REVOLUTIONARY GOVERNMENT OF ZANZIBAR

MINISTRY OF HEALTH

ZANZIBAR INTEGRATED HIV, TUBERCULOSIS & LEPROSY

PROGRAMME (ZIHTLP)

ANNUAL REPORT

2016

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ACRONYMS

ACSM	Advocacy Communication and Social Mobilization
AFB	Acid Fast Bacilli
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal-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 2016 annual report is the sixth report on the progress to the HIV, STI, TB and Leprosy responses since 2011. 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.

HIV Counselling and Testing Services: During 2016, the number of Counselling and Testing sites offering HIV Counselling and testing services were123 including 26 sites providing VCT alone, 50 PITC alone and 47 both PITC and VCT. A total of 94,507 individuals from general population were counselled and tested for HIV in 2016 compared with 101,669 clients in 2015. Among the clients tested, 46,146 (48.8%) were females and 48,353 (51.2%) 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 43,937 pregnant women were tested for HIV which is 72% of all estimated pregnant women, wherein 235 (55%) HIV positive pregnant women out of 423 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 was 146/232 (63%) and all were started on Cotrimoxazole within two months of birth.

Key Population services: As of December, 2016, about 4,135 of key population including 2,294 FSWs, 588 MSMs and 1,253 PWIDs were reached with different services. A total of 281 (70% of the year one target) clients who inject/use drugs were enrolled at MAT. As of December 2016, number of clients who have been on MAT for six months and above were 194 (69%) of whom 30 (15.5%) are HIV positive clients who continue to receiving HIV care and treatment services at different CTCs.

STI/RTI Control and Prevention Programme: In 2016, a total of 8,354 STI cases reported and managed which is a decrease from 9,063 episodes reported in 2015. There was a slight decrease in STI cases diagnosed compared to 2015. Of these episodes, 7,787 were syndromic and 567 were etiological. Number of male condoms distributed through various condom

outlets in Zanzibar has declined from 15,860 in the year 2015 to 8773 in the year 2016. This decline was due to frequent stock out of male condoms in health facilities.

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 2016, a total of twelve ART clinics were provide care and treatment services with 9,289 patients ever been enrolled in CTCs of whom 6,956 (75%) are ever started on ARVs at these facilities. However, patients who are currently on ARVs including transfer in are 4,346 which is 60% (4,346/7229) of patients estimated to be in need of treatment according to spectrum 2016. About 71.3% 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 5,373 patients who were screened for TB 73 were diagnosed with TB and were started on anti TB.

Home Bases Care services: During 2016, a total of 2,351 patients received HBC services which is a decrease as compared to2,694 clients reported in 2015. Among those received services 1,255 were people living with HIV (817 females and 438 males) and 1,096 were chronically ill patients (575 females and 521 males). Children below 15 years of age were 179.

Tuberculosis and Leprosy control services: For TB services, a total number of all registered TB cases were 723, where number of new smear positive TB cases was 384. TB success rate was 93% and the cure rate was 90.2%. For TB/HIV collaborative activities, 718 TB patients tested for HIV and 110 (15%) were positive for HIV. Eighty-eight percent (88%) of the co-infected patients started ART through under one roof service. The number of new leprosy cases registered in 2016 was 77cases of whom 71.8% 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, 19.4% were children, 9.0% had disability grade 2.

Laboratory Services: A total of 23,797 clinical tests were performed in 2016 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 222HIV exposed infants and children less than 18 months of age have been tested by DNA-PCR. For TB diagnosis, in 2016,

diagnostic performance decreased from 5,934 (2015) with 518 positives to 4,914 (2016) with 356 positives. Mnazi Mmoja laboratory examined 2,737 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 2016, the programme conducted meeting on TB/HIV sensitization and health education to the community, Correction facility and to School health education program. Also, sensitization meetings on Leprosy to the community, Sensitization meeting to key community leaders on importance of Male involvement in ANC services, Sensitization meeting to key community leaders on mother mentor program, MAT services sensitization meeting to key community leaders and Workshop to create TB awareness among non -health Sectors. Also, different IEC/BCC materials on HIV and TB were developed, printed and distributed.

Strategic Information Management: Some of the key achievements during 2016 are development of 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. Also, the unit in collaboration with TB department managed to conduct study to assess Knowledge, Attitude and Practice Associated with Tuberculosis in Zanzibar community and to Health care workers. 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. These programmes were originally established as individual programmes in 1987 and were then officially joined in February 2012 in order to maximize provision of services for two interrelated diseases and efficiently utilize resources.

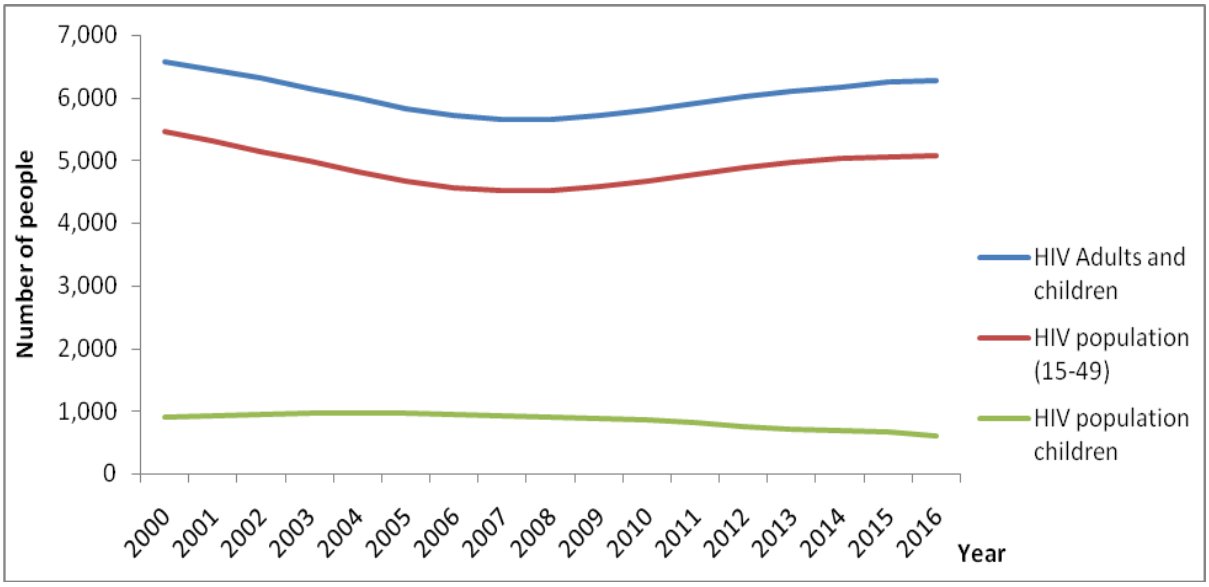
1.2 The burden of diseases (HIV, TB and Leprosy)

1.2.1 HIV situation

The first three AIDS cases in Zanzibar 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 2.6% among SWs, PWID and MSM, respectively. This is according to the Integrated Bio-Behavioral Surveillance Survey (IBBSS) conducted in 2012.

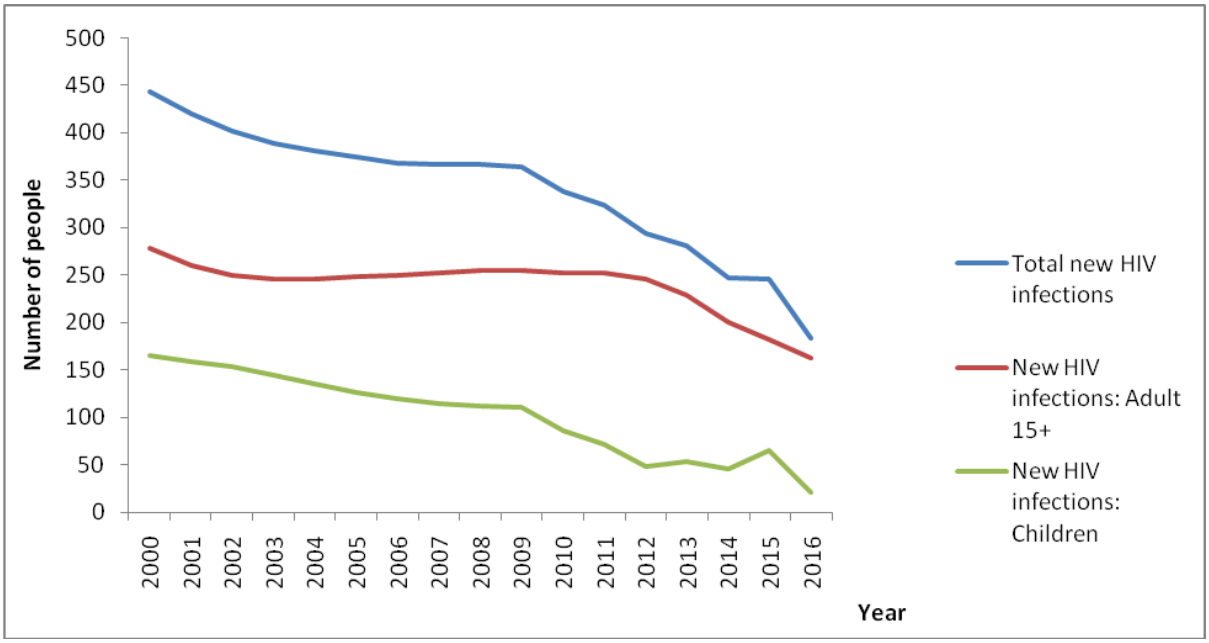
Based on the spectrum data, it is estimated that an average of 6,269 people including adults and children will be living with HIV in 2016. Among them 81% (5,063) will be people in age group of 15-49 years and 9.5% (600) are children less than 15 years of age. The population of people living with HIV (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 – 2016, Zanzibar



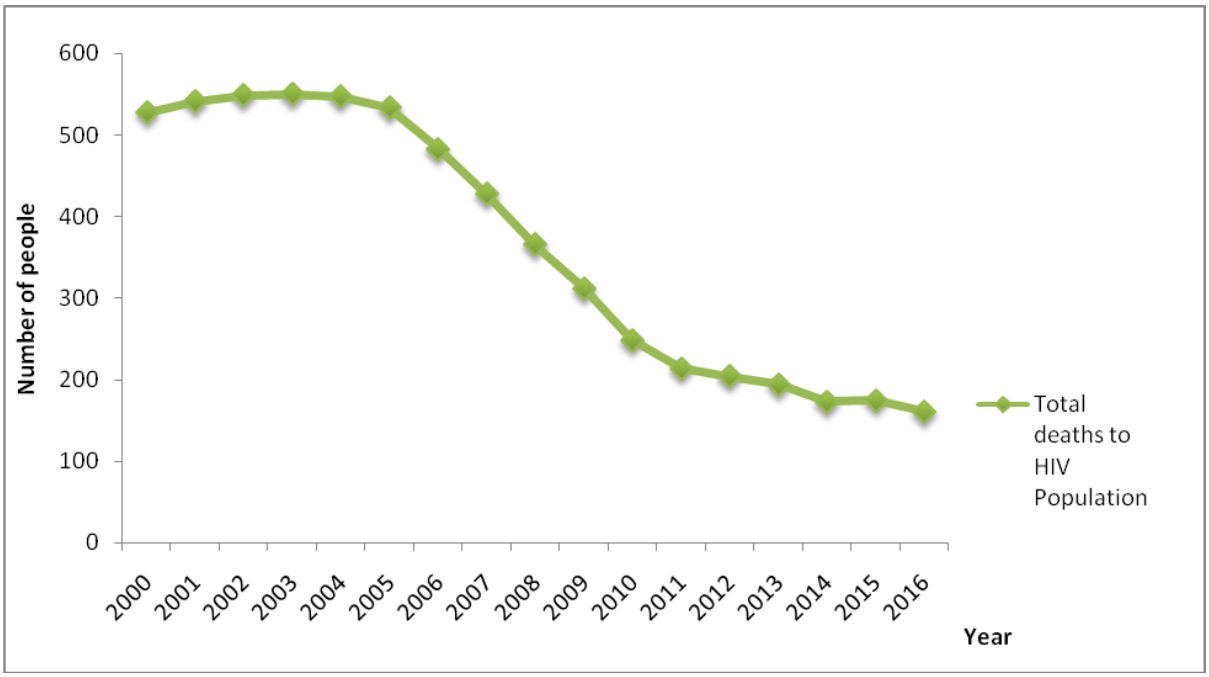
The number of new HIV infections from 2005 shows a downward trend across all age groups (figure 1.2). In 2016, 183 new cases are estimated whereby 11% (21) are children less than 15 years. The decline of new HIV cases indicates that HIV prevention and treatment interventions are fruitful.

