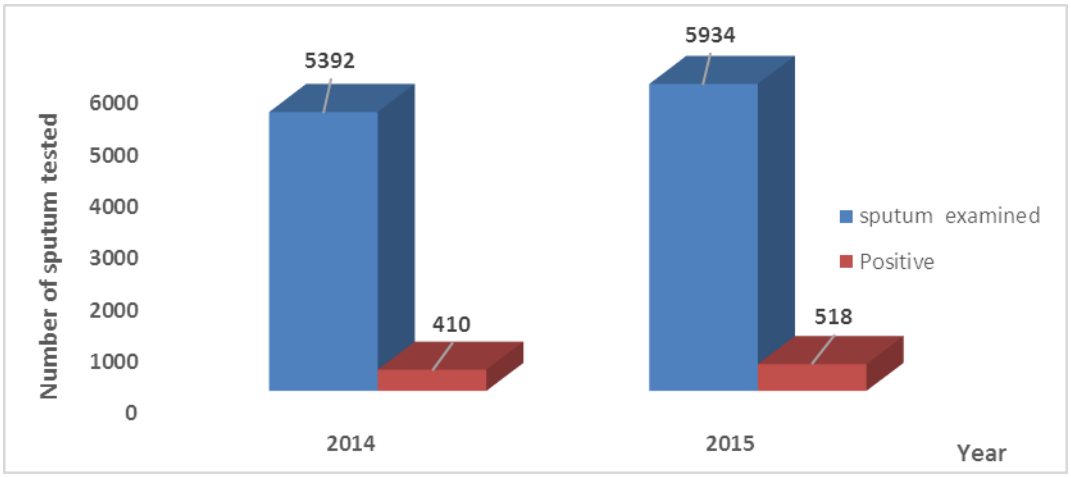
For the period of January – December 2015, a total of 41 TB diagnostic sites participated in proficiency testing for TB using lot EQA the sites remained the same as 2014. Performance was 100% (43/43) for all TB sites.

5. Number of TB diagnostic sites that perform AFB examination

Diagnostic sites which perform AFB examination has decreased from 43 in 2014 to 41 in 2015. However, the diagnostic performance increased from 5,392 with 410 positives (2014) to 5,934 (2015) with 518 positives. Sputum are examined in all TB diagnostic sites by microscopy technique with the exception of one site (Mnazi Mmoja) that use both Gene X-pert and microscopy examination.

There was an increased number of samples from CTC patients, from 229 with 12 positives in 2014 to 391 samples with 15 positives in 2015. Mnazi Mmoja examined 1,517 (2015) compared to 745 (2014) using Gene X-pert. This technique is specific and sensitive in diagnosis even in low infectious case and MDR cases. Furthermore, extra pulmonary samples for AFB was diagnosed using Gene X-pert which shows 4 samples out of 33 were positives in (2014) and 5 samples out of 65 were positive in 2015.

Figure 5.2: Sputum examination using Microscopy examination by year, Zanzibar, 2014-2015



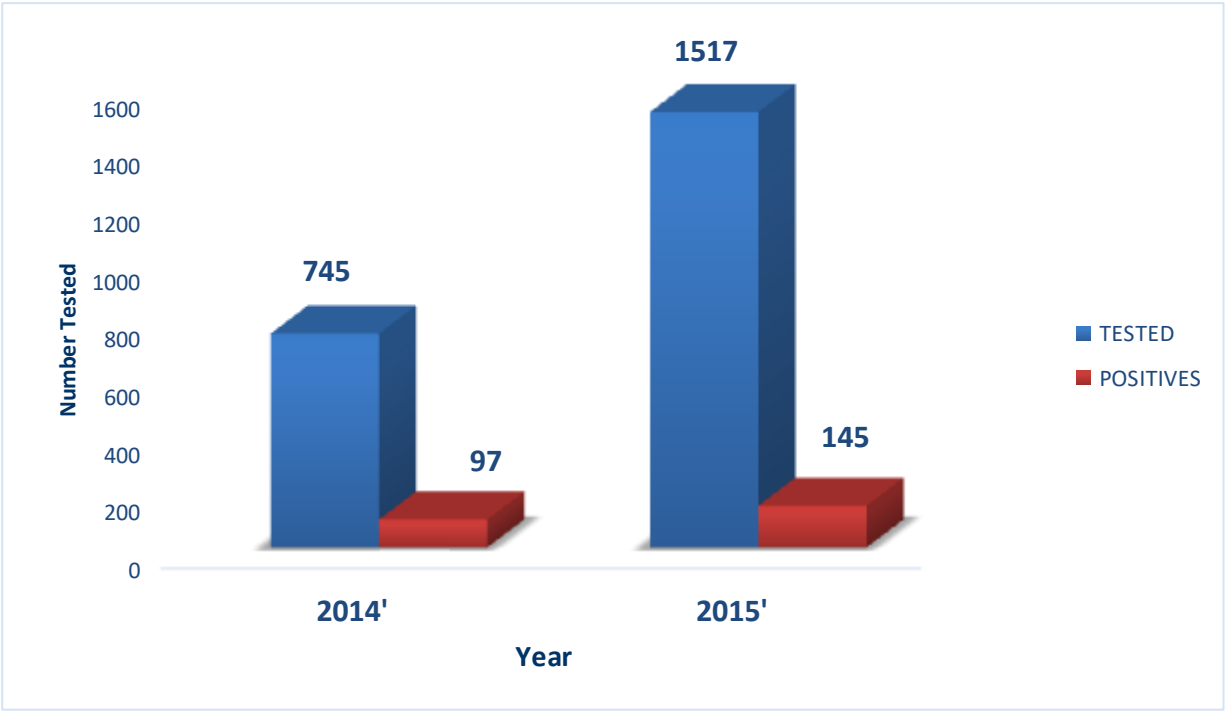


Figure 5.3: Sputum Examination using Gene X-pert by year, Zanzibar, 2015

5.7 Challenges

- Delay in receiving DBS sample results
- Under-utilization of the TB diagnostic sites for TB diagnosis by prescribers
- Irregular availability of laboratory reagents and supplies

- Limited space of laboratory rooms for performance of sputum analysis

CHAPTER 6: INFORMATION, EDUCATION AND COMMUNICATION/ BEHAVIOUR CHANGE COMMUNICATION

6.1 Background

Information, Education and Communication/Behaviour Change Communication (**IEC/BCC**) is one of the ZIHTLP units which create awareness and facilitate changing behaviours that put individual at risk of contracting or transmitting HIV, TB and Leprosy in the community. IEC/BCC is cross cutting to all ZIHTLP units in control and prevention interventions. Also, ZIHTLP recognizes that information and education for behaviour change to the community are crucial in improving health status of Zanzibar population. Furthermore, Communication strategy is a guiding tool for the implementation of IEC/BCC in Zanzibar. ZIHTLP through IEC/BCC unit is expecting to further strengthen its activities on HIV/AIDS, TB and Leprosy BCC strategies.

6.2 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 behaviours positively from the risk behaviours and accessing the related services that could help in HIV, TB and Leprosy prevention in Zanzibar.

6.3 Objectives

1**)** To empower community with knowledge and skills to utilize culturally appropriate approaches in prevention of HIV, TB and Leprosy transmission

2) To raise public awareness about behaviours that put individuals at the risk of contracting or transmitting HIV, TB, Leprosy and other STIs

3) To empower communities on TB, TB/HIV and Leprosy prevention, care and support through Advocacy Communication and Social Mobilization (**ACSM**)

6.4 Programme Implementation

6.4.1 Capacity Building

6.4.1.1 Conduct training on pathway to behaviour change game

IEC/BCC unit conducted ten days training on pathway to behaviour change game for **36** peer educators, **20** from Unguja and **16** from Pemba among Key Populations (KPs) in Zanzibar. The aim was to train peer educators on how to use the game to facilitate change of risk behaviours among KPs in their outreach interventions.