Figure 1.2: Trend of new HIV infection from 2000 – 2016, 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 2016 in Zanzibar

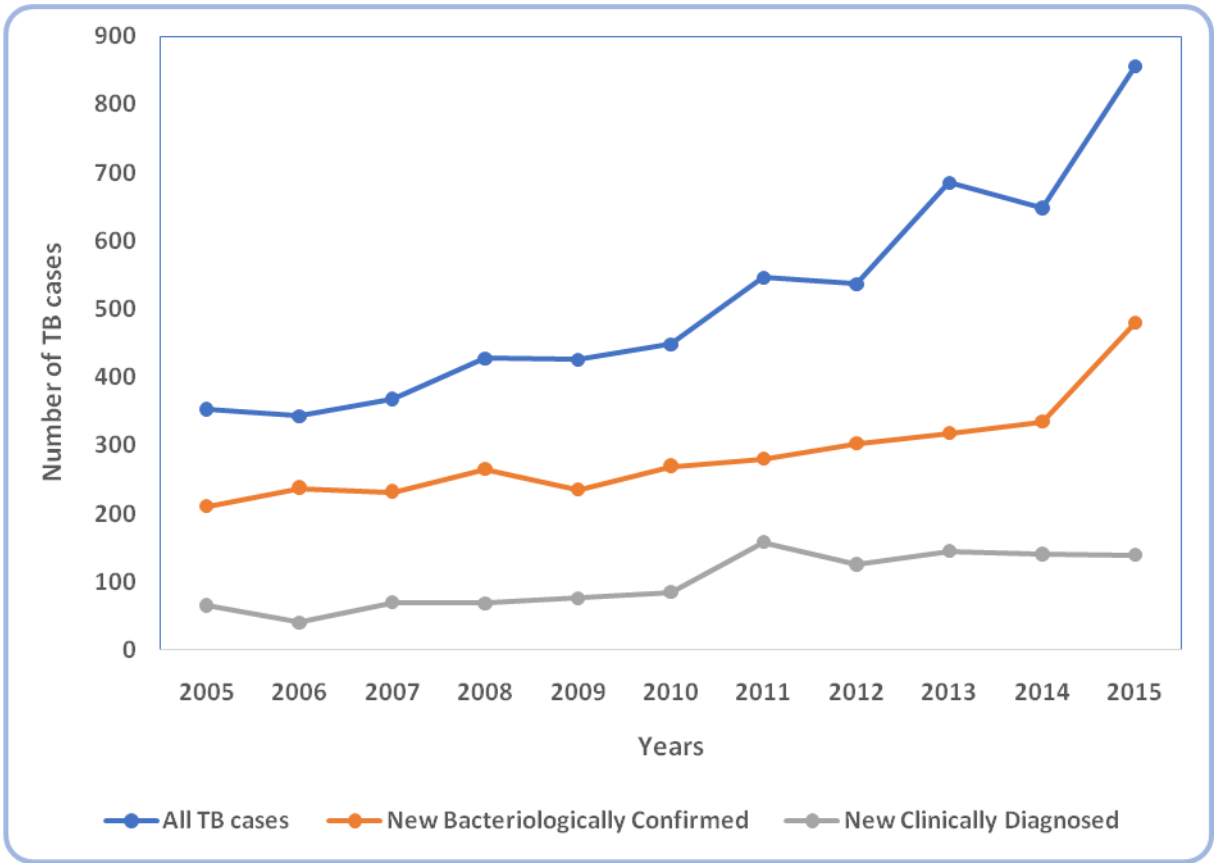


1.2.2 TB situation

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 354 in 2005 to 855 in 2015. The increase in the notification was largest in the group of bacteriological confirmed TB cases between 2014 and 2015 (Figure 1.4). Considering the age group specific notification, we observe that the group of 25-34 years is the most affected. Men are more affected than women.

Though the programme has shown an increasing trend in notification of all forms of TB in the past 11 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 method of identification from 2005-2015, Zanzibar



In 2015, a total of 855 patients were diagnosed of whom 814 (95%) were new patients. Out of 814 new patients, 479 (59%) were bacteriological confirmed, 140 (17%) clinically diagnosed and 195 (24%) were extra pulmonary TB patients. A total of 39 re-treatment patients registered during 2015, among them 19 (49%) were relapse, 4 (10%) were failure and 6 (15%) 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. In 2015, 2 MDR-TB cases were notified.

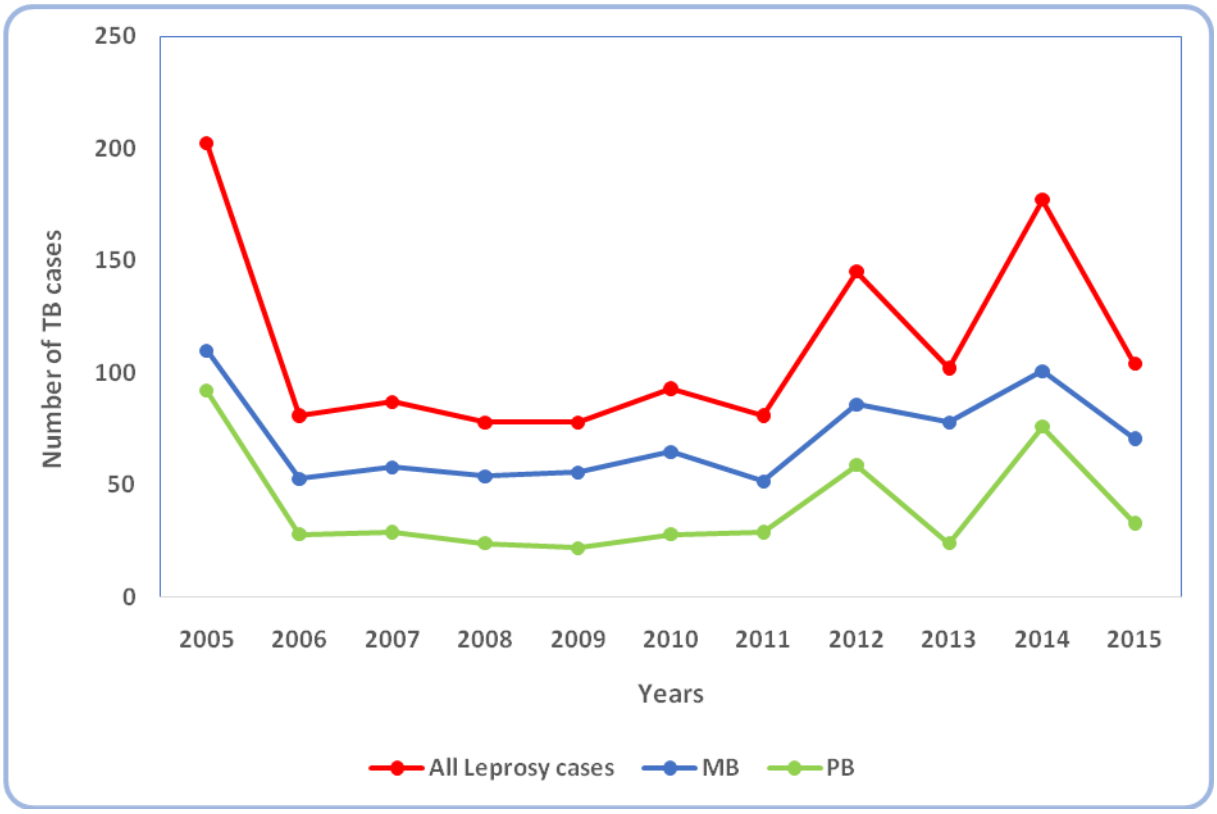
1.2.3 Leprosy situation

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 2015, the total number of Leprosy cases registered was 104, being a decrease from 177 cases in 2014. The case detection rate was slightly less than 1 per 10,000 populations.

The trend of new registered Leprosy cases has been fluctuating in the last 11 years (figure 1.5) with prevalence rate of less than 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, Urban and West 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 2005-2015 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.

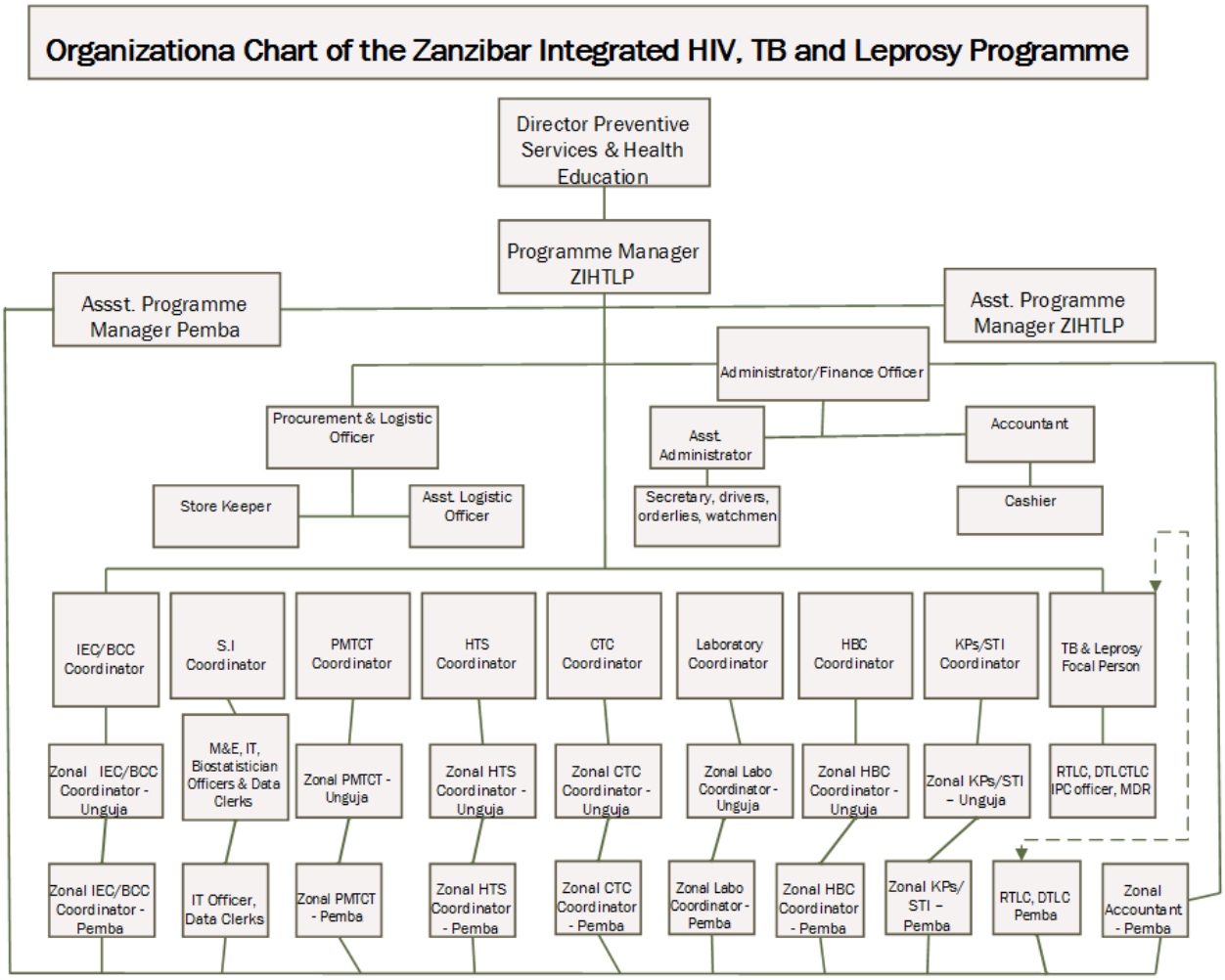
1.6 Program's Core Functions

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/Behavioural 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 Zanzibar Integrated HIV, TB and Leprosy Programme



1.8 Implementation status of previous year (2015) recommendations

Recommendation	Implementation status
Liaise with DHMTs members and Hospital management team to replenish the depleted HTS trained services providers	The unit provided a list of HTS sites and name of trained providers to DHMTs and hospital management teams. Negotiation was made with management of MMH and Fuoni PHCU+ and the following were agreed: - MMH formulated a technical committee to oversee implementation of PITC services, planned to conduct CME, developed a tool to record patients tested for HIV &recommended ward in charges to be PITC focal persons - Fuoni PHCU+ in charge agreed to conduct PITC CME for staff
ZIHTLP management should ensure adequate and timely availability of HIV test kits and other supplies at all HTS sites	ZIHTLP management introduced new logistic system to ensure HIV testing commodities are adequate and available at all HTS sites. However, problem of frequent stock out of these commodities at facility level persisted while the logistic arrangements were in process.
PITC services should be reinforced as a routine service for all patients who attend OPD, IPD and other clinics at all health facilities	HTS unit continued to reinforce the provision of PITC services as a routine. More effort will be taken to ensure DHMTs and hospital managers closely support and monitor PITC services.

CTC unit should collaborate with HTS unit to promote escorted referrals of all newly identified HIV positive patients	Effort to promote escorted referral were made including: -Develop standard referral form -Introduction of escorted referral -Transport reimbursement for counsellors -Record of CTC ID number of client in HTS register
RCH clinics should integrate ART services for HIV positive pregnant women	Work plan and budget are in place to conduct needs assessment to establish ART services at Fuoni and KMKM RCH clinics during 2016/17 financial year.
Liaise with DHMT and Hospital management teams to replenish the depleted PMTCT trained providers	The challenge was discussed with District Medical Officers in Urban and South districts and it was agreed that district will ensure there is at least one PMTCT provider at site. In worse scenario, PMTCT services will be provided as outreach by trained HCP from other sites.
IRCH/PMTCT should improve male user friendly services	PMTCT unit and IRCH program agreed that couples should be prioritised in service provision and apart from ANC and PMTCT services, male partners will be offered basic medical check up including blood glucose level, blood pressure monitoring, haemoglobin levels and determination of blood group.
Conduct sensitization workshop to PWID and key community leaders on MAT services	Two sensitization workshops involving key community leaders were conducted in Unguja and Pemba.
Secure and allocate funds for procurement of urine test kits and alcohol breathalyser for MAT clinic	Funds are available but procurement has not yet materialized. Efforts to follow up on the procurement of these materials and supplies

	is going on.
Liaise with UNICEF to procure HBV reagents and vaccines	UNICEF officers were contacted and responded that due to the UN guidelines they were not mandated to support viral hepatitis interventions targeting adults and advised to contact other UN family members as UNFPA and WHO
Strengthen and scale up KPs clinical friendly services	Equipment (Computers, printers, fingerprint machine, fridge, scanner, photocopier, stationeries and disposable drinking cups) are in place. Essential drugs, supplies and stationeries were procured and distributed to all three KP friendly sites (Mnazi Mmoja, ZAYEDESA and MAT clinic). The scale up of two additional KPs friendly sites (Correctional Facility – Kilimani Unguja and ChakeChake, Pemba) are not yet done due to insufficiency of essential resources
Mobilize financial resources for procurement and timely distribution of STI drugs at all health facilities	STI drugs have been procured in late 2016 but are not distributed. The drugs will be distributed in health facilities in the year 2017.
Conduct STI training to at least **50** (**30** in Unguja and **20** in Pemba) HCWs	Two training involving 50 (29 in Unguja and 21 in Pemba) HCWs was conducted.
Support HCWs to emphasize partner tracing through routine STI diagnosis and treatment of index cases at their health facilities.	Emphasis was made during the training and support supervision on the importance of partner tracing on STI case management however partner tracing is still a challenge.
Liaise with DHMT and Private hospital board to sustain and report management of	DMOs were involved in STI interventions, unfortunately Private hospital board were