6.4.2 Service Monitoring

6.4.2.1 Conduct FBO Technical Working Group meetings

During this year, two FBO TWG meetings were conducted to assess the progress of planned activities, challenges and plan for the programme improvement. Some of the issues discussed were:

- Shortage of IEC/BCC materials in school health clubs: Members agreed to ask school health clubs to approach other partners with similar interest to acquire those materials

- Documentation of HIV success stories: TWG members agreed to prepare and document success stories so that other people can learn in the future

- Adherence to treatment for PLHIV during the holy month of Ramadan: Members suggested that PLHIV should not fast so as to adhere to treatment as religion allows sick person to continue with treatment.

6.4.2.2 Conduct Spiritual Counselling at Mnazi Mmoja VCT Gold Standard Centre

In 2015, a total of **1,503** individuals and **53** couples received spiritual counselling at Mnazi Mmoja Gold Standard Centre. TWG FBO continued to provide spiritual counselling to clients who come for VCT, clients who do not accept to receive their HIV results, clients who need further counselling and PLHIV who were referred to them. The aim was to provide psychological relief and reinforce adherence to ARV treatment to PLHIV.

6.4.2.3 Participate in commemorations of the World AIDS, TB and Leprosy Days

IEC/BCC Unit participated in commemoration of World AIDS, TB and Leprosy days. In AIDS commemoration, the theme emphasized the "**Stakeholders to use opportunities they have in the prevention of HIV**". Also, related educational materials were distributed. In addition to that, TB and Leprosy days were commemorated by airing of radio interviews in **eight** radio stations whereby the TB theme was "**Reach, Treat, Cure Everyone**" and Leprosy theme was "**Eliminate Leprosy**".

6.4.2.4 Workshop to develop IEC/BCC materials for HIV, TB and Leprosy

In this calendar year, a five days workshop to review, adapt and develop HIV, TB and Leprosy IEC/BCC materials was conducted by a team of **22** participants, **17** from Unguja and **5** from Pemba. Objective of the workshop was to develop IEC/BCC materials that sensitize TB screening among PLHIV and HIV testing among TB patients. At the end of the workshop, **three** radio and TV spots on adherence to TB and ART medication, relationship between TB and HIV, and avoiding stigma to PLHIV and TB patients were developed. Also, one sticker with a message of "Avoid stigma to PLHIV, Leprosy and TB patients" and one brochure on Leprosy was developed.

6.4.2.5 Workshop to develop IEC/BCC materials on PMTCT services

In 2015, five days workshop to develop PMTCT IEC/BCC materials was conducted in Unguja by a team of **28** participants, **20** from Unguja and **8** from Pemba. The objective of this workshop was to develop IEC/BCC materials on PMTCT services reflecting option B+ including adherence and ARVs literacy for PMTCT mothers and their infants. Participants were able to develop **four** pamphlets and posters, and **three** stickers that target pregnant mothers, male partner and HCWs.

6.4.2.6 Conduct sensitization meetings on Leprosy to the community

IEC/BCC unit in collaboration with community leaders and community Leprosy committees conducted sensitization meetings within community on quarterly basis. Aim of these meetings was to create community awareness on Leprosy so as to facilitate early health care seeking behaviour and conduct screening for Leprosy at Shehia level.

A total of **1,230** people (**490** people from **9** Shehias in Pemba and **740** from 9 Shehias in Unguja) were sensitized and screened. During these meetings, a total of **8** suspects all from Unguja were identified and **2** (**25**%) were confirmed to have Leprosy. Among them, one was MB grade 0 and the remaining was PB. At the end of each meeting IEC materials were distributed.

6.4.2.7 Conduct Health Education at Health Facilities, Shehias and Sober Houses

In 2015, TB health education sessions and screening were conducted in the community to **540** and **253** people from Unguja and Pemba respectively through village health days and sober houses. During these meetings, **22** suspects were obtained, **2** patients diagnosed with TB and **1** diagnosed with leprosy. At the end of each meeting IEC materials were distributed.

6.4.2.8 School Health Education Program

Two TB school health education sessions and screening were conducted to **93** participants in Unguja while **10** were conducted to **886** participants in Pemba. Among them, **3** TB suspects were identified in Unguja and **6** in Pemba. All suspects were found negative.

6.4.2.9 Printing and distributing of IEC/BCC materials

The following table describes the materials printed and distributed in 2015.

Table 6.1: Printed and distributed IEC/BCC materials by theme, Zanzibar, 2015

Type of Materials	Theme	Target populations	Number printed and distributed
	1.Mama mjamzito tumia dawa za kupunguza makali ya VVU kwa usahihi (Pregnant mother take your ARV drugs appropriately)	General Population	2,500
	2.Baba na Mama mkingeni mtoto dhidi ya maambukizi ya VVU (Father and mother prevent your child from getting HIV infection)	General Population	2,500

Brochure	3.Tambua huduma za kumkinga mtoto dhidi ya maambukizi ya VVU (Understand prevention of mother to child transmission of HIV services)	General Population	2,500
	4.Epuka unyanyapaa kwa mjamzito mwenye VVU (Avoid stigma to pregnant mother living with HIV)	General Population	2,500
	5. Tumia dawa za kupunguza makali ya VVU na kifua kikuu kwa usahihi (Use ARV and TB drugs appropriately)	PLHIV, TB Patients	2,500
	6. Chunguza kifua kikuu na pima VVU mapema (Screen for TB and test for HIV early)	General Population	2,500
	7.Huduma za Methadone kwa watumiaji wa dawa za kulevya (MAT services for People who use drugs (Heroin))	PWUD and PWID	3,200
	8.Methadone: Matibabu sahihi kwa watumiaji wa Heroin (Methadone: Appropriate treatment for heroin users)	Heroin Users	3,200
	9. Epuka kuchanganya methadone na dawa za kulevya (Avoid using methadone and other illicit drugs)	Methadone Users	3,200
	10.Fahamu ukweli kuhusu ugonjwa wa Ukoma (Understand facts about Leprosy)	General Population, Health Care Providers	7,200
Poster	1. Baba na Mama mkingeni mtoto dhidi ya maambukizi ya VVU (Father and mother prevent your child from getting HIV infection)	General Populations	500
	2.Pata huduma ya kuzuia maambukizi ya VVU kutoka kwa mama kwenda kwa mtoto (Receive Prevention of mother to child transmission of HIV services)	General Populations	500
	3.Tumia dawa za ARV kwa usahihi (Use ARV drugs appropriately)	PLHIV and TB patients	500
Sticker	1. Matumizi ya ARV kwa mama mjamzito mwenye VVU huimarisha afya ya mama na mtoto (Use of ARV	General Populations	1000

	to pregnant mother living with HIV improve the health of mother and her child)		

6.5 Challenges

- Shortage of fund to implement IEC/BCC activities

CHAPTER 7: MONITORING AND EVALUATION OF HIV, TB AND LEPROSY SERVICES

7.1 Background

The Strategic Information (SI) unit of ZIHTLP in collaboration with Health Management Information System (HMIS) unit of Ministry of Health (MOH) is the custodian of health sector HIV data in Zanzibar. The unit is accountable for overseeing implementation of Monitoring and Evaluation (M&E) framework and performance of M&E system. It is responsible for coordinating, collecting, storing, retrieving and analysing data from various projects in ZIHTLP. The data is disseminated and used to assist in planning and policy formulation at district and national levels and service improvement at all levels.

The SI unit is overseeing data management from the following projects: HIV surveillance, Care and Treatment, PEP, PMTCT, HIV testing, Home Based Care, Laboratory, STI, KPs, TB and Leprosy services. It also provides technical assistance on record keeping to sites providing these services, DHMT offices, HMIS Unit and other non-governmental organizations.

7.2 Goal

The goal of Strategic Information unit is to provide information for tracking progress and informing decision makers on implementation of HIV, STI, TB and Leprosy interventions.

7.3 Objectives

1. To ensure HIV, TB and Leprosy data is accurately, completely and timely collected and reported

2. To assess risk factors for transmission and monitor trends of HIV, TB and Leprosy among general population and KP groups

3. To enhance human capacity in SI among facility-level, district health management team (DHMTs) and ZIHTLP staff

4. To develop and implement health sector HIV, TB and Leprosy M&E Plan

7.4 Implementation and M&E system performance

In 2015, the program has managed to implement **10 out of 12** components of the M&E system as follows:

7.4.1. Component 1: Organizational Structure with M&E Functions

The component outlines key organizational structure, roles and responsibilities for implementing the M&E activities within the programme. Its main goal is to establish and maintain a network of organizations responsible for HIV, TB and Leprosy M&E at the national, district and service-delivery levels.

ZIHTLP has a strategic information unit which is responsible for coordinating, monitoring and evaluation of health sector HIV, TB and Leprosy interventions. The unit has staff responsible to perform M&E functions and these include: SI coordinator, Epidemiologist, M&E officer, Data managers, IT officer, Surveillance officer and Data clerks. This staffs have clearly defined job descriptions coupled with M&E roles and responsibilities. Also, each staff is assigned a service to provide technical assistance on M&E related issues. At district level, the unit works closely with DHMTs especially district surveillance officers (DSOs) who are responsible for collection of reports from service delivery sites and data management at district level.

7.4.2 Component 2: Supportive supervision and data auditing

Supportive supervision and data auditing are integral parts of a routine monitoring system. The performance goal is to monitor data quality periodically and address obstacles to produce high quality data (i.e. valid, reliable, comprehensive, and timely). Supportive supervision for different services was conducted quarterly by unit coordinators accompanied by other technical and SI officers within the program.

7.4.2.1 Supportive supervision at district level

Supervision to all 10 DSOs in Unguja and Pemba was conducted twice, with the aim of monitoring how HIV/STI/TB and Leprosy data are handled at district level. Areas supervised include availability of monthly monitoring tools, collection of the tools from sites, data entry, analysis and use at district level. A general observation was that, DSOs collected HIV, STI, TB and Leprosy services data from sites and entered the data in District Health Information System 2 (DHIS2) database. However the following challenges were identified:

- Inaccuracy and incompleteness of reports collected
- Inadequate maintenance of ICT equipment and unreliable internet availability at district level
- Inadequate data cleaning, analysis and use of HIV, STI, TB and Leprosy data at district level

7.4.2.2 HIV/STI, TB and Leprosy data verification at health facility level

HIV, STI, TB and Leprosy data verification was conducted in **83/245** (34%) health facilities (29 in North Region Unguja and 54 in South and North Regions Pemba). 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 key findings from this activity were:

- Almost all health facilities had required guidelines for service provision, standard data collection tools and reporting forms, though few health facilities did not have HBC and STI guidelines.

- Most of the service indicators were not 100% accurate, i.e. there were either under-reporting or over-reporting but the discrepancies were higher for HBC, PMTCT indicators and less for STI and HTS indicators.

During the data verification exercise, all the reports in the visited sites for the period that was verified were corrected, issues noted were shared with staff on site and strategies for improving their reporting agreed upon.

7.4.3 Component 3: Human Capacity for M&E

The main goal of human resource capacity building for M&E is to establish adequate skilled human resources at all levels of the M&E system. In this year the following trainings and mentorships were conducted to enhance staff capacity at different levels.

7.4.3.1 Training on HIV estimates and projections using Spectrum

SI unit conducted a three days training for 36 staff (27 from Unguja and 9 from Pemba) on the use of spectrum model of HIV estimates and projections. The objective of the training was to build capacity of staff to use spectrum and produce HIV estimates and projections that are necessary to plan and monitor the HIV epidemic. The participants for this training were drawn from various units within and outside program including HMIS unit of MoH, Office of Chief Government Statistician and Zanzibar AIDS Commission.

7.4.3.2 Mentorship on data management at district level

Mentorship was conducted to DSOs of all the 10 DHMTs in Unguja and Pemba. The objective was to build their capacity on managing HIV/STI/TB& Leprosy data including collection, verification, entering in computer, cleaning, analysis, interpretation and presentation. During the mentorship, data quality issues were observed in facilities including incompleteness and inconsistence of collected reports. Hence, corrections were done and DSOs were mentored on how to verify data before collection and entry in DHIS2.

7.4.3.3 Mentorship on data recording and reporting at facility level

Following data verification, mentorship was conducted for HCWs at **24** health facilities (18 in Unguja and 6 in Pemba) on proper filling of data recording and reporting tools, using trained mentors from their respective districts. Each site had one mentor for three days. The mentees were mentored on how to fill registers, prepare monthly reports as well as to develop an action plan on all identified issues. The action plan will be used as reference on the next verification and mentorship to assess whether the mentorship has made any changes to address the identified gaps.

7.4.4 Component 4: M&E Partnerships

M&E partnership refers to a cooperative relationship between people or groups of people who agree to share responsibility for achieving the requirements of the M&E plan. The goal is to establish and maintain partnerships among in-country and international stakeholders who are involved in planning and managing the national HIV/TB and Leprosy M&E system.

During the reporting period, ZIHTLP worked with different local and international partners on the following M&E activities:

- CDC provided technical assistance to develop study protocol on formative assessment for KPs
- THPS supported harmonization and development of national KP monitoring tools
- Measure Evaluation conducted assessment of data demand and use
- UNDP provided financial assistance for fishermen IBBSS
- UNAIDS provided financial support and technical assistance to train staff on use of spectrum for HIV estimates and projections.

7.4.5 Component 5: Monitoring and Evaluation Plan/Framework

The program has developed HIV M&E plan for 2012-2016 that aimed at measuring the level of implementation of Zanzibar HIV Health Sector Strategic plan II and TB M&E plan for 2011 to 2015 to monitor implementation of Zanzibar TB and Leprosy Strategic Plan. These plans are coming to an end this year and hence the programme is under preparation to develop new frameworks.

7.4.6 Component 6: Survey and surveillance

Periodic survey and surveillance were conducted to track the trend of HIV infections to provide information for program planning. In 2015 the program has managed to do the following:

7.4.6.1 IBBSS for fishermen

IBBSS for fishermen was conducted with the objective of determining HIV prevalence and accompanied behavioural pre-disposing factors associated with HIV/STI transmission among fishermen in Zanzibar. Data collection was conducted whereby a total of 1,021 fishermen from all districts of Zanzibar were enrolled in the study; this was followed by data entry, cleaning and analysis. Report writing and dissemination will be conducted in the year 2016.

7.4.6.2 Pilot study on HBV/HIV co-infection management for PLHIV

Pilot study on HBV/HIV co-infection management for PLHIV in Mnazi Mmoja CTC started on 16th July 2012. The objective of the study is to determine hepatitis B prevalence among HIV patients. Patients who test negative for HBV receive vaccination and those positive are initiated/shifted to proper ARV regimen. Up to December 2015 a total of **2,676** patients have been enrolled, **766** have received vaccination and those HBV positive are receiving treatment according to Zanzibar ART guidelines. Data collection for this study is in the final stages, however cleaning and preliminary analysis of the already collected data was conducted.

7.4.6.3 Formative assessment for IBBSS among KPs

Protocol for conducting formative assessment to determine methods that can be used to conduct next round of IBBSS including size estimation for KPs has been prepared and submitted to ZAMREC and CDC IRB for ethical clearance. Once it has been cleared, the formative assessment will be conducted in 2016.

7.4.7 Component 7: Routine monitoring

Routine monitoring provides real-time data that are used for day-to-day monitoring, coordination and planning of the HIV, STI, TB and Leprosy response. The main goal is to produce timely and high quality routine programme monitoring data.

The program has monitoring tools for all services. Patients/client forms/cards; registers, report forms together with guides are available in most of HIV, STI, TB and Leprosy health facilities. On tracking service delivery, data are recorded daily at facilities by service providers. Monthly reports for HTS, HBC, Laboratory, STI/RTI and PMTCT and quarterly reports for TB and Leprosy are prepared by service providers. The paper based reports are collected from the facilities and sent to DHMT whereby the DSO is responsible for data entry into DHIS2. However HIV care and treatment data are entered in CTC2 database at health facilities by data clerks and its reports are generated quarterly and sent to ZIHTLP.