STI cases	not involved during this year, efforts will be made to ensure involvement of Private hospital board in the coming years.
Strengthen quality improvement teams at CTCs to address retention through quarterly quality improvement meetings	One quarterly quality improvement meeting has been conducted in Unguja and Pemba. Due to shortage of funds, the target for the quarterly meetings has not been attained. Efforts will be made to solicit fund to ensure quarterly meetings are conducted in the coming year.
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	Health facility providers have started to supervise CHBC during their supportive supervision.
Conduct formal HBC trainings to HBC providers	Formal HBC training to HBC providers was not conducted due to inadequate fund
ZIHTLP to mobilize resources for procurement and distribution of HBC kits	Procurement process is ongoing and HBC kits are expected to be delivered and distributed in early 2017
Strengthen collaboration and communication between MSD, NTLP, CMS and ZIHTLP for a reliable system for distribution of TB and leprosy commodities	The system has been strengthened through MSD where by TB and leprosy commodities were incorporated in Zanzibar Integrated Logistic System (ZILS) of MOH. Moreover, the pull system has been introduced through record and reporting forms (RR) to all facilities in Zanzibar. A total of 60 health care workers (30 Unguja, 30 Pemba) were trained on Electronic

	Management Logistic system (ELMs) and proper recording and reporting of health care commodities. More training to be conducted in 2017
Enhance the capacity of HCWs and establish system to manage MDR cases in Zanzibar	The program strengthened sputum collection and transportation to X-pert machine and Central TB Reference Laboratory (CTRL) which has capacity to diagnose MDR TB. Despite of these effort the number of MDR cases notified in 2016 is still low 3 cases compared to target, 5 cases. More intervention will be conducted in 2017 including purchasing of two X-pert machines and training of health care providers on Programmatic Management of MDR TB. The program also planned to conduct drug resistance survey in 2017 to explore the actual prevalence of MDR TB in Zanzibar.
Capacity building of HCWs on diagnosis and management of Leprosy	The unit conducted on job training through supportive supervision at all level. However, the challenge still exists as the intervention was inadequate due to lack of funds to implement leprosy activities. More training will be conducted through government budget for the year 2017-2018.
Collaborate with partners to procure HIV DNA PCR machine for infant diagnosis	Negotiation with Global Fund to secure funds for DNA PCR was done and allocation is in place. Procurement will be done in 2017.
In collaboration with other partners mobilize resources for procurement of laboratory	Funds for reagents and supplies are available under GF support. However the process of procurement was delayed.

reagents and supplies	
In collaboration with other partners expand laboratory rooms in which sputum examination is done	Ten facilities were assessed and renovation planned for two laboratories i.e.Kwamtipura and Wingwi under the support of GF. Furthermore, discussion with DHMT south was done and it was agreed to allocate a new room at Muyuni PHCU and equip it with furniture to cater for lab services
Program to mobilize resources for IEC/BCC interventions	Funds for IEC/BCC activities were mobilized from development partners and through these funds, the unit was able to conduct several IEC/BCC activities e.g. development of IEC/BCC materials, sensitization meetings, radio and TV programs etc.
Organize data review meetings on quarterly basis that persuade use of data for program improvement	Strategic information in collaboration with TB/Leprosy unit conducted quarterly data review meeting that assisted to review services performance and agree on strategies to improve performance. However, plan for this year is to expand data review meeting to HIV services.
Upcoming development of TB and Leprosy M&E plan should be coupled with development of an annual costed M&E work plan	TB and Leprosy M&E plan **2015-2019** has been developed including costed M&E work plan; the plan is used for monitoring implementation of TB and Leprosy strategic plan II.
Solicit technical assistance to enhance capacity for SI and ZIHTLP staff to conduct impact evaluation and operational research	Plan for enhancing capacity of staff on operational research are in place and will be implemented in early 2017.
Establish programme website	Initiative has been made to request for technical assistance from our implementing partners. One partner (MDH) has agreed to

	provide technical support on development of the programme website that will be done in 2017.
Central Government should increase funds allocation for HIV, TB and Leprosy	Lobbying for an increase in Government funds for HIV, TB and Leprosy services has been done. In the financial year 2016/2017, programme has been allocated Tshs 100,000,000. The expenditure of these funds will start in early 2017.
Ministry of Health should develop strategy to obtain funds to fill the HIV financing gap	Mobilization of funds from different partners was conducted. In 2016, HIV received funds from several development and implementing partners including PEPFAR, THPS, GF and UN family. However, strategies to increase local financial support for HIV interventions should be developed and implemented.

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 2016. 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 (VCT)/Voluntary Counselling and Testing (VCT)
- Provider Initiated Testing and Counselling (PITC)
- Mobile HIV Testing and Counselling

The HTS have been established in **123** 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, **26** sites provide VCT services alone, **50** provide PITC services alone and **47** 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 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

During 2016, HTS Unit conducted a six days training on PITC services for **32** health care workers (**21** in Unguja and **11** in Pemba).The objective of the training was to equip health care providers with knowledge, skills and attitude in providing PITC services.

In collaboration with TB program, the unit conducted two sessions (one in Unguja and one in Pemba) of five days refresher training on PITC services for health care providers. A total of 65 health care providers from TB clinics (30 in Unguja and 35 in Pemba) participated. The

objective of the training was to build capacity of clinicians, DOT nurses and other staff on provision of quality HIV counselling and testing services to all diagnosed TB patients so as to give comprehensive services for co infected patients.

2.1.4.2 Service Monitoring

In 2016, the unit conducted supportive supervisions to 68 sites which provide VCT and PITC services (40 Unguja and Pemba 28). The objective of supervision was to monitor the progress of HTS provision and support providers to improve their performance.

Following the supervision, the unit conducted six feedback meetings for **150** HCWs (Unguja 100 and Pemba 50) providing VCT services and **154** HCWs who are providing PITC services (Unguja 100 and Pemba 54). The objective of these meetings was to share experience between HCWs and discuss success and challenges in implementing HTS.

Also, one day coordination meeting with 40 HTS stakeholders was conducted in Unguja. The aim of the meeting was to share best practice, challenges, and find the solutions that focus on the provision of quality HTS.

2.1.5: HIV Testing Services indicators and trend from 2014 to 2016

Indicator		**Year**		
		2014	**2015**	**2016**
1	Number of health facilities and sites offering HTS	**97 HTS sites** (VCT alone, 31 PITC alone, 37 and 29 both VCT and PITC)	**98 HTS sites** **(**23 VCT alone, 32 PITC alone and 43 both PITC and VCT)	**123 HTS sites** **(**26 VCT alone, 50 PITC alone and 47 both PITC and VCT
2	Number of individuals who received testing and counselling services for HIV and received their results	**123,456**	**101,669**	**94,507**
	• Individuals identified as HIV positive	**1,381**	**1,172**	**1,064**

1. Number of sites offering HTS

HTS sites have increased from **98** in 2015 to **123** in 2016. Three PITC trainings were conducted in existing and new sites. As a result, HTS services were scaled up to 18 PITC sites (11 in Unguja and 7 in Pemba) and 3 VCT in 2016. This lead to increased availability of HTS services to the population and utilization of the services.

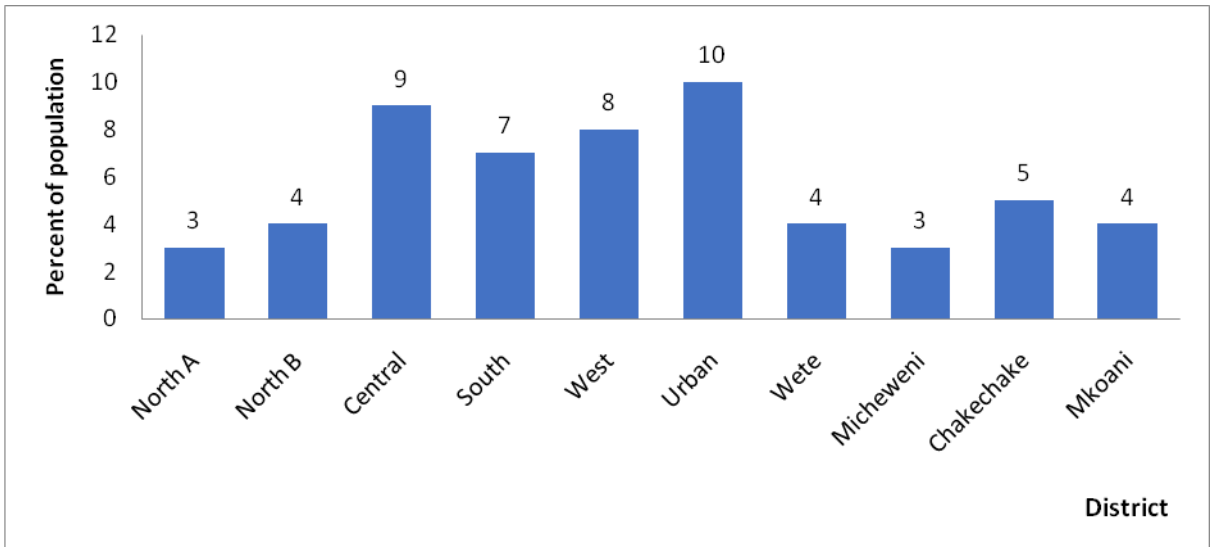
2. Individuals received HIV testing and received their test results

In 2016, a total of **94,507** individuals were counselled and tested for HIV in Zanzibar; equivalent to **6.1%** of the Zanzibar projected population. This shows a decrease of **0.6%** from the number of people who were counselled and tested in 2015**.** Among the reason of a decrease in the number of people counselled and tested was:

- Frequent stock outs of HIV test kits caused by introduction of new logistics system and inadequate capacity of HTS provider in filling the Report and Request (R&R) forms
- Shortage of trained staff at testing sites
- Transfer of skilled providers without replacement.

The figure below shows the proportion of individuals counselled and tested by district. Urban district had the highest proportion of people tested (**10%**) of district projected population, followed by Central district **(9%)** while Micheweni and North A district had the least **(3%)** each (Figure 2.1.1).

Figure 2.1.1: Percent of population received HTS by district, Zanzibar, 2016



The overall proportion of HIV positive cases among tested was **1.1% (1,064/94,507).** HIV prevalence was highest in South district (**1.6%)** and least in Mkoani district (**0.4%).** Furthermore, prevalence was two times higher in Unguja (**1.2%)** as compared to Pemba (**0.6%). (Table 2.1.1)**

Table 2.1.1: HIV proportion among tested by district of residence, Zanzibar 2016

District	Number tested for HIV	Number HIV positive	% of HIV positive
North A	5,474	55	1.0
North B	3,588	46	1.3
Urban	23,749	274	1.2
West	33,289	369	1.1
Central	7,512	110	1.5
South	3,220	50	1.6
Unguja	**76,832**	**904**	**1.2**
Wete	4,410	29	0.7
Micheweni	3,070	17	0.6
Chake chake	5,088	31	0.6
Mkoani	4,014	15	0.4
Pemba	**16,582**	**92**	**0.6**
Outside Zanzibar	**1,093**	**68**	**6.2**
TOTAL	**94,507**	**1,064**	**1.1**

Out of all people (**94,507)** received HIV testing and counselling services, **46,144** (**48.83%)** were females and **48,350** (**51.16%**) were males, with HIV prevalence being almost twice higher among females (**1.4%)** than males (**0.8%).** The age group of 45+ had high prevalence **(2.1%)** and age 15 – 24 had low prevalence **(0.5%). (Table 2.1.2)**

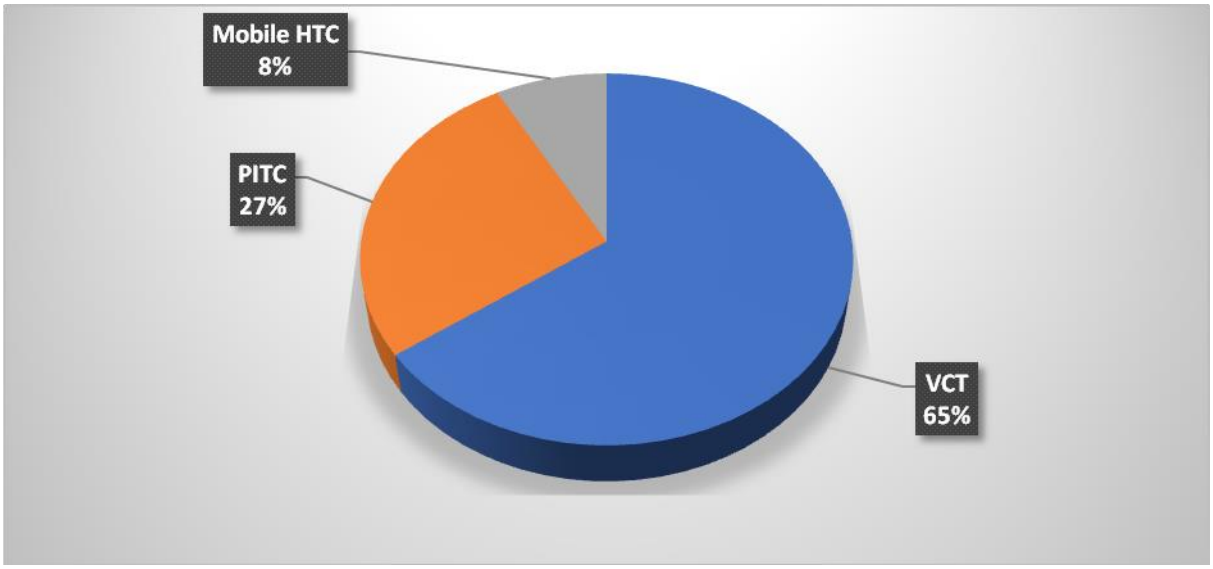
Table 2.1.2: HIV proportion among tested by age groups and sex, Zanzibar, 2016

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	1,042	13	1.3	1,070	14	1.3	2,112	27	1.3
5-14	865	12	1.4	741	15	2.0	1,606	27	1.7
15-24	19,494	134	0.7	12,584	25	0.2	32,078	159	0.5
25-34	15,523	279	1.8	20,727	131	0.6	36,250	410	1.1
35-44	6,056	140	2.3	8,149	126	1.6	14,205	266	1.9
45+	3,164	84	2.7	5,079	91	1.8	8,243	175	2.1
Total	**46,144**	**662**	**1.4**	**48,350**	**402**	**0.8**	**94,494**	**1,064**	**1.1**