7.4.7.1 Monitoring tools review meetings

SI unit in collaboration with other units such as PMTCT, HTS, HBC, STIs, CTC, TB and Leprosy conducted 6 sessions of tools review meetings. The objective of this activity was to review the existing monitoring tools based on additional new indicators that the program is required to report on different reporting cycles for the government and other key stakeholders.

7.4.7.2 Strategic information indicator trends

On tracking routine program services, data is entered into DHIS2. Report for three years (2013-2015) was generated from DHIS2 to show the trends of completeness and timeliness of the HIV/TB and Leprosy data.

Table 7.1: Strategic Information Indicator and Trend, 2013 - 2015

Indicator	Measurement	2013	2014	2015
Percent of facilities submitting complete and timely HIV reports	Completeness	85	85	88
	Timeliness	39	37	50

The completeness of reports collected from health facilities has increased from 85% to 88% from 2014 to 2015. Timeliness of entering reports into the DHIS2 database has also increased

from 37% to 50%. Among contributing factors for this are increased support provided to DSOs through DHMTs supportive supervision and mentorship, and availability of transport to collect reports. However, timeliness still needs to be improved in the coming years.

7.4.8 Component 8: National M&E databases

The HMIS of MoH maintains a DHIS2 as a national M&E database which houses majority of data across all health sector programs including HIV, STI, TB and Leprosy services data. This database is regularly updated based on the need of the program. ZIHTLP staffs have access to the DHIS2 through a web-based interface. Despite of program data being integrated into HMIS, the program still hosts some databases to track case by case data as need arises including:

- HTS database: This is case by case HTS surveillance database using EPI Info. HTS data is collected directly from facilities to ZIHTLP for entry. Data entry is done by SI unit staff on daily basis, cleaning on monthly basis while the analysis, presentation and interpretation is done on quarterly, semi-annually and annually.
- CTC2 database: All CTC sites have installed electronic database whereby data clerks directly enter patient level data and quarterly reports are generated and sent to ZIHTLP.

7.4.9 Component 9: Data Dissemination and Use

This involves a strategic and operational plan for information use that includes opportunities for data analysis and interpretation. The performance goal is to disseminate and use data from the M&E system to guide policy formulation and program planning and improvement.

7.4.9.1 Data dissemination

The program conducted dissemination meetings and produced several reports for informing the stakeholders on status and the level of implementation of various services as follow:

- Two days dissemination meeting to 83 participants (45 Unguja and 38 Pemba) of the findings for the 2014 ANC surveillance survey among pregnant women was conducted both in Unguja and Pemba. The objective of the meeting was to share results of the ANC surveillance to key stakeholders and discuss the findings
- Preparation of ZIHTLP annual report 2014 that printed 800 copies and distributed to stakeholders for use
- Preparation and sharing of quarterly, semi-annual and annual narrative progress and detailed indicators performance based reports for tracking HIV and TB epidemic has been done and submitted to MOH, ZAC, National TB and Leprosy Programme, CDC, Global Fund and other development partners.
- One day data review meeting with program units and other stakeholders was conducted. The meeting involved participants from ZIHTLP, DHMTs, HTS, PMTCT,

CTC, KP and TB providers and ZAPHA+ (30 Unguja and 7 Pemba). Data from different units were presented that assisted to see the comparison and find mechanisms to strengthen referral and linkages of HIV and TB related services.

- An oral presentation was made at the 2nd African Conference on Key Populations in the HIV Epidemic in Dar es Salaam, Tanzania. The presentation was titled 'Establishment of medically assisted therapy (MAT) clinic for people who inject drugs (PWID) in resource limited settings in Zanzibar, United Republic of Tanzania'. Abstract for the presentation is attached in **Appendix II.**

7.4.9.2 Data use

HIV/TB and leprosy data were used for planning purposes e.g. designing interventions, prioritization, and resource allocation and setting targets. In 2015, the programme has used data for various activities including the following:

- Resource mobilization such as writing of Global Fund Concept Note
- Tracking patients on HIV care and treatment who are lost to follow up
- Following up HIV positive pregnant women and their exposed infants who are lost to follow up
- TB and Leprosy contact tracing

However use of data for service improvement at all levels was still inadequate and needs strengthening.

7.4.10 Component 10: M&E advocacy, communication and culture

The main goal of this component is to ensure knowledge of and commitment to HIV, TB and Leprosy M&E among policy makers, program managers, program staff and other stakeholders. Commitment to M&E activities exists within ZIHTLP whereby it is well reflected in national strategic plans, annual work plans. In addition M&E personnel are part of management and planning team at national and district level and M&E performance is communicated in quarterly, semi-annual and annual reports. Furthermore, HIV, TB and Leprosy information are requested by different stakeholders. However, M&E system information products are largely disseminated within the health care system and not to the public e.g. through newsletters and website.

7.4.11 Components 11&12: Annual costed M&E work plan and Evaluation and Research

Two M&E system components which are annual costed M&E work plan and Evaluation and Research are areas of concern that needs more attention in the next year as nothing had been done recently. Therefore, these needs further strengthening.

7.5 Challenges

- Inadequate quality of service data
- Inadequate use of data for service improvement

- Lack of annual costed M& E work plan
- Inadequate capacity to conduct impact evaluation studies and operational research
- Lack of programme website

CHAPTER 8: PROGRAMME MANAGEMENT AND FINANCE

8.1 Overview

The principal role of Programme Management Unit (PMU) is to coordinate and support the other programme units to implement technical roles by ensuring availability of necessary requirements to execute their normal official duties. In addition to coordination, it also oversees all administrative and financial management aspects of the program including human resource, financial resource, procurements as well as tracking of the procured goods and services. PMU is responsible for preparing financial reports and, in collaboration with other units, compiling technical reports and submission of reports to the Ministry and stakeholders. It is also responsible to ensure proper implementation of programme work plan towards meeting its objectives.

8.2 Goal

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

8.3 Planning and administration

Apart from coordinating other units, Programme Management Unit is also responsible for the following areas: a) Policy guidance; b) Planning and budget; c) Management of staff; d) Capacity building; e)Inter and Intra Coordination; f) Procurement and provision of logistics; g) Financial management; and h)Monitoring, evaluation and reporting.

8.3.1 Policy Guidance

Programme Management Unit has the mandate to develop policy guidelines to guide the technical unit staff within the Programme and all HIV and TB implementers in the Country on the processes and procedures that are requisite for ensuring accountability of funds disbursed to them and guide them on reporting requirement to HIV, TB and Leprosy partners. In this reporting period, the unit managed to develop Sub-Recipient financial guideline for Global Fund to be used by sub-recipients.

8.3.2 Planning and budget

Every financial year, the programme prepares a comprehensive work plan and budget that includes Government plus different HIV, TB and Leprosy partners' budgets in the fiscal year. The Government financial year runs from July to June, however some of the partner's budget is not in line with the above mention period, i.e. they follow calendar year. The final consolidated budget is then submitted to the Ministry of Health for submission to the Ministry of Finance and presentation to the House of Representatives.

8.3.3 Management of staff

The Zanzibar Integrated HIV, TB and Leprosy Programme receives staff mainly from the Ministry of Health. However over the years, there were needs for additional staff to implement specific tasks/projects within the programme, which development partners were willing to support on contractual basis. By December 2015, a total of **92** staff (84 Government and 8 on contractual basis) with different specialties were working in the programme.

8.3.4 Capacity building

During the reporting period, technical staff from the programme participated in In-country, Regional and International Conferences/Meetings/Exchange visits/Training funded through HIV, TB and Leprosy partners in different service areas. These include the following:

- National Meetings/Conferences
  - PMTCT and ART implementing partners meeting in Tanzania Mainland organized by CDC- Care and Treatment Coordinator
  - QPR, SAPR, APR and EA meeting organized by CDC Office Dar es Salaam – Strategic Information Coordinator, M&E Officer and Programme Accountant
- Training
  - Survival analysis training – Programme Manager and 2 Coordinators
  - Master in Applied Epidemiology – Strategic Information Officer

8.3.5 Inter and Intra Coordination

The ZIHTLP in collaboration with development partners has continued to support implementation of HIV, TB and Leprosy activities at all level in providing technical support for improving quality of services, enhancing capacity of programme staff and efficient implementation of the programme interventions. Outlined in table 8.1 below are the partners working together and providing support to ZIHTLP during the year 2015.

Table 8.1: ZIHTLP Technical Support by Partners, Zanzibar, 2015

NAME OF PARTNERS	TECHNICAL SUPPORT PROVIDED
1. Grant Management Solution (GMS)	• Development of Financial Management guideline for the Management of Global Funds grants • Orientation training to GF financial procedures to technical staff
2. Pathfinder International	• Develop HBC SOP and monitoring tools • Printing of HBC guideline

3. François Xavier Bagnoud (FXB)	• Support meeting of Technical Working Group to develop ART job aids
4. Pangaea Global AIDS Foundation (PANGAEA)	• Continue to provide technical assistance in establishment of methadone services in Unguja
5. UN agencies	• Support consultants and in country technical staff in development of three year (2015- 2017) New Funding Model on HIV/TB funded by Global Fund • Support development of five years TB Strategic Plan
5. Measure Evaluation	• Data demand and information use assessment

8.3.6 Procurement and provision of logistics

In the year 2015, the programme procured the following health and non- health equipment for Unguja and Pemba:

- Six LED microscopes and One Centrifuge were procured and distributed to health facilities in Unguja and Pemba to enhance diagnosis of TB
- Server with its accessories was procured for programme use
- 4 Laptop and two desk top computers with accessories were procured and distributed to Care and Treatment, PMTCT and Key Population Coordinators

8.3.7 Financial Management

Finance unit support other technical unit in the area of financial management, budget and reporting according to financial regulation and procedures. It also has a responsibility of providing the summary of cumulative budget, income together with expenditures and share within the program and other beneficiaries periodically.

8.3.7.1 Income

In this reporting period, program received financial support from different sources for implementation of HIV, TB and Leprosy interventions in the Island. The major funding support came from the Revolutionary Government of Zanzibar and development partners namely: PEPFAR, Global Fund, United Nation Agencies-UNICEF through United Nations Development Assistance Plan (UNDAP), Tanzania Health Promotion Support (THPS) and Germany Leprosy Relief Association (GLRA). However the analysis shows that the funds received was 75% out of total budget as indicated in table below.

Table 8.2: Analysis of ZIHTLP Funds received vs Budget amount from different sources, Zanzibar, 2015

SOURCE OF FUND	BUDGET (US$)	FUND RECEIVED (US$)	% OF FUNDS RECEIVED VS BUDGET
PEPFAR(CDC)	2,552,039.00	1,968,819.65	77.15
THPS	19,201.11	14,836.91	77.27
UNDAP	11,798.61	11,798.61	100.00
TB GFR10	401,065.75	276,057.81	68.83
GLRA	12,614.00	12,614.00	100.00
GOVERNMENT	50,403.23	2,568 .00	0.05
UNICEF	61,304.28	39,194.24	63.93
TOTAL	**3,108,425.97**	**2,323,321.23**	**75.00**

The funds budgeted were to support areas outlined in table 8.3 below:

Table 8.3: Source of funds from the Government and development partners during the year 2015

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, • 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.	Tanzania Health Promotion Support	Provision of Comprehensive Care and Treatment Program in Zanzibar	• Strengthening of HIV Care and Treatment services to 11 sites (Mnazi Mmoja, Kivunge Cottage, Mwembeladu, Micheweni, Al Rahma, Chake Chake, Makunduchi, Mkoani ZAYEDESA and

			Wete Hospitals). • Key Population activities including MAT service • TB/HIV integrated services and Provider Initiated Testing and Counseling (PITC) • Gap filler to support Laboratory reagents and supplies
4.	United National Development Program – Tanzania (UNDP, UNICEF,		• Provide bridge support on HIV health sector interventions including M&E, PMTCT, Key Population and Surveillance activities
5.	GLRA (German Leprosy Relief Association)		• Monthly supervision to the sites providing Leprosy services • Contact tracing for Multi bacillary Leprosy patients, • Health education on leprosy to the community, • Training on prevention of disability committees • Reconstructive surgery for leprosy patients • Follow up of existing self-care groups
6	**Government of Zanzibar**	Developing Program	• Support HIV,TB and leprosy programme activities.

8.3.7.2 Expenditures

Expenditure reports help the management in making decision on the allocation of funds and projection of coming budget. All expenditures of the Program were prepared by complying with Public Finance Act, Public Financial Manual, Program Financial Manual and Public Procurement Act.

For the financial year 2015, the program revealed expenditures of total amount of **USD 2,051,322.76** as described in table below:

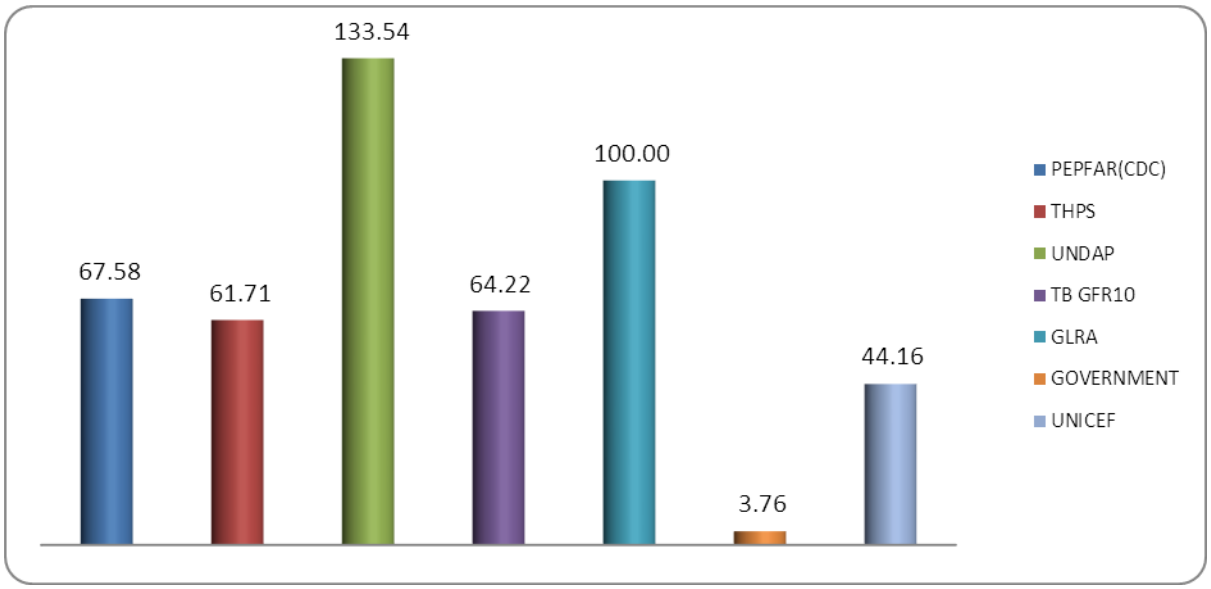
Table 8.4: Analysis of ZIHTLP Expenditure vs Funds received from different sources, Zanzibar, 2015

SOURCE OF FUND	FUND RECEIVED (US$)	EXPENDITURE (US$)	% EXPENDITURE VS FUNDS RECEIVED
PEPFAR(CDC)	1,968,819.65	1,724,559.03	87.59
THPS	14,836.91	11,849.68	79.87
UNDAP	11,798.61	15,756.12	133.54
TB GFR10	276,057.81	257,577.51	93.31
GLRA	12,614.00	12,614.00	100.00
GOVERNMENT	2,568 .00	1,893.97	73.75
UNICEF	39,194.24	27,072.44	69.07
TOTAL	**2,323,321.23**	**2,051,322.76**	**88.30**

8.3.7.3 Analysis of Budget, Income and Expenditures

ZIHTLP received total amount of **USD 2,323,321.23** out of total budgeted **USD 3,108,425.97** and resulted to the expenditures of **USD 2,051,322.76.** This shows that the Programme has received 75% of funds from the total budget while the expenditures was 88.3% of the amount received. This implies that only 66% of the total budget has been implemented during the year 2015 as per figure below.