***Note; 13 records excluded (5 with missing values in age group, 8 with missing values in sex variable)*

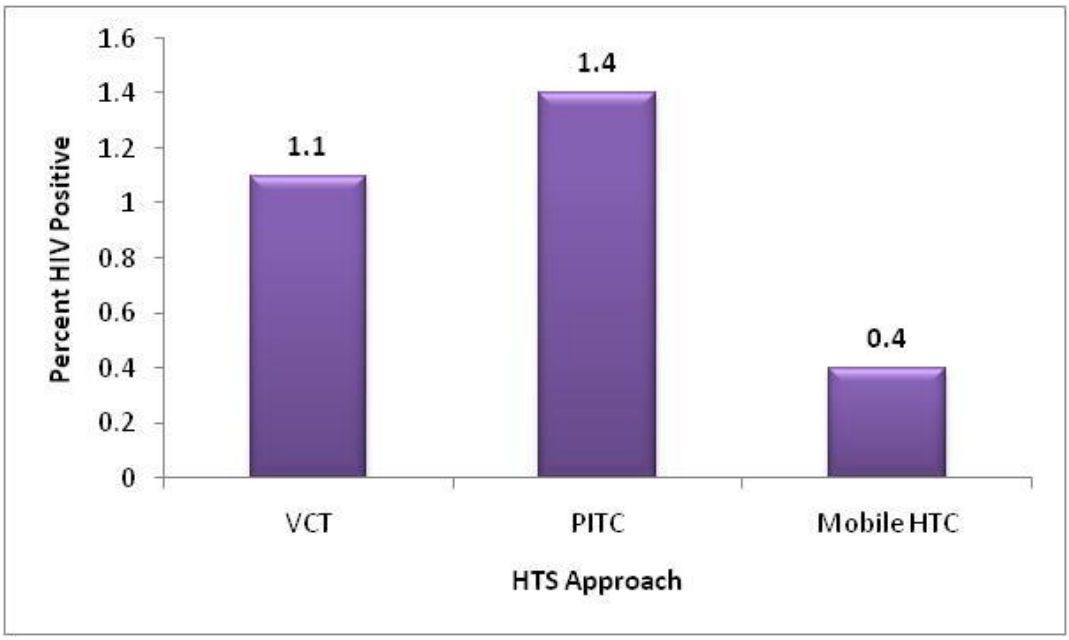
Among the people tested, 27% (**25,517/94,507**) were reached through PITC approach while the majority **(68,990/94,507)** were reached though VCT approach. Data shows that, there is 6% increasing of people reached through PITC in 2016 (Figure 2.1.2).

Figure 2.1.2: HIV testing by HTS approach, Zanzibar, 2016



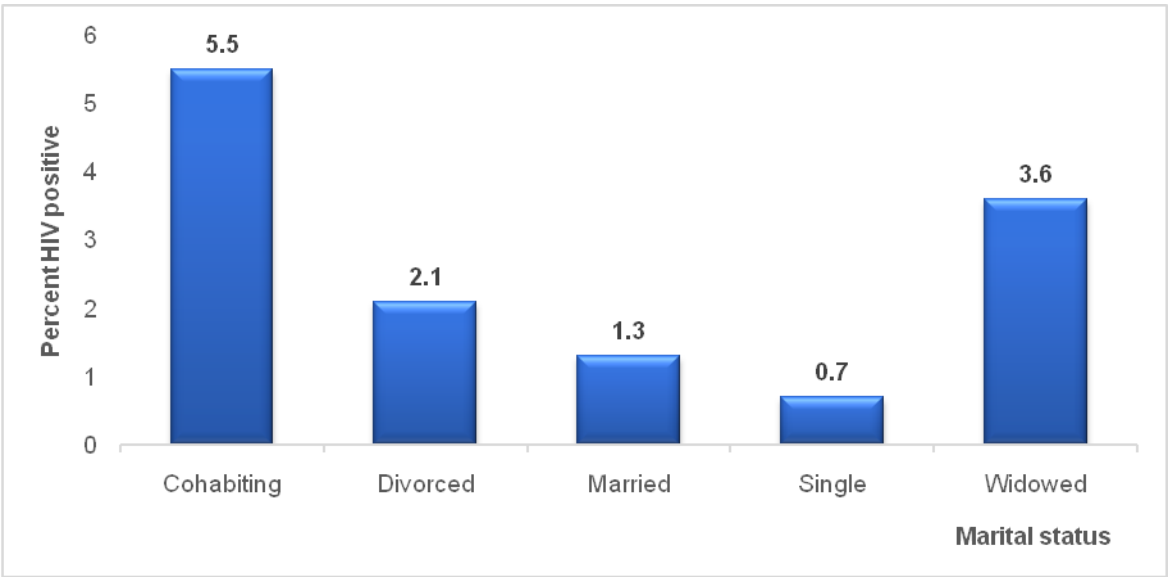
However, HIV proportion among those tested through PITC was higher **(1.4%)** than those tested through VCT **(1.1%)** and lowest tested through mobile HTS services (**0.4%). (Figure 2.1.3)**

Figure 2.1.3: HIV proportion among tested by HTS approach, Zanzibar, 2016



HIV positivity was highest among those tested as cohabiting (**5.5%**) followed by widowed (**3.6%**). The lowest **(0.7%)** was among those tested singles. **(Figure 2.1.4)**

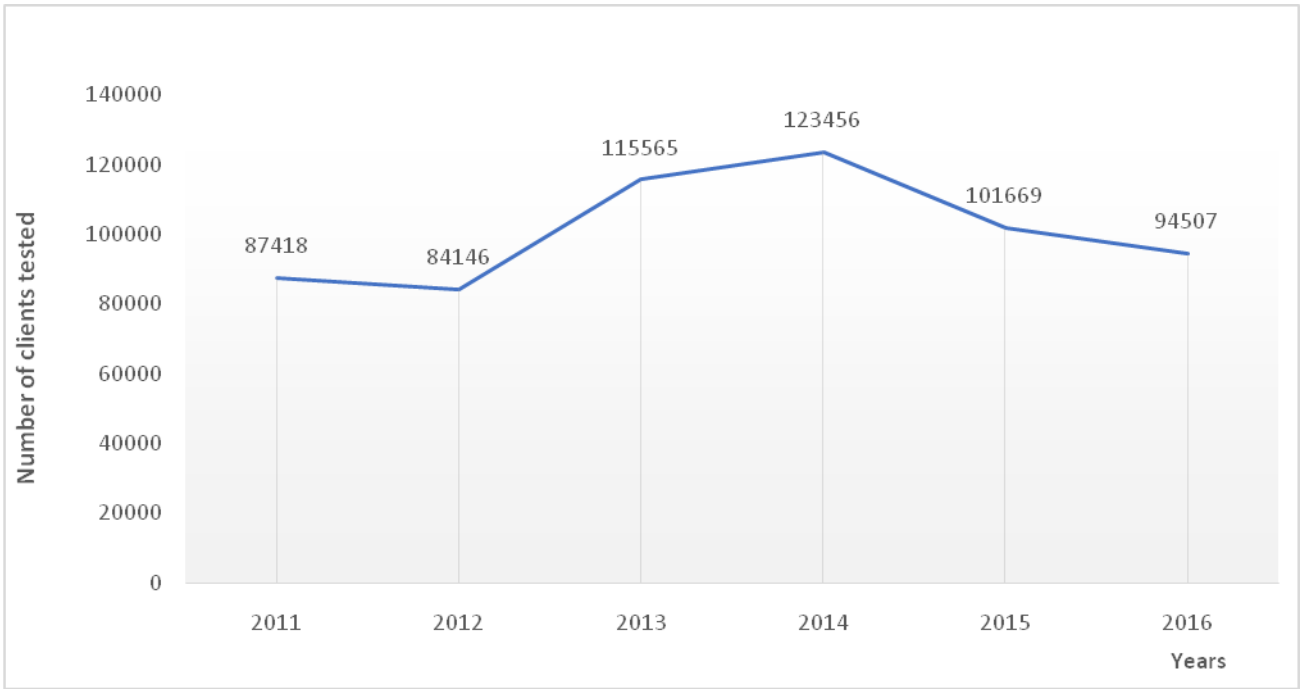
Figure 2.1.4: HIV proportion among tested by Marital Status, Zanzibar, 2016



2.1.6 Trend of number of individuals who received HIV testing services and received their results from 2011 to 2016

The number of individuals who tested for HIV has increased progressively from 2011 (**87,418**) to 2014 (**123,456**). However, there was a decrease in number people tested in 2015(**101,699**) and 2016 **(94,507).** (Figure 2.1.5)

Figure 2.1.5: Trend of people received HIV testing and received their results, Zanzibar (2012 – 2016)



2.1.7 Challenges

- Inadequate knowledge of HTS providers on filling the Report and Request (R&R) form for HIV commodities
- Low uptake of PITC services due to inadequate commitment of services providers

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

2.2.1 Background

Ministry of Health Zanzibar established PMTCT services in 2005 at 3 antenatal clinics (ANC), and to date, the services are provided at 168 reproductive and child health (RCH) clinics (100 Unguja and 68 Pemba), across all ten districts of Zanzibar.

PMTCT program targets women of reproductive health, pregnant women, breastfeeding mothers, their partners and infants. In addition, early infant diagnosis (EID) is a component of PMTCT program that entails early identification of HIV-exposed and infected infants for prompt management to improve their wellbeing and survival.

All identified HIV-infected pregnant and breastfeeding women are initiated lifelong ART soon after diagnosis, regardless of immunologic (CD4 count) or clinical (WHO staging) status, in accordance with Option B+ strategy recommended by World Health Organization (WHO).

2.2.2 Goal

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

2.2.3 Objectives

1. To eliminate transmission of HIV from mother to child during pregnancy, birth, and breastfeeding and ensure enrolment into care and treatment services for mother and HIV infected baby.

2. To improve child survival among HIV-exposed and infected children.

3. To increase utilization of PMTCT services by pregnant women and their male partners.

4. To increase percentage of HIV-positive pregnant and breastfeeding women who receive ART.

2.2.4 Program Implementation

2.2.4.1 Capacity Building

PMTCT refresher training was conducted to 70 PMTCT providers from 6 districts, Unguja. The training aimed at enhancing provider's knowledge and skills in providing quality and comprehensive PMTCT services as well as understanding new HIV testing algorithm.

In addition, the unit conducted training for 30 potential mother mentors, with an objective to empower and promote greater involvement of HIV-infected women in improving implementation of PMTCT program at health facility and community levels. The mother mentors were trained and deployed to 30 health facilities (25 Unguja and 5 Pemba) as peers, with key responsibilities to provide basic one-to-one counseling, guidance and assistance to HIV-infected pregnant and breastfeeding women to comply with PMTCT care cascade.

The unit conducted two PMTCT Score Card trainings to 60 participants (30 in Unguja and 30 in Pemba), including District Health Management Teams (DHMT), PMTCT providers, ZIHTLP, IRCH and HMIS staff. The objective of the training was to orient program administrators, supervisors and implementers on score cards and enhance its use.

2.2.4.2 Service monitoring

Jointly quarterly supportive supervision was conducted by PMTCT unit and DHMT members. A total of **94** PMTCT sites (**55** Unguja and **39** Pemba) were visited with the objective to monitor implementation of PMTCT program and provide technical assistance to health care providers. The supervision also aimed at improving quality of services for HIV-infected pregnant women, breastfeeding mothers, their partners and infants.

PMTCT unit conducted mentorship to PMTCT providers in 28 health facilities (13 Unguja and 15 in Pemba). The activity aimed at addressing implementation and technical challenges that were identified during routine site visits and preceding supportive supervision. Healthcare providers were mentored on performing HIV testing and counseling, Syphilis testing and documentation in PMTCT monitoring tools.

Follow up of HIV-infected pregnant women, breastfeeding mothers and their infants was done at 89 health facilities to track those who missed appointments or dropped out of PMTCT care cascade. As a result, 39 women and 11 infants were returned to the services.

2.2.5 PMTCT services indicators and trend from 2014 to 2016

S/N	Indicators	Year		
		2014	**2015**	**2016**
1	Number of health facilities providing RCH services that also provide both HIV testing and counseling and ARVs for PMTCT on the site	156/164 (95%)	159/164 (97%)	168/168 (100%)
2	Number and percent of pregnant women who were tested for HIV and know their results	60,132/60,132 (100%)	31,536/64,085 (49%)	43,937/61,147 (72%)
3	Number and percent of known positive pregnant women	359/361 (99%)	230/385 (59.7%)	235/423 (55%)
4	Percent of HIV positive pregnant women who receive ARVs to reduce the risk of mother to-child transmission of HIV	287/361 (80%)	200/385 (51.9%)	197/423 (47%)
5	Percent of HIV positive pregnant women delivering in health facilities	291/361 (81%)	232/385 (60.2%)	232/423 (55%)
6	Percent of male partners of pregnant women who are tested for HIV in last 12 months	1,643/60,132 (3%)	1,059/64,085 (1.6%)	2,286/61,147 (3.7%)
7	Percent of infants born to HIV positive pregnant women who are started on Cotrimoxazole within two months of birth	194/359 (54%)	180/230 (78.2%)	146/232 (63%)

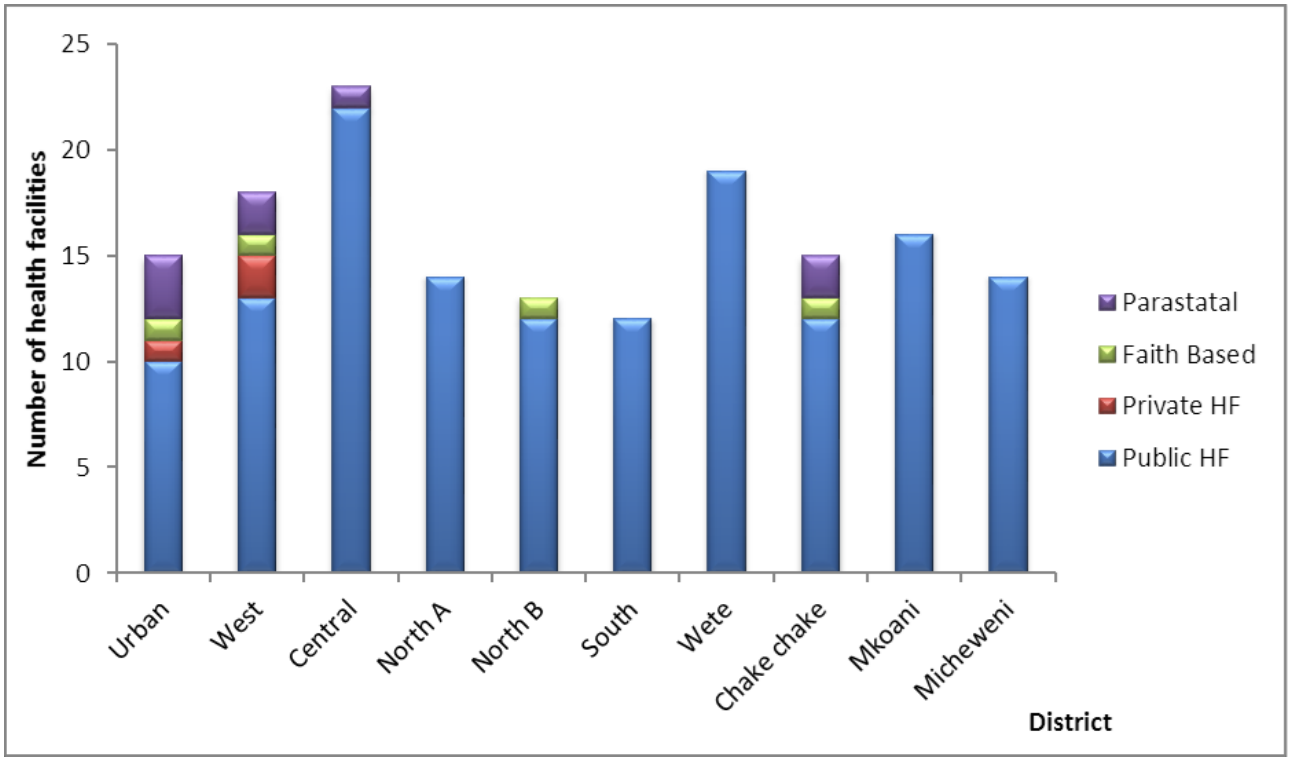
8	Percent of infants born to HIV positive mothers who receive HIV antigen test (DNA PCR) within 2 months of birth	270/359 (75%)	180/230 (78.2%)	146/232 (63%)
9	Percent of HIV positive infants started on ART	9/7 (128%)	9/6 (150%)	4/10 (40%)

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

The number of RCH clinics that provide PMTCT services has increased from 159 (97%) in 2015 to 168 (100%) in 2016, out of which 100 (60%) health facilities are in Unguja and 68 (40%) in Pemba. Majority, 153 (91%) of health facilities providing PMTCT services are public, 8 (5%) are parastatal (mostly military health facilities), 4 (2%) are faith based and 3 (2%) are private.

Appendix I shows a list of health facilities by district and the figure below illustrates the number of health facilities located by districts. Central district comprises the highest number of health facilities with PMTCT services and South district has lowest as indicated in figure 2.2.1.

Figure 2.2.1: Health facilities providing PMTCT services by district, Zanzibar, 2016

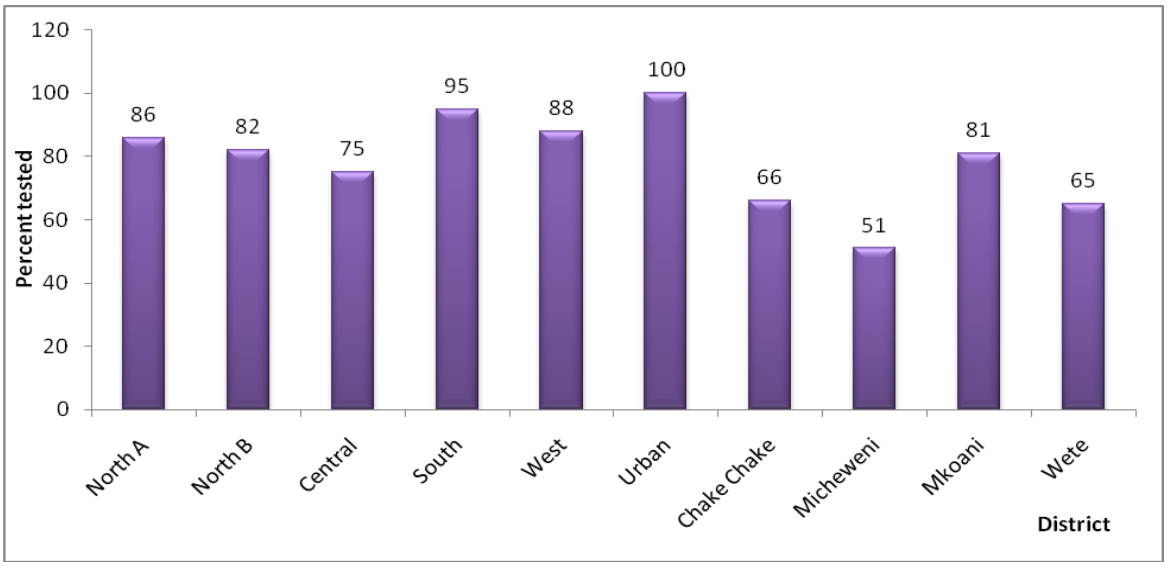


2. Number and percent of pregnant women who tested for HIV and know their results.

HIV testing for pregnant women has significantly increased from **49% (31,536/64,085)** in 2015 to **72% (43,937/61,147)** in 2016 among those expected to be pregnant. The achievement is commendable and ongoing efforts are being taken to reach the set target **(95%)** through reinforced counselling for pregnant women as well as ensuring adequate, consistent and timely supply of HIV test kits to PMTCT sites.

Among all clients who attended ANC services, urban district had the highest proportion **(100%)** of clients tested for HIV, followed by South district Unguja **(95%)**. Micheweni district remained with the least **(51%)** of ANC clients tested for HIV, since 2015 **(50%)**, as indicated in figure 2.2.2 below.

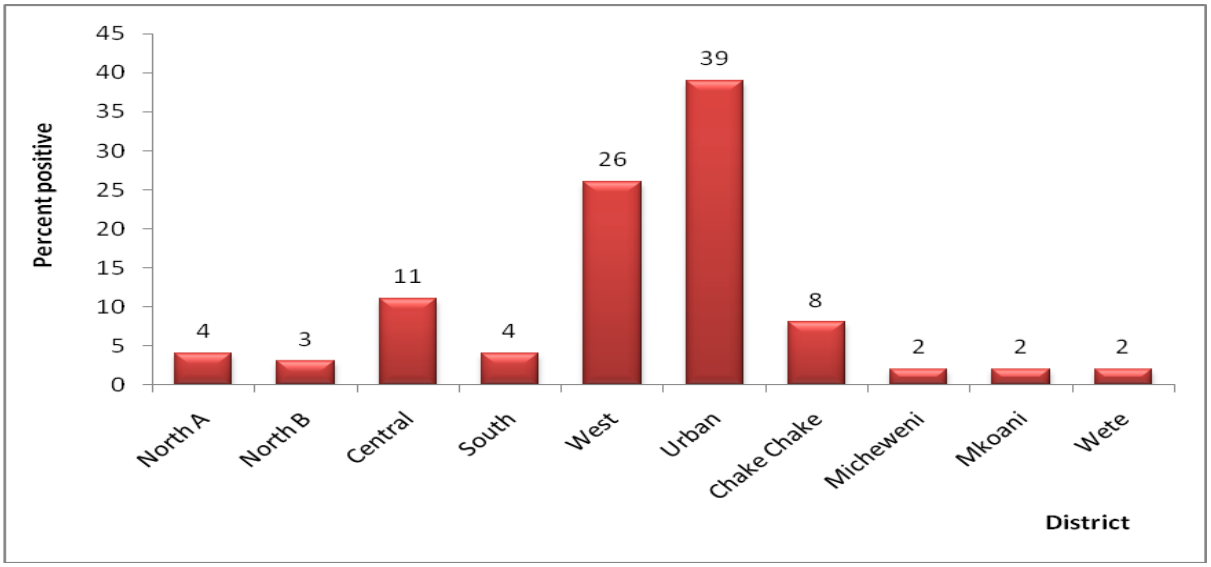
Figure 2.2.2 Proportion of ANC clients tested for HIV by district, Zanzibar, 2016.



3. Number and percent of known positive pregnant women.

Proportion of known positive pregnant women has decreased from **58% (230/385)** in 2015 to **53% (235/423)** in 2016. Among positive pregnant women, **50.2% (118/235)** were previously known and **49.8% (117/235)** were newly tested positive at ANC and maternity. Eighty six percent **(86%)** of all identified positive pregnant women were from Unguja, where Urban district reported **35%** of the cases, followed by West District **26%.** Low numbers of cases were identified in Wete, Mkoani and Micheweni, as shown in the figure below.

Figure 2.2.3: Percentage of known HIV Positive Pregnant Women Identified by District, Zanzibar, 2016



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

Proportion of HIV-infected pregnant women who started ART to reduce the risk of mother-to-child transmission out of estimated HIV positive pregnant women has decreased from **80% (287/361)** in 2015 to **55% (235/423)** in 2016. However, out of all identified HIV positive pregnant women in 2016, **84% (197/235)** were started on ART. Among them **41%** were newly identified positive from ANC, **55%** were previously known pregnant women and **4%** started ART at maternity.

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

Percentage of HIV positive pregnant women delivering at health facilities out of estimated HIV positive pregnant women decreased from **60% (232/385)** in 2015 to **55% (232/423)** in 2016. In spite of that, out of all identified HIV-infected pregnant women, a great proportion **99% (232/235)** delivered at health facilities.

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

There is an increase of male involvement in PMTCT services from **1.6% (1,059/64,085)** in 2015 to **3.7% (2,286/61,147)** in 2016. This increase could be influenced by ongoing counselling at site level, community sensitization and engagement as well as service prioritization for couples attending ANC. However, the accomplishment is far beyond the set target (30%).

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

Proportion of HIV-exposed infants started on cotrimoxazole prophylaxis within the first 2 months of birth decreased from **78% (180/230)** in 2015 to **63% (146/232)** in 2016. Despite that, out of 181 HIV-exposed infants who were documented to receive cotrimoxazole, **81% (146/181)** of them received within 2 months and **19% (35/181**) within one year of age. It was noted that during stock outs of cotrimoxazole, most mothers buy the drug from pharmacies but health care providers at several sites do not document, as the drug was not provided by the serving health facility.

Percent of infants born to HIV-positive mothers who received HIV antigen test (DNA PCR) within 2 months of birth.

Proportion of infants born to HIV positive mothers who received HIV antigen test (DNA PCR) within 2 months of birth decreased from **78%** (**180/230**) in 2015 to **63%** (**146/232**) in 2016.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, 2016

Quarter	Number of infants tested
January – March	**24**
April – June	**60**
July – September	**30**
October – December	**32**
Total	**146**

In this year, a total of 221 HIV-exposed infants were tested with HIV antigen test (DNA PCR), irrespective of age. Among these infants, **4.5% (10/221)** were found to be HIV-infected. It was observed that **3 (30%)** mothers of these infants started ART during pregnancy (1 in second semester and 2 in third trimester) but the remaining **7 (70%)** never received any PMTCT intervention.

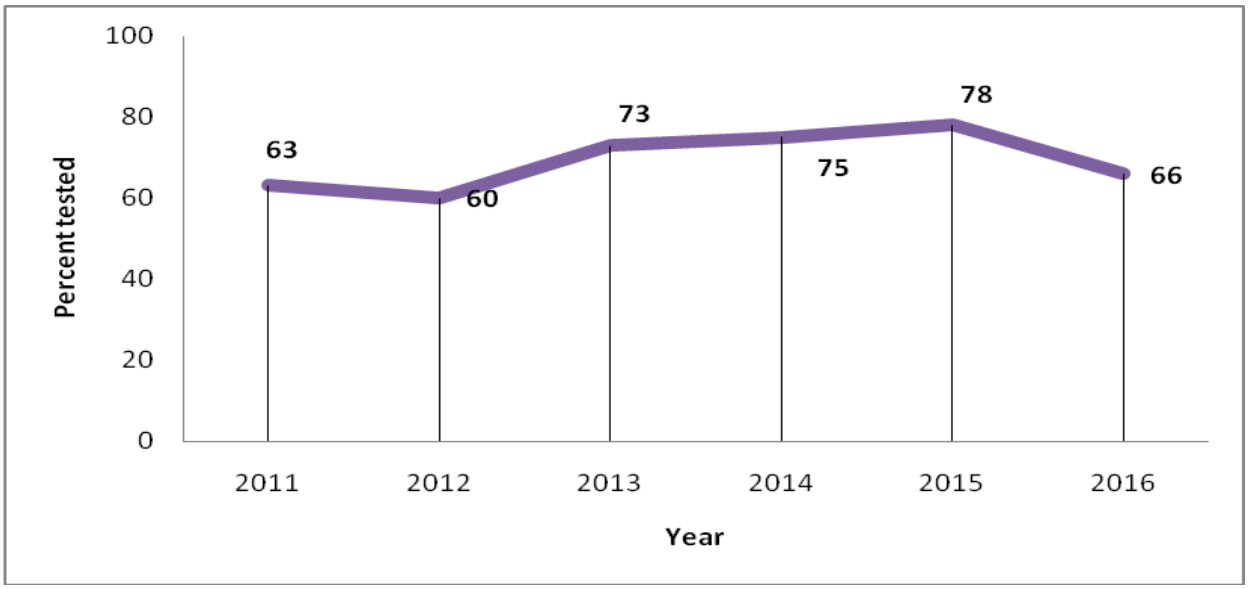
9. Percent of HIV positive infants started on ART

Among 10 identified HIV-positive infants in 2016, **4 (40%)** were started on ART. However, 5 infants were started ART in early 2017, as the turnaround for DBS results from Mainland was delayed (more than 6 months) till end of December 2016 and 1 infant was lost to follow up.

2.2.6 Trend of HIV exposed infants testing by HIV DNA PCR from 2011 to 2016

The figure 2.2.4 below shows trend in proportion of HIV-exposed infants who received first HIV antigen test (DNA PCR) within 2 months of birth. The proportion dropped slightly from 63% in 2011 to 60% in 2012, then increased gradually till 2016, when it dropped to 66%. The decline could be attributed to absence of many PMTCT providers who went to attend upgrading course outside health facilities, expiry of DBS kits at many sites and drop out of UNICEF-supported mother mentors who were assisting in basic counselling and tracking of mother-infant's pairs.