Figure 8.1: ZIHTLP Expenditures for received funds by funder name for the year, 2015



8.3.7.4 Projection of budget for the year 2016/2017

For the financial year 2016/2017, projected budget amount of USD 4,953,676.00 is from development partners and Tshs. 100,000,000.00 is from the Government to support the implementation of HIV, TB and Leprosy activities. This shows that 90% of funds pledge is by Development Partners and 10% is from Government contribution as per table below.

Table 8.5: ZIHTLP Budget Projections from different sources for 2016/2017

SOURCE OF FUND	AMOUNT IN
PEPFAR/CDC	$1,096,793.00
UNICEF	$40,945.00
WHO	$111,954.00
GLOBAL FUND	$3,694,042.00
GLRA	$9,942.00
GOVERNMENT	Tshs. 100,000,000.00

8.4 Challenges

- Decreased financial and technical support from partners (CDC, ICAP, PATH, UNDP, MSH)
- Shortage of human resource (skilled and unskilled)
- Lack of staff development plan
- Lack of Procurement Plan

CHAPTER 9: RECOMMENDATIONS

Despite ZIHTLP having achievements in the year 2015; these were coupled with quite a number of challenges as outlined in the previous chapters. In order to enhance programme implementation and to improve quality of HIV, TB and Leprosy services, ZIHTLP will put emphasis on the following recommendations in 2016:

- Liaise with DHMTs members and Hospital management team to replenish the depleted HTS trained services providers
- ZIHTLP management should ensure adequate and timely availability of HIV test kits and other supplies at all HTS sites
- PITC services should be reinforced as a routine service for all patients who attend OPD, IPD and other clinics at all health facilities
- RCH clinics should integrate ART services for HIV positive pregnant women
- Liaise with DHMT and Hospitals management team to replenish the depleted PMTCT trained providers
- IRCH/PMTCT should improve male user friendly services
- Conduct sensitization workshop to PWID and key community leaders on MAT services
- Secure and allocate funds for procurement of urine test kits and alcohol breathalyser for MAT clinic
- Liaise with UNICEF to procure HBV reagents and vaccines
- Strengthen and scale up KPs clinical friendly services
- Mobilize financial resources for procurement and timely distribution of STI drugs at all health facilities
- Conduct STI training to at least **50** (**30** in Unguja and **20** in Pemba) HCWs
- Support HCWs to emphasize partner tracing through routine STI diagnosis and treatment of index cases at their health facilities.
- Liaise with DHMT and Private hospital board to sustain and reporting management of STI cases
- CTC unit should collaborate with HTS unit to promote escorted referrals of all newly identified HIV positive patients
- Strengthen quality improvement teams at CTCs to address retention through quarterly quality improvement meetings
- Collaborate with DHMT and health facilities management to mentor, motivate and assist facility-based HBC providers to supervise community-based HBC providers in the field and to ensure regular documentation of findings and submission of reports
- Conduct formal HBC trainings to HBC providers
- ZIHTLP to mobilize resources for procurement and distribution of HBC kits
- Strengthen collaboration and communication between MSD, NTLP, CMS and ZIHTLP for a reliable system for distribution of TB and leprosy commodities
- Enhance the capacity of HCWs and establish system to manage MDR cases in Zanzibar
- Improve MDR TB case detection through the use of X-pert MTB/RIF
- Capacity building of HCWs on diagnosis and management of Leprosy

- Collaborate with partners to procure HIV DNA PCR machine for infant diagnosis
- Encourage prescribers to utilize available diagnostic sites for TB diagnosis
- In collaboration with other partners mobilize resources for procurement of laboratory reagents and supplies
- In collaboration with other partners' expand of laboratory rooms in which sputum examination is done
- Program to mobilize resources for IEC/BCC interventions
- Data quality assessment guideline should be developed and implemented
- Organize data review meetings on quarterly basis that persuade use of data for program improvement
- Upcoming development of TB and Leprosy M&E plan should be coupled with development of an annual costed M&E work plan
- Solicit technical assistance to enhance capacity for SI and ZIHTLP staff to conduct impact evaluation and operational research
- Establish programme website
- Central Government should increase funds allocation for HIV, TB and Leprosy
- Ministry of Health should develop strategy to obtain funds to fill the HIV financing gap
- Program should develop procurement plan

Appendix I: List of Facilities providing different HIV, TB and Leprosy services by type of service and district

UNGUJA

Urban District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	MNAZI MMOJA HOSPITAL	PUBLIC	✓	✓	✓	✓	✓
2	AL RAHMA HOSPITAL	PRIVATE	✓			✓	✓
3	RAHALEO PHCU	PUBLIC	✓	✓	✓	✓	✓
4	MAFUNZO PHCU	PARASTATAL	✓	✓	✓	✓	✓
5	MARIE STOPES HOSPITAL	PRIVATE	✓		✓	✓	
6	ZAYEDESA MIEMBENI	NGO	✓				✓
7	JKU PHCU	PARASTATAL	✓	✓	✓	✓	✓
8	CHUMBUNI PHCU	PUBLIC		✓	✓	✓	✓
9	ZANGOC KIDONGO CHEKUNDU	NGO	✓				
10	DSAPR KIDONGO CHEKUNDU	PUBLIC	✓				
11	ZIWANI POLICE PHCU	PARASTATAL	✓	✓	✓	✓	✓
12	ZAPHA+	NGO	✓				
13	MWEMBELADU RCH	PUBLIC		✓	✓	✓	✓
14	MPENDAE PHCU	PUBLIC	✓	✓	✓	✓	
15	KWAMTIPURA PHCU	PUBLIC		✓	✓	✓	✓
16	SEBLENI PHCU	PUBLIC		✓	✓	✓	✓
17	MATARUMBETA PHCU	PUBLIC		✓	✓	✓	✓
18	UTAPOA DISPENSARY	PRIVATE	✓				
19	AFYA MEDICAL CENTRE	PRIVATE	✓				
20	SEVENTH DAY ADVENTIST DISPENSARY	FBO			✓	✓	✓
21	SHAURIMOYO PHCU	PUBLIC			✓	✓	✓
22	OTTU RCH	PUBLIC			✓	✓	
23	MENTAL HOSPITAL	PUBLIC				✓	
24	K/CHEKUNDU PHCU	PUBLIC				✓	✓

West District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	KMKM KIBWENI PHCU	PARASTATAL	✓	✓	✓	✓	✓
2	BUBUBU JESHINI HOSPITAL	PARASTATAL	✓	✓	✓	✓	✓
3	ZANGOC MWANAKWEREKWE	NGO	✓				
4	SOS MEDICAL CENTRE	PRIVATE	✓		✓	✓	✓
5	FUONI PHCU	PUBLIC	✓	✓	✓	✓	✓
6	AKBAR HOSPITAL	PRIVATE	✓				
7	KIEMBE SAMAKI PHCU	PUBLIC	✓	✓	✓	✓	✓

8	KIZIMBANI PHCU	PUBLIC	✓	✓	✓	✓	✓
9	CHUKWANI PHCU	PUBLIC	✓	✓	✓	✓	✓
10	SELEM PHCU	PUBLIC	✓	✓	✓	✓	✓
11	ST CAMILAS DISPENSARY	FBO	✓		✓		✓
12	BWEFUMU PHCU	PUBLIC			✓	✓	✓
13	FUONI KIBONDENI PHCU	PUBLIC			✓	✓	✓
14	KOMBENI PHCU	PUBLIC			✓	✓	✓
15	MAGOGONI PHCU	PUBLIC			✓	✓	✓
16	SHAKANI PHCU	PUBLIC			✓	✓	✓
17	SANASA DISPENSARY	PRIVATE			✓	✓	
18	MWANAKWEREKWE KKT DISPENSARY	FBO				✓	
19	KISAUNI PHCU	PUBLIC			✓	✓	✓
20	WELEZO CAMP PHCU	PUBLIC			✓	✓	✓
21	BEIT EL RAAS PHCU	PUBLIC				✓	✓
22	CHUINI PHCU	PUBLIC			✓	✓	✓