Figure 2.2.4: Percent of infants born to HIV positive mothers who received HIV antigen test (DNA PCR) within 2 months of birth, Zanzibar, 2011-2016



2.2.7 Challenges

1. Impaired performance of the newly-introduced HIV test kits supply system at national, district and site levels
2. Inadequate coordination of tracking mechanisms for mother-infant pairs
3. Delayed turnaround time for DBS results
4. Low male involvement in ANC 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 and other STI/RTI infections. 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 so as 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 centres situated at Mnazi Mmoja Hospital, ZAYEDESA and Methadone Assisted Treatment (MAT) clinic at Kidongo Chekundu - Unguja. There is also 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. The objective of the unit is 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 unit conducted three days orientation training on KPs National Monitoring tools to seventeen (14 from NGOs, 1 from ZAC and 2 from ZIHTLP) participants. The objective of

this training was to orient KPs service providers on how to properly fill the KPs national monitoring tools. The tools consist of four forms namely: Client/Registration form, follow up form, Referrals form and Monthly summary form.

Moreover, the unit conducted training on proper use of condom to KPs. A total of 165 participants (105 in Unguja and 60 in Pemba) from different KPs hot spots including NGOs attended the training. Participants were divided into three groups (SWs, MSM and PWID), each group attended for two days. The objective of the training was to build capacity of Key populations on proper use of condoms including condom negotiation skills so as to reduce number of new STIs/RTI cases.

2.3.4.2 Service monitoring

Five days (5) supportive supervision at the facilities implementing KPs services in Unguja and Pemba was conducted. A total of 19 sites (3 NGOs, 5 Health facilities, 9 sober houses and 2 ZAC Offices) were supervised. The objective of this supervision was to assess the quality of STIs and other services provided to key populations as well as to support service providers in improving quality of services to clients. In addition, ZAC was supervised to monitor the level and quality of managing GF support received from ZIHTLP but also to assess how they oversees, provide technical support, monitor and evaluate the implementation of GF supported interventions conducted by NGOs whom they contracted to implement through GF support.

Three days' workshop to develop KPs National monitoring tools was conducted in Unguja. The workshop involved 13 experts from MoH, ZIHTLP, ZAC, NCDC, THPS, and ZAYEDESA. The aim was to develop national monitoring tools that will be used to collect and report all KP interventions implemented by any KP related organization in Zanzibar. Four types of KP monitoring tools (client/Registration, follow-up, referrals and monthly summary forms) were developed.

The unit also conducted one day KPs stakeholders meeting which involved 29 members from 18 different institutions. The objective of this meeting was to strengthen coordination and feedback mechanism among key implementers by sharing experiences and discuss various barriers towards the implementation of KP interventions so as to have unified strategies on improving KPs services in Zanzibar.

2.3.5 KP services indicators and trend from 2014 - 2016

SNo.	Indicators	Achievement		
		2014	2015	2016
1.	Number and percentage of MARPs (KPs) who received an HIV test in the past 12 months and who know their results	1,427	1,895	4,135
	MSM	146	153	588
	SWs	941	1,323	2,294
	PWID	340	419	1,253
2.	Number of people who inject drugs on MAT for at least six months	-	159	194

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

Number of KPs who received HIV test in the past 12 months and know their results has increased from 1,895 in 2015 to 4,135 in 2016. This increase may be contributed by increase in number of NGOs implementing KPs interventions in Unguja and Pemba, which has been supported by different partners.

Table 2.3.1 indicates that there was variation in HIV positivity between KPs who tested through outreach services, compared to those who tested through VCT sites (0.8% and 3.9% 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, 2016

KPs category	Outreach services			VCT clinics		
	Tested	Positive	Percent	Tested	Positive	Percent
PWID	725	4	0.6%	528	26	5.2%
MSM	336	3	0.9%	252	5	2.0%
SW	1249	11	0.9%	1045	38	3.8%
Total	**2310**	**18**	**0.8%**	**1825**	**69**	**3.9%**

2. Number of people who inject drugs on MAT

Comprehensive MAT services for heroin users in Zanzibar were established in February 2015. As of December 2016, a total of 281 (**47%** of the target) clients were enrolled at MAT clinic in Unguja of whom **85%** were male. By December 2016, among **281** clients who were ever enrolled in MAT services, **73** (25.9%) are defaulters and **14** (4.9%) died. The number of clients who had been on MAT for six months and above by December 2016 was **194** (**69%**), as indicated in table 2.3.2 below.

Table 2.3.2: Number of heroin users who were enrolled and received MAT services by MAT service status, Zanzibar, 2016

ITEM	MALE	FEMALE	TOTAL
Clients ever enrolled	239	42	**281**
Defaulters	63	10	**73**
Death	13	1	**14**
Current on MAT (≥ 6 months)	163	31	**194**

Other services provided at MAT clinic includes, HIV, TB and Viral Hepatitis. A total of 57/281 (20.2%) were identified positive for HIV and (48) 84% were on ARV in different CTC in Unguja. Furthermore, a total of **125** clients were TB suspect and **3**of them were confirmed with TB. A total of **78** clients tested HCV positive and referred to Mnazi Mmoja Hospital for further management as shown in figure 2.3.2.1.

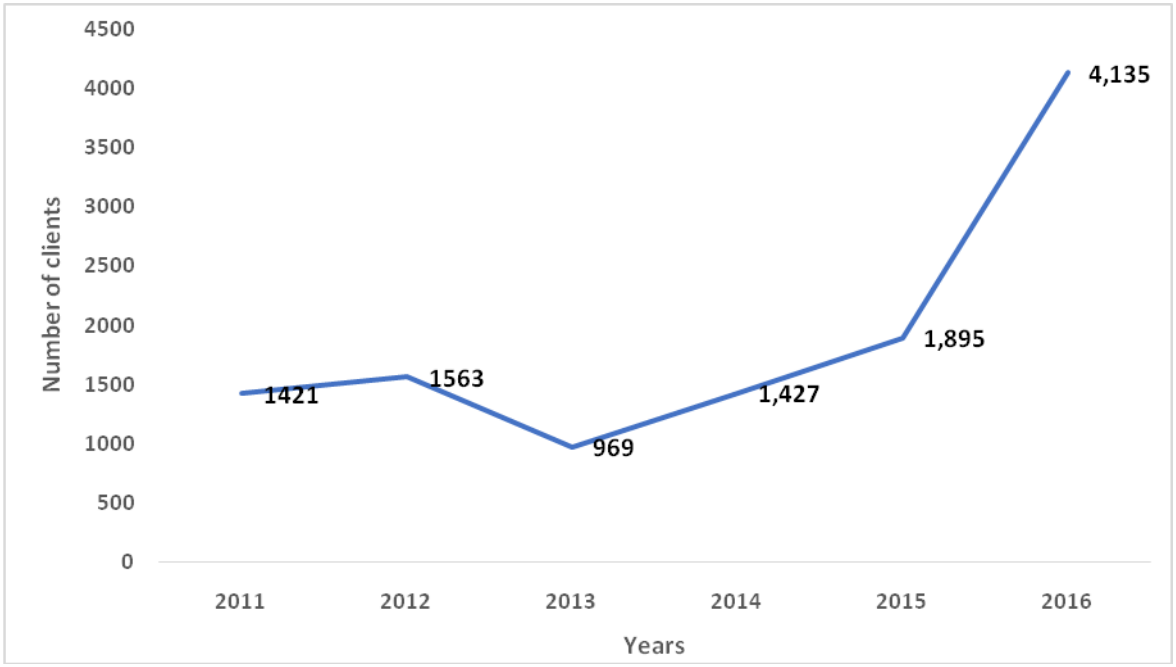
Table 2.3.2.1 Services provided at MAT Clinic, 2016

ITEM	MALE	FEMALE	TOTAL
HIV positive	42	15	**57**
On ARVs	26	22	**48**
TB Suspect	107	18	**125**
TB positive	3	0	**3**
Viral Hepatitis C positive	71	7	**78**

2.3.6 Trend of HIV testing services among KPs from 2011 - 2016

There was an increase in number of KPs who received HIV testing services for the six years period from 1,421 in 2011 to 4,135 in 2016 as indicated in figure number 2.3.1 below.

Figure 2.3.1: Trend of HIV testing services among KPs from 2011 – 2016, Zanzibar



2.3.7 Challenges

- Low enrolment of clients at MAT clinic
- Lack of alcohol breathalyzer and Urine substance diagnostic kits
- Low turn up of KPs in friendly clinics
- Lack of Viral Hepatitis B reagents and vaccine

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 individual and the society in general.

Early diagnosis 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. This 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 **253** (**161** in Unguja and **92** 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 Capacity building

KP/STI unit conducted five days STIs/RTIs Training of Trainers in Unguja. A total of 10 trainees (8 from Unguja and 2 from Pemba) attended. The objective was to build their capacity to facilitate future STIs/RTIs trainings for health care workers based on the revised guideline.

Following TOT, the trainers facilitated five days STIs/RTIs management training to health care workers. A total of 50 (21 from Pemba and 29 from Unguja) health care workers were trained. The participants were selected from facilities with higher reported number of cases and facilities which reports cases but with no trained personnel on managing STI/RTI cases.

The objective of this training was to increase capacity of service providers on proper management of STIs/RTIs.

2.4.4.2 Service monitoring

The unit has developed the first National STIs/RTIs management guidelines for Zanzibar. These guidelines have been developed considering the nature and context of HIV epidemic for Zanzibar, but also due to new recommendations by WHO on management of STI cases. Based on these, two more syndromic diagnoses have been added namely; anorectal and oral pharyngeal syndromes. Before these guidelines, the STI/RTI cases were managed using the National STI/RTI management guideline for Tanzania.

As of December 2016, the unit distributed **8,773** pieces of condoms (8,318 male and 455 Female) through NGOs implementing KPs interventions and health facilities in Zanzibar as indicated in the table 2.3.2 below: -

2.4.5 STI services indicators and trend from 2014 to 2016

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 has been increased from **85** in 2015 to **96** in 2016.This increase was due to STI/RTI management training conducted in Zanzibar, which added 11 more health facilities whose service providers were trained.

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

In the year 2016, a total of **8,354** STI cases were diagnosed. Among them, **1,860 (22.3%)** were males and **6494 (77.3%)** were females. However, compared to 2015 data, there was a decrease in STI cases diagnosed (**9,063** in 2015 to **8,354** in 2016). This decrease may be due to various factors including under reporting caused by patients going to private hospitals or pharmacies where there is no formal system of patients recording and reporting that is linked to MoH systems.

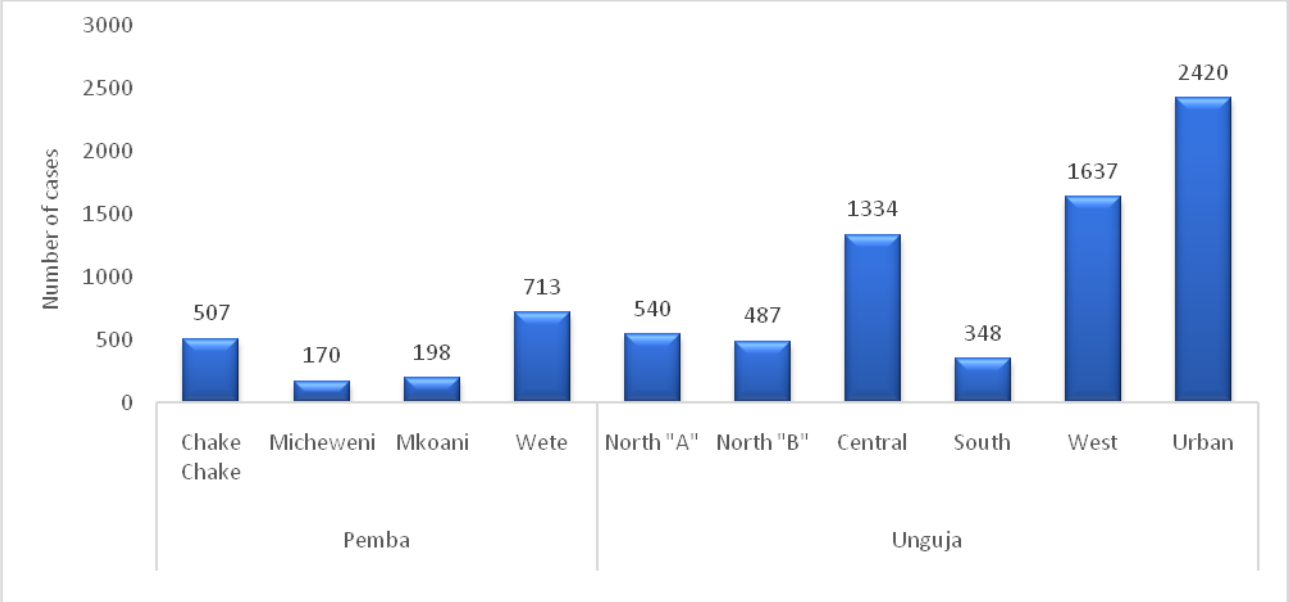
Moreover, it was noted that, most diagnosed STI cases in 2016 was Vaginal Discharge Syndrome **(46.3%)** followed by Lower Abdominal Pain (**23.4**%) as indicated in table 2.4.2 below.

Table 2.4.1Number of STI cases diagnosed and treated by age and gender, Zanzibar, 2016

Diagnosis	Age (years) and Gender						Total
Syndromic Diagnosis	Male			Female			
	0-14	15-24	25+	0-14	15-24	25 +	
Genital Ulcer (GU)	3	26	67	2	30	59	187
Inguinal Bubo (IB)	1	4	7	0	8	14	34
Oral Pharyngeal (OP)	0	0	0	0	0	0	0
Anorectal (ARS)	0	0	0	0	0	0	0
Lower abdominal pain (LAP)				72	747	1137	1956
Vaginal Discharge(VD)				97	1389	2381	3867
Urethral Discharge (UD)	6	290	924				1220
Painful Scrotal Swelling (PSS)	15	64	143				222
Neonatal Conjunctivitis (0 – 28 days)	167			134			301
Total Syndromic Diagnosis	**192**	**384**	**1141**	**305**	**2174**	**3591**	**7787**
Aetiological Diagnosis							
Gonorrhea	2	18	42	0	17	18	97
Syphilis	0	16	14	0	4	16	50
Trichomonas Vaginalis	1	2	4	4	43	52	106
Chlamydia	0	12	10	0	10	10	42
Candidiasis	0	12	10	4	94	152	272
Hepatitis B	0	0	0	0	0	0	0
Hepatitis C	0	0	0	0	0	0	0
Total Aetiological Diagnosis	**3**	**60**	**80**	**8**	**168**	**248**	**567**
Total	**195**	**444**	**1221**	**313**	**2342**	**3839**	**8354**

Urban district reported high number of STI cases **2,420** (**29**%), followed by West and Central districts with **1,637** (**20**%) and **1,334** (**16**%) respectively. South Unguja, Mkoani and Micheweni districts reported few cases 348 (**4.2**%), **170** (**2.0**%), and **198** (**2.3**%) respectively as indicated in figure 2.4.1 below.

Figure 2.4.1: Number of STI/RTI cases by District, Zanzibar, 2016



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

The percentage of sexual partners whose index are notified of their infections has decreased from **1,043 (11.5%)** in 2015 to **802 (9.6%)** in 2016. However, the proportion of notified partners has not even reached half of index patients' number. This decrease may be due to patient's perception on the services, cultural barriers among the community members on the nature of the infection/diseases.

4. Number of male condoms distributed

Number of male condoms distributed through various condom outlets has declined from 15,860 in 2015 to 8,318 in 2016 as indicated in Table **2.3.2** below. This decline was due to frequent stock out of male condom in health facilities.

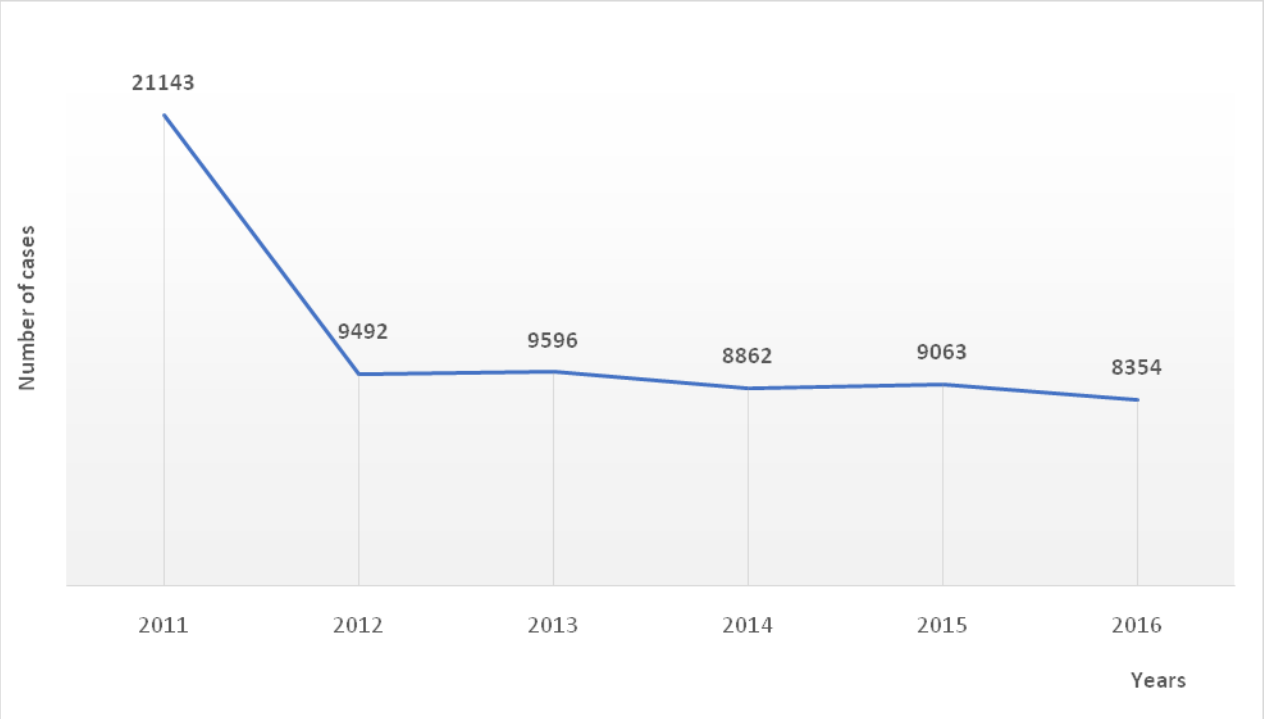
Table 2.3.2 Number of condoms distributed in different facilities in Zanzibar, 2016.

Facility type	Male	Female	Total
NGOs	4,464	-	4,464
Health facilities	3,854	455	4,309
Total	**8,318**	**455**	**8,773**

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 – 2016

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 2016 as indicated in figure 2.4.2 below**.**

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 – 2016



2.4.7 Challenges

- Shortage of STI/RTI drugs
- Shortage of trained STI providers
- Low number of sexual partners who access management of STIs

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 Program Implementation

3.1.4.1 Capacity building

Two days treatment failure training to care and treatment providers was conducted; Involving **30** participants (20 from Unguja and 10 from Pemba). The aim of the training was to build capacity of health care workers to identify suspects of treatment failure earlier so as to take deliberate measures and change them to the appropriate regimen timely.

Four days refresher family planning training was conducted to PMTCT and care and treatment providers in Unguja and Pemba. A total of **32** participants (18 from Unguja and 14 from Pemba) attended the training. The objective of the training was to impart them with the knowledge and skills to provide quality family planning services. Following this training, PMTCT and CTC providers were expected to provide family planning health education, counsel clients for informed choice of family planning methods and provide family planning methods based on clients' informed choice.

3.1.4.2 Service monitoring

During this year, two supportive supervisions were conducted to all 12CTCs including under one roof TB/HIV clinics and three refilling sites in Zanzibar. The aim of supervision was to

monitor the standards and quality of care provided at care and treatment clinics in line with Zanzibar ART Guidelines.

In addition, two days mentorship was conducted to three care and treatment clinics in Pemba (Chakechake, Micheweni and Mkoani). Areas mentored included counselling, arrangement and filling of different check list in the patients' files, proper documentation of both paper (pre–ART & ART register) and data base.

Furthermore, one day feedback meeting to care and treatment service providers were conducted in Unguja and Pemba following supportive supervisions, to discuss and address issues identified during supportive supervision.

CTC staff in collaboration with peers and Community Home Based Care (CHBC) providers conducted home visits to 10 patients who were bedridden and 477 defaulters. A total of 255 patients out of 477 were successfully returned back into care. The rest were not returned back due to various reasons including home deaths, provision of wrong addresses and travel with no information.

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

- Two days ART technical working group meeting. The objective of the meeting was to conduct situational analysis of ART services and provide recommendations for treatment scaling up in Zanzibar. The strongest recommendation from this meeting was Zanzibar to move to test and treat approach and adaptation of different WHO recommended services delivery model.
- One day meeting with care and treatment providers in Unguja and Pemba to orient them on new criteria for ART initiation, whereby all HIV positive are eligible for ART regardless of CD4 cell count or WHO Clinical Staging (Test and treat approach).
- Coordination meeting between ZIHTLP units and other stake holders to improve collaboration amongst them
- One day meeting with care and treatment and PMTCT providers on Quality Improvement in Unguja and Pemba.

3.1.5 HIV care and treatment indicators and trend from 2014 to 2016

SN	Indicator	Year		
		2014	2015	2016
1	Number of comprehensive care and treatment clinics	11	12	12
2	Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	73.1	79.3	71.3
3	Number of PLHIV attending HIV treatment and care settings, who were screened for TB symptoms, in the preceding 12 months	4,786/4,798 (99%)	5,013/5,051 (99%)	5373/5404 (99%)
4	Number of adults and children with advanced HIV infection currently receiving ART	3,587	3,907	4, 346
5	Number of health facilities providing comprehensive TB/HIV collaborative activities	2	2	2

1. Number of comprehensive care and treatment clinics

By 2016, 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 an increased enrolment of **751** patients, compared to **699** patients in 2015. (See figure 3.1.1). The remarkable increase of enrolment of HIV positive patients' above15 years was noted in Kivunge, Muembeladu, Bububu and ZAYEDESA CTCs. However, there was decreased enrolment of the same age group at Mnazi Mmoja and Al Rahma CTCs in 2016 compared to 2015. For the last two years Micheweni and Mkoani had the lowest enrolment among all CTC. These clinics enrol patients referred from various entry points that include PITC, VCT, TB, and PMTCT etc.

Table 3.1.1: Patients enrolment at CTC by age group and facility 2015 versus 2016, Zanzibar

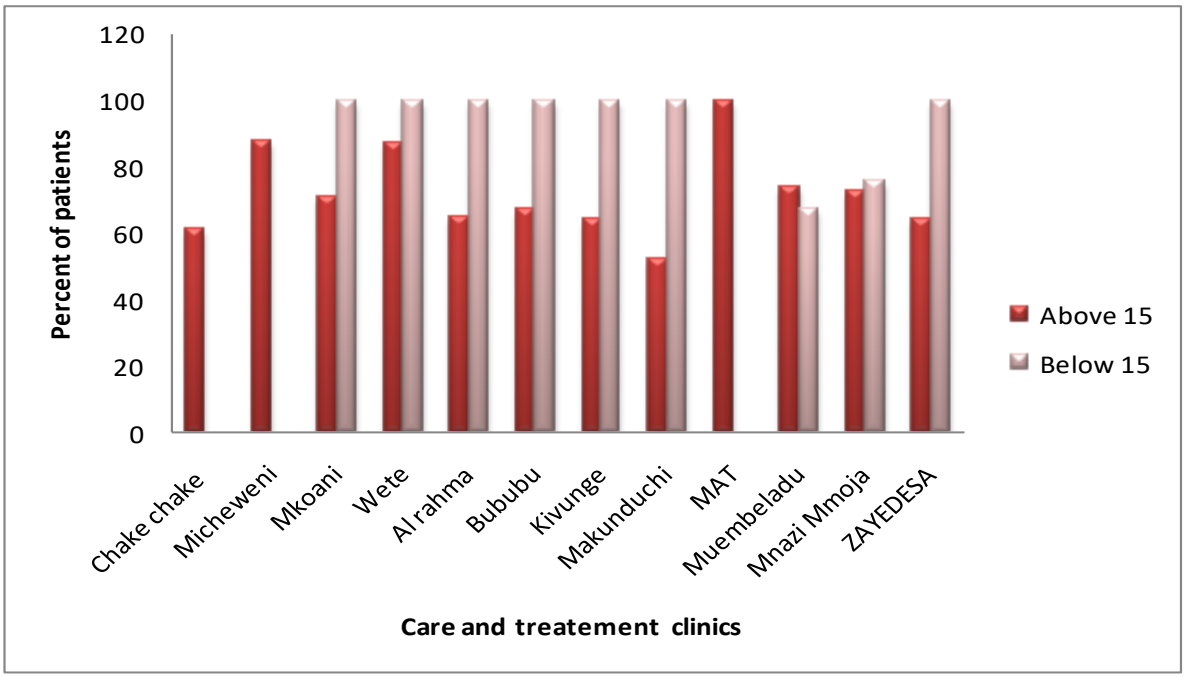
Facility	Below 15 yrs		Above 15 yrs	
	2015	2016	2015	2016
Wete	1	1	16	22
Chakechake	1	2	21	19
Micheweni	0	0	0	5
Mkoani	2	0	5	3
Bububu	2	2	64	79
Kivunge	2	2	18	41
Muembe ladu	1	8	124	146
Mnazi mmoja	21	29	301	274
Alrahma	0	0	34	19
Makunduchi	1	1	17	16
MAT clinic	0	0	0	1
ZAYEDESA	0	0	70	81
TOTAL	**31**	**45**	**670**	**706**

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 decreased from **79.3%** in 2015 to **72**% in 2016.The retention rate is lower compared to target of **87%** by 2016. It has been observed that children below fifteen years have high retention rate compared to adult in all care and treatment centres. MAT and Wete clinics had highest retention of **100%**and **88%;**while and Chakechake Mkunduchi had the lowest retention rate **58%**and **54%.**Some of the reasons that are assumed to contribute to low retention include seasonal travellers and stigma.

In Chakechake, Micheweni, and MAT CTCs there was no child below 15 years who were started on ART in 2015, hence there was no retention of the children below 15 years, however Mnazi Mmoja and Muembeladu there were children below 15 years who started on ART but were not retained after 12 months (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, 2016*.

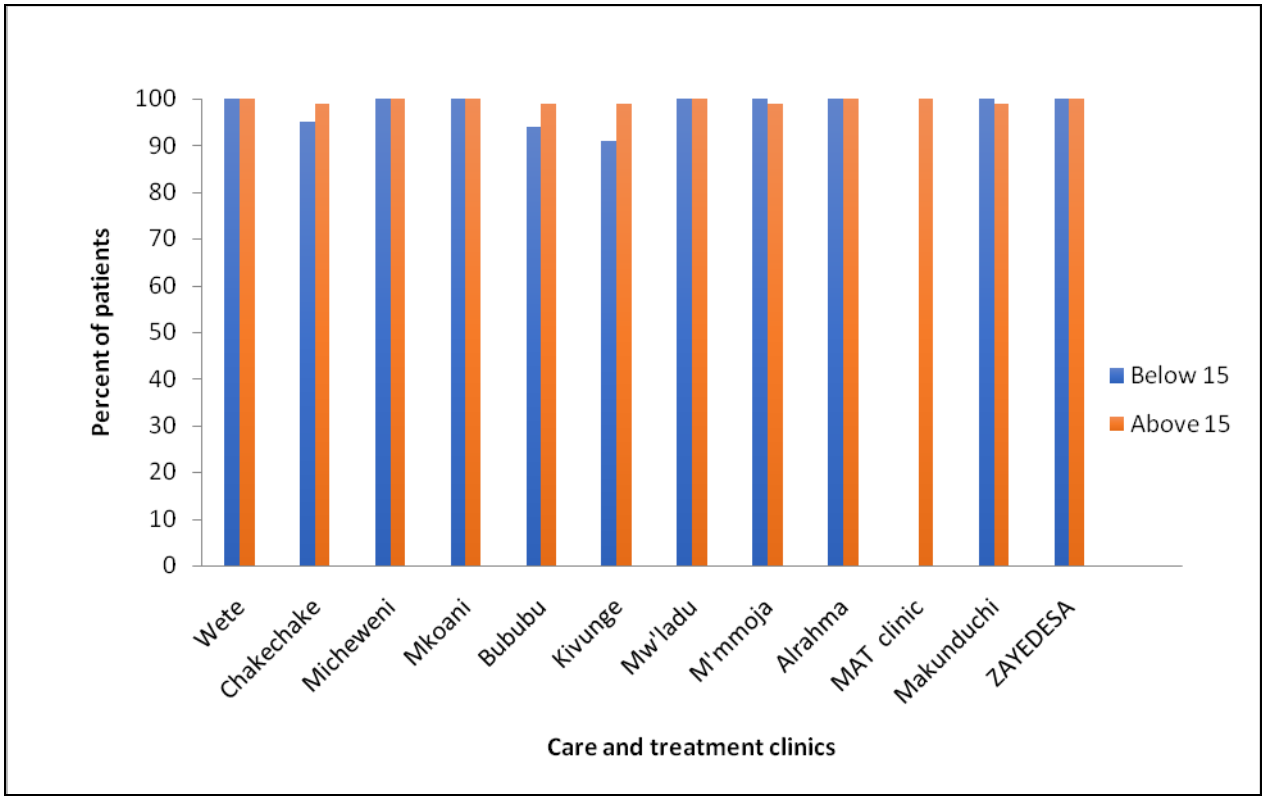


***Cohorts of January to December 2015, reported in 2016**

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. Overall percentage of patients screened for TB has remained the same at **99%** in 2015 and 2016.However percentage of patients screened for TB in Kivunge and Bububu CTCs was below **95%,** this has been contributed by collection of drugs by treatment supporters which was noted during supportive supervision. The figure below shows the number of HIV patients who were screened for TB out of those who received care during the period. Among **5,351** patients who were screened for TB **73** were diagnosed and 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, 2016.