Central District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	UNGUJA UKUU PHCU	PUBLIC	✓	✓	✓	✓	✓
2	ST LUKAS MACHUI	FBO	✓			✓	
3	UROA PHCU	PUBLIC	✓	✓	✓	✓	✓
4	DUNGA PHCU	PUBLIC	✓	✓	✓	✓	
5	KIDIMNI DISPENSARY	PRIVATE	✓				
6	UBAGO MILLITARY HOSPITAL	PARASTATAL	✓	✓	✓	✓	✓
7	MWERA PHCU	PUBLIC		✓	✓	✓	✓
8	KIBOJE PHCU	PUBLIC		✓	✓	✓	✓
9	CHWAKA PHCU	PUBLIC	✓	✓	✓	✓	✓
10	JENDELE PHCU	PUBLIC	✓	✓	✓	✓	✓
11	MIWANI PHCU	PUBLIC	✓		✓	✓	✓
12	UZINI PHCU	PUBLIC	✓	✓	✓	✓	✓
13	TUNGUU PHCU	PUBLIC		✓	✓	✓	✓
14	BAMBI PHCU	PUBLIC			✓	✓	✓
15	UZI PHCU	PUBLIC			✓	✓	✓
16	MARUMBI PHCU	PUBLIC			✓	✓	✓
17	PONGWE PHCU	PUBLIC			✓	✓	✓
18	NDIJANI KWABANIANI PHCU	PUBLIC			✓	✓	✓
19	NDIJANI MSEWENI PHCU	PUBLIC			✓	✓	✓
20	MWERA PONGWE PHCU	PUBLIC			✓	✓	
21	UKONGORONI PHCU	PUBLIC			✓	✓	
22	CHARAWE PHCU	PUBLIC			✓	✓	✓
23	CHEJU PHCU	PUBLIC			✓	✓	

24	TUNGUU UNIVERSITY	PRIVATE				✓	
25	MACHUI PHCU	PUBLIC			✓	✓	✓
26	MCHANGANI PHCU	PUBLIC			✓	✓	✓
27	UMBUJI PHCU	PUBLIC				✓	✓

South District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	MAKUNDUCHI COTTAGE HOSPITAL	PUBLIC	✓	✓	✓	✓	✓
2	JAMBIANI PHCU	PUBLIC		✓	✓	✓	✓
3	MUYUNI PHCU	PUBLIC	✓	✓	✓	✓	✓
4	ZAYEDESA PAJE	NGO	✓				
5	KIZIMKAZI MKUNGUNI PHCU	PUBLIC		✓	✓	✓	✓
6	PAJE PHCU	PUBLIC		✓	✓	✓	✓
7	MTENDE PHCU	PUBLIC		✓	✓	✓	✓
8	KIBUTENI PHCU	PUBLIC			✓	✓	✓
9	KIZIMKAZI DIMBANI PHCU	PUBLIC			✓	✓	✓
10	MUUNGONI PHCU	PUBLIC			✓	✓	✓
11	BWEJUU PHCU	PUBLIC			✓	✓	✓
12	KAJENGWA PHCU	PUBLIC			✓	✓	✓
13	MICHAMVI PHCU	PUBLIC		✓	✓	✓	✓

North A District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	KIVUNGE COTTAGE HOSPITAL	PUBLIC	✓	✓	✓	✓	✓
2	MATEMWE PHCU	PUBLIC		✓	✓	✓	✓
3	PWANI MCHANGANI PHCU	PUBLIC		✓	✓	✓	✓
4	NUNGWI PHCU	PUBLIC		✓	✓	✓	✓
5	RGF KENDWA	PUBLIC		✓	✓	✓	✓
6	TUMBATU JONGOWE	PUBLIC	✓	✓	✓	✓	✓
7	TUMBATU GOMANI	PUBLIC		✓	✓	✓	✓
8	ZAYEDESA NUNGWI	NGO	✓				
9	MKOKOTONI PHCU	PUBLIC		✓	✓	✓	✓
10	CHAANI KUBWA PHCU	PUBLIC			✓	✓	✓
11	CHAANI MASINGINI PHCU	PUBLIC			✓	✓	✓
12	GAMBA PHCU	PUBLIC			✓	✓	✓
13	KIDOTI PHCU	PUBLIC			✓	✓	✓
14	TAZARI PHCU	PUBLIC			✓	✓	✓
15	KIJINI PHCU	PUBLIC			✓	✓	✓

North B District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	BUMBWINI MISUFINI PHCU	PUBLIC	✓	✓	✓	✓	✓
2	BUMBWINI MAKOBA PHCU	PUBLIC			✓	✓	✓
3	KITOPE PHCU	PUBLIC		✓	✓	✓	✓
4	KITOPE RC	FBO	✓	✓	✓	✓	
5	KIWENGWA PHCU	PUBLIC	✓	✓	✓	✓	✓
6	MAHONDA PHCU	PUBLIC	✓	✓	✓	✓	✓
7	UPENJA PHCU	PUBLIC	✓	✓	✓	✓	✓
8	ZANGOC MAHONDA	NGO	✓				
9	DONGE MCHANGANI PHCU	PUBLIC			✓	✓	✓
10	DONGE VIJIBWENI PHCU	PUBLIC			✓	✓	✓
11	FUJONI PHCU	PUBLIC			✓	✓	✓
12	KIOMBA MVUA PHCU	PUBLIC			✓	✓	✓
13	KIYONGWE PHCU	PUBLIC			✓	✓	✓
14	ZINGWE ZINGWE PHCU	PUBLIC			✓	✓	✓

PEMBA

Chake Chake District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	CHAKE CHAKE HOSPITAL	PUBLIC	✓	✓	✓	✓	✓
2	GOMBANI PHC	PUBLIC		✓	✓	✓	✓
3	VITONGOJI COTTAGE HOSPITAL	PUBLIC		✓	✓	✓	✓
4	ALI KHAMIS CAMP	PARASTATAL	✓	✓	✓	✓	
5	DIRA	PRIVATE	✓			✓	
6	ZAPHA+	NGO	✓				
7	MVUMONI PHCU	PUBLIC			✓	✓	✓
8	MGELEMA PHCU	PUBLIC			✓	✓	✓
9	SHUNGI PHCU	PUBLIC			✓	✓	✓
10	CHONGA PHCU	PUBLIC			✓	✓	✓
11	WESHA PHCU	PUBLIC			✓	✓	✓
12	JKU WAWI PHCU	PARASTATAL			✓	✓	✓
13	UWANDANI PHCU	PUBLIC			✓	✓	✓
14	PUJINI PHCU	PUBLIC			✓	✓	✓
15	ZIWANI PHCU	PUBLIC			✓	✓	✓
16	PUBLIC HEALTH LAB(PHL)	PUBLIC				✓	
17	TUNDAUWA PHCU	PUBLIC			✓	✓	✓
18	SDA WAWI DISPENSARY	FBO			✓		

Mkoani District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	ZAYEDESA MKOANI	NGO	✓				
2	ABDALLA MZEE HOSPITAL	PUBLIC	✓	✓	✓	✓	✓*
3	BOGOA PHCU	PUBLIC	✓	✓	✓	✓	✓
4	MTAMBILE PHCU	PUBLIC	✓	✓	✓	✓	✓
5	KIWANI PCHU	PUBLIC		✓	✓	✓	✓
6	KANGANI PHCU	PUBLIC		✓	✓	✓	✓
7	KENGEJA PHCU	PUBLIC		✓	✓	✓	✓
8	WAMBAA PHCU	PUBLIC		✓	✓	✓	✓
9	MWAMBE PHCU	PUBLIC			✓	✓	✓
10	CHAMBANI PHCU	PUBLIC			✓	✓	✓
11	KISIWA PANZA PHCU	PUBLIC			✓	✓	✓
12	MAKOMBENI PHCU	PUBLIC			✓	✓	✓
13	MTANGANI PHCU	PUBLIC			✓	✓	
14	SHIDI PHCU	PUBLIC			✓	✓	✓
15	UKUTINI PHCU	PUBLIC			✓	✓	
16	SHAMIANI PHCU	PUBLIC			✓	✓	
17	MAKOONGWE PHCU	PUBLIC			✓	✓	

* In Abdalla Mzee Hospital, HBC services are provided by the hospital and by RCH clinic and for HBC these are considered as 2 separate sites

Wete District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	WETE HOSPITAL	PUBLIC	✓	✓	✓	✓	✓*
2	PANDANI PHCU	PUBLIC	✓	✓	✓	✓	✓
3	ZANGOC MSHELISHELI KIBUTU	NGO	✓				
4	KAMBINI PHCU	PUBLIC	✓	✓	✓	✓	✓
5	JADIDA PHCU	PUBLIC		✓	✓	✓	✓
6	KIUYU MINUNGWINI PHCU	PUBLIC		✓	✓	✓	✓
7	CHWALE PHCU	PUBLIC		✓	✓	✓	✓
8	JUNGUNI PHCU	PUBLIC			✓	✓	✓
9	FUNDO PHCU	PUBLIC			✓	✓	✓
10	KISIWANI PHCU	PUBLIC			✓	✓	✓
11	OLE PHCU	PUBLIC			✓	✓	✓
12	UONDWE PHCU	PUBLIC			✓	✓	✓
13	KIUNGONI PHCU	PUBLIC			✓	✓	✓
14	VUMBA PHCU	PUBLIC			✓	✓	
15	MZAMBARAUNI TAKAO PHCU	PUBLIC			✓	✓	
16	UKUNJWI PHCU	PUBLIC			✓	✓	✓
17	KANGAGANI PHCU	PUBLIC			✓	✓	✓
18	MAKONGENI PHCU	PUBLIC			✓	✓	✓
19	KOJANI PHCU	PUBLIC			✓	✓	
20	BWAGAMOYO PHCU	PUBLIC			✓	✓	

* In Wete Hospital, HBC services are provided by the hospital and by RCH clinic and for HBC these are considered as 2 separate sites

Micheweni District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	MICHEWENI COTTAGE HOSPITAL	PUBLIC	✓	✓	✓	✓	✓
2	WINGWI PHCU	PUBLIC	✓	✓	✓	✓	✓
3	KONDE PHCU	PUBLIC	✓	✓	✓	✓	✓
4	ZANGOC MICHEWENI	NGO	✓				
5	KIUYU MBUYUNI PHCU	PUBLIC		✓	✓	✓	✓
6	SHUMBA VIAMBONI PHCU	PUBLIC	✓	✓	✓	✓	✓
7	CHIMBA PHCU	PUBLIC		✓	✓	✓	
8	MSUKA PHCU	PUBLIC	✓	✓	✓	✓	✓
9	MAKANGALE PHCU	PUBLIC	✓	✓	✓	✓	✓
10	TUMBE PHCU	PUBLIC		✓	✓	✓	✓
11	KIUYU MAZIWA NG'OMBE PHCU	PUBLIC			✓	✓	
12	KIUYU KIPANGANI PHCU	PUBLIC			✓	✓	
13	SIZINI PHCU	PUBLIC				✓	✓
14	MKIA WA NG'OMBE PHCU	PUBLIC				✓	
15	FINYA PHCU	PUBLIC			✓	✓	✓
16	KINYASINI PHCU	PUBLIC			✓	✓	✓
17	KIFUNDI PHCU	PUBLIC			✓	✓	

Appendix II: Abstract for the oral presentation made at 2nd African Conference on Key Populations in the HIV Epidemic in Dar Es Salaam, Tanzania

Title: Establishment of medically assisted therapy (MAT) clinic for people who inject drugs (PWID) in resource limited settings in Zanzibar, United Republic of Tanzania

Authors: Shaaban H Haji[1], Farhat J Khalid[1], Ahmed M Khatib[1], Benedicta Masanja[2], Frida Godfrey[2], Asanteeli Kweka[2], Christopher Henjewele[2], Sisty Moshi[2] and Redempta Mbatia[2]

Affiliations: [1]Zanzibar Integrated HIV TB and Leprosy Program, [2]Tanzania Health Promotion Support

Background: The HIV epidemic in Zanzibar is concentrated with prevalence of <1% in the general population. Among key population prevalence is 11.7% in people who inject drugs (PWID), 2.6% in MSM and 19.3% among sex workers. PWID are at high risk of acquiring HIV, HBV and HCV and co-infection with these viruses have implications for HIV treatment. Despite many prevention efforts, injection drug use increases worldwide and the spread to East African countries well established. Zanzibar is a target for drug trafficking due to its location along African drug trafficking route and bears a high burden of PWID. Harm reduction through medically assisted therapy (MAT) is effective in treating dependence to illicit drugs and preventing new HIV infections. Coverage of MAT services is extremely low in resource limited settings and PWID have no access to methadone. Delayed access to methadone increases chances for PWID to acquire blood borne infections. This abstract is a descriptive account sharing experience of establishing MAT services in resource limited setting.

Methods: Stakeholders engagement meetings (Zanzibar Integrated HIV TB and Leprosy Program, Zanzibar Drug Control Commission, and PEPFAR implementing partners) were done and the government of Zanzibar through Ministry of Health selected Kidongochekundu Mental Hospital to be the center for MAT clinic. Through PEPFAR support the clinic was rehabilitated. Series of community sensitization meetings were conducted involving police department, social welfare and NGOs working with KPs. Health care providers were trained for 14 days including 4 days of field attachment at the Muhimbili National hospital, Mwananyamala and Temeke MAT clinics in Dar es Salaam on MAT and services started in February 2015. Post training follow up, supportive supervisions and mentorship sessions were conducted to address challenges faced by healthcare providers while enrolling in the methadone program.

Results: Between February and September 2015, 140 clients eligible for methadone were enrolled in the program, 83.6% were male. Their ages ranged between 20 – 60 years, 21% were in the 20 – 30 years age group, 46% in 31 – 40 years age group, 32% in the 41 – 50 years age group and 1% between 51 – 60 years. Thirty five (25%). PWID were known to be HIV positive. Five enrolled PWID were lost to follow up, two of them died due to other reasons; tracking efforts facilitated return of 2 clients who was re-engaged on methadone. Retention at nine months was 96%

Conclusions and recommendations: It is feasible to set up MAT services as part of harm reduction for comprehensive HIV prevention in resource limited settings. Demand for the service is high as demonstrated by increasing numbers of the clients enrolled. The high male: female ratio is similar to other settings and efforts and strategies to increase uptake of methadone among female clients are needed. Challenges such as lost to follow up are anticipated in PWID indicating the need for strong psychosocial support program. Experience from the MAT clinic in Zanzibar will inform the Ministry of Health on strategic scale up of the intervention and reach as many PWID as possible.

Appendix III: Distribution of ZIHTLP Funds received By Development Partners, Zanzibar, 2013 -2015

YEARS	PEPFAR (CDC)	COLUMBIA (ICAP)	THPS	UNDAP	TB GFR10	GLRA	GOVERNMENT	WHO	UNICEF	TOTAL
2013	2,539,365.00	45,301.51	-	15,545.87	924,511.00	16,793.62	23,978.00	-	-	**3,565,495.00**
2014	2,967,890.00	53,704.36	-	23,293.87		12,690.82	1,164.69	6,921.77	12,155.76	**3,077,821.27**
2015	2,008,104.69	-	55,095.29	10,271.11	276,057.81	12,614.00	-	-	39,194.24	**2,401,337.14**
TOTAL	**7,515,359.69**	**99,005.87**	**55,095.29**	**49,110.85**	**1,200,568.81**	**42,098.44**	**25,142.69**	**6,921.77**	**51,350.00**	**9,044,653.41**