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

As of December 2016, a total of **9,289** patients have ever been enrolled in CTCs of whom **6,956 (75%)** were ever started on ARVs at these facilities. However, patients who were receiving ARVs including transfer in are **4,346** which were **60% (4,346/7229)** of patients estimated to be in need of treatment according to spectrum 2016. Number of patients receiving ART has increased from **3,907** in 2015 to **4,346** in 2016. However, the percentage of patients currently receiving ART is lower compared to the set target of 80% in the M&E plan by 2016.

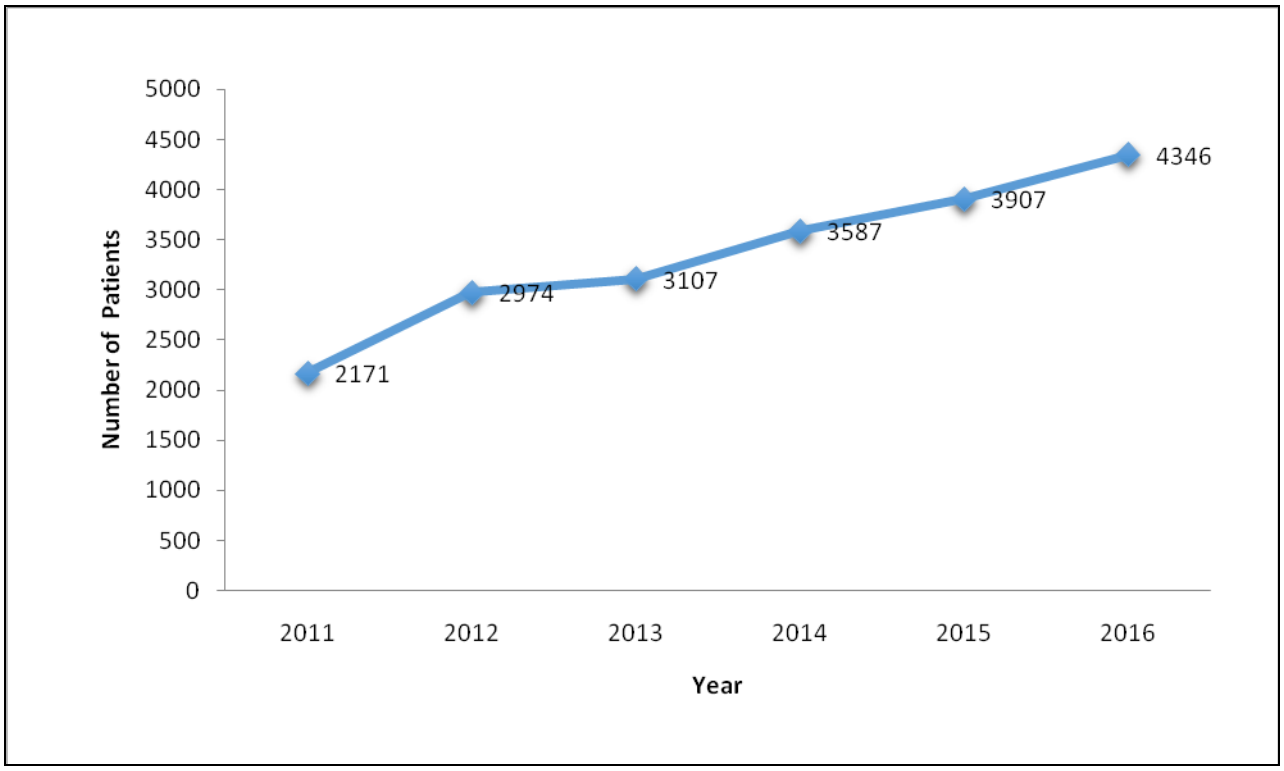
5. Number of health facilities providing comprehensive TB/HIV collaborative activities

Currently there are two sites providing comprehensive TB/HIV services (Mnazi Mmoja and Chake chake hospitals). During this year, there were **74** TB/HIV co-infected patients who were treated for TB and receive ARV drugs in these clinics.

3.1.6 Trend of PLHIV currently on ART from 2011 to 2016

The figure below shows patients currently on ART have increased progressively from **2,171** in 2011 to **4,346** by December 2016. The increase in 2016 was contributed by adaptation of new WHO recommended Test and Treat approach.

Figure 3.1.4: Number of PLHIV currently receiving ART 2011-2016, Zanzibar.



3.1.7 Challenges

- Low ART retention of enrolled patients
- Shortage of CTC staff

3.2 HOME BASED CARE SERVICES

3.2.1 Background

Home Based Care 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 of Home based care services:

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 42 health facilities in all Unguja districts (8 North 'A' 6 North B 7 Urban 9 west 6 south and 6 central). The objective of supportive supervision was to improve performance of home based care providers to deliver quality and comprehensive HBC services, including appropriate documentation.

In addition, a total of **10** feedback meetings were conducted for district supervisors and facility-based HBC providers in **6** districts (35 participants per session) in Unguja and **4** meetings were conducted in **4** districts (25 participants per session) in Pemba.

Furthermore, ten orientation HBC tools meetings were conducted for **210** community-based HBC volunteers in Unguja (35 participants per district) and 4 meetings in Pemba (25 participants per district). The objective of the training was to orient the CHBC providers who are providing HBC services in the community on the revised HBC monitoring tools, shared experience during implementing HBC services, addressing challenges encountered as well as to provide opportunity for sharing experiences and best practices.

Moreover, a total of **200** CHBC providers (120 in Unguja and 80 in Pemba) were provided with incentive in all districts. The incentive is provided with aim of motivating CHBC to continue providing care to patients, as well as to share experience and challenge faced during provision of HBC services.

3.2.5 HBC Services indicators and Trends from 2014-2016, Zanzibar

Indicator	2014	2015	2016
1. Number of skilled facility-based HBC providers	187	167	167
2. Number of skilled community-based HBC providers	412	409	407
3. Number of adults and children provided with home based care (HBC) services	3,725	2,694	2,351

1. Number of skilled facility-based HBC providers.

The number of skilled facility-based HBC providers has remained same 167 in 2016 as compared to 2015 because there was no new HBC site that might require new health providers.

2. Number of skilled community-based HBC providers.

Number of skilled community-based HBC providers has decreased from 409 in 2015 to 407 in 2016 because 2 CHBC providers have died.

3. Number of adults and children provided with HBC services.

In comparison, more patients were provided with HBC services in 2015 (2,694) than 2016 (2,351) due to lack of support for HBC service providers.

Table: 3.2.1: Number of health facilities with active HBC providers implementing HBC services by districts, Zanzibar, 2016.

District	Number of HBC sites	Number of HBC providers active in field
Urban	14	18
West	18	20
South	12	16
Central	21	23
North A	14	16
North B	11	13
Chake Chake	13	14
Wete	17	18
Mkoani	13	16
Micheweni	11	13
Total	**144**	**167**

The table above shows that there are 144 sites (54 in Pemba and 90 Unguja) that implement HBC services which are provided by 167 skilled service providers (106 in Unguja and Pemba 61). The number of these providers has been decreasing due to various reasons but the providers at the sites are not replenished, hence the quality of services is compromised.

Table number 3.2.2: Number of CHBC providers by districts, Zanzibar, 2016

District	Number of community volunteers (CHBC)
Urban	43
West	64
North A	30
North B	28
Central	42
South	38
Chake	41
Wete	46
Mkoani	37
Micheweni	40
Total	409

The table above shows that there are 409 CHBCs (in 245 Unguja and in 164 Pemba) that are currently providing HBC services, but the number is not adequate to cover all the catchment areas for currently existing clients.

During this year, a total of 2,351 patients received HBC services, out of them 1,255 were people living with HIV (817 females and 438 males) and 1,096 were chronically ill patients (575 females and 521 males).

Table 3.2.3 Number of clients who received HBC services by disease category, sex and age group in Zanzibar, 2016

Age (years)	HIV patients		Other chronic diseases		Total
	M	F	M	F	
0 – 4	13	5	11	8	**37**
5 – 14	37	37	37	31	**142**
≥ 15	388	775	473	536	**2,172**
Total	**438**	**817**	**521**	**575**	**2,351**

Home based care 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 centres, NGOs and CBOs.

3.2.6 Challenges

- Lack of formal HBC training for HBC services providers
- Lack of HBC kits

CHAPTER 4: TUBERCULOSIS AND LEPROSY SERVICES

4.1 Background

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 55 TB diagnostic centres do smear examination (20 Pemba and 35 in Unguja) and one Public Health Laboratory performing TB culture.

4.2 Goal

To reduce the incidence by 25% and mortality by 50% of TB and Leprosy by 2019

4.3 Objectives

1. To provide universal access to quality assured services to detect and treat 90% of all forms of estimated TB cases by 2019
2. To diagnose and properly manage all estimated MDR TB cases by 2019
3. To increase the proportion of TB patients co-infected with HIV receiving timely ART from 52% to 100% by 2019
4. To reduce new leprosy cases with disability grade 2 from 0.9 to 0.3 per 100,000 populations by 2019.

4.4 Programme Implementation

4.4.1 Capacity building

In 2016, the program conducted the following trainings to health care workers (HCWs) of different cadres in Unguja and Pemba:

- Five days training on 3Is for 60 HCWs, (30 in Unguja and 30 Pemba). Thegoal is to equip health care workers with knowledge and skills to enable them to implement TB IPC procedure to reduce TB transmission as well as to use intensified case finding and Isoniazid Preventive Therapy to reduce the burden of Tuberculosis among patients with HIV.

- Five days Pediatric TB training was conducted involving 30 health care workers (25 from Unguja and 5 from Pemba).The aim of the training was to build capacity of health care workers to diagnose and provide proper care to children with tuberculosis.
- TB care and control training was conducted for seven youth groups (3 in Unguja and 4 in Pemba). The training involved 60 members (30 Unguja, 30 Pemba). The objective of the training was to build capacity of youth groups on TB so as to enable them to identify TB suspects among key and general population and refer them to the nearest health facilities for investigation.
- TB management and infection control training that involved 65 health care providers (35 from Unguja and 30 from Pemba) was conducted for five days. The objective of the training was to impart knowledge on TB management and infection prevention and control issues to healthcare workers so as to improve providers' ability to diagnose and manage TB/HIV collaborative activities.
- Three days training on TB prevention and control was conducted to three CSOs in Pemba. A total of 35 participants were involved. The objective of the training was to build capacity of CSOs members on TB prevention and control so as to facilitate appropriate health education on TB in the community in order to identify TB presumptive symptoms and refer to health facility for TB investigation
- Mentorship for HCWs providing TB and leprosy services in 26 health facilities (16 Unguja and 10 Pemba). The aim was to address gaps identified during supportive supervision and enhance capacity of HCWs so as to provide quality TB, TBHIV and leprosy services. The area mentored were updating patients card and unit register, how to identify TB presumptive case and use of TB diagnostic algorithms.

4.4.2 Service Monitoring

For the year 2016 the unit conducted supportive supervision to health care facilities at all levels to monitor the implementation of TB and leprosy activities. The supervision involved Central Regional and District levels. The aim of the supervisions was to assess the performance of District coordinators and other HCWs working in TB, TB/HIV and Leprosy within health care facilities. In addition, program conducted feedback meetings with health care providers to discuss supervision findings and plan way forward to resolve the challenges identified during supervision.

Moreover, program conducted quarterly program review meetings which involved key stake holders that include coordinators, staff from ZIHTLP and other stakeholders. The aim of the meeting was to discuss various TB, TB-HIV and leprosy issues including success, challenges and share best practices.

During this reporting period, the program conducted house to house contact investigation for leprosy patients in North and South region Unguja. The aim was to identify and treat leprosy cases early so as to reduce transmission within the community. A total of 1312 houses were visited, whereby 4015 household members were screened for leprosy and six among them diagnosed with leprosy (5PB, 1MB).

Furthermore, the program facilitated 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.

4.5 Tuberculosis service indicators and trend from 2014 to 2016

Indicators		Year		
		2014	2015	2016
1.	Number of notified cases all form of TB – Bacteriological confirmed plus clinical diagnosed new and relapse cases	648	855	723
2.	Percent of new bacteriological confirm TB	51%	56%	50%
4	Treatment success rate bacteriological confirmed TB cases	89%	91%	91%
5	Treatment success rate–-all new TB cases	92.5%	92.5%	93%
6	Percentage of patient who had HIV test result recorded in the TB register	95.3%	93%	99%
7	Proportion of registered new and relapse TB patients with documented HIV positive status	18%	14%	15%
8	Percent of HIV positive TB patient initiated on ART	80%	86%	88%
9	Percent of HIV positive TB patient on CPT	97%	98%	90
10	Number of bacteriological confirmed drug resistant TB cases	3	2	3
11	Number of cases with drug resistant TB that began second-line treatment	3	2	1

1. **Number of notified cases all form of TB –Bacteriological confirmed plus clinical diagnosed new and relapse cases**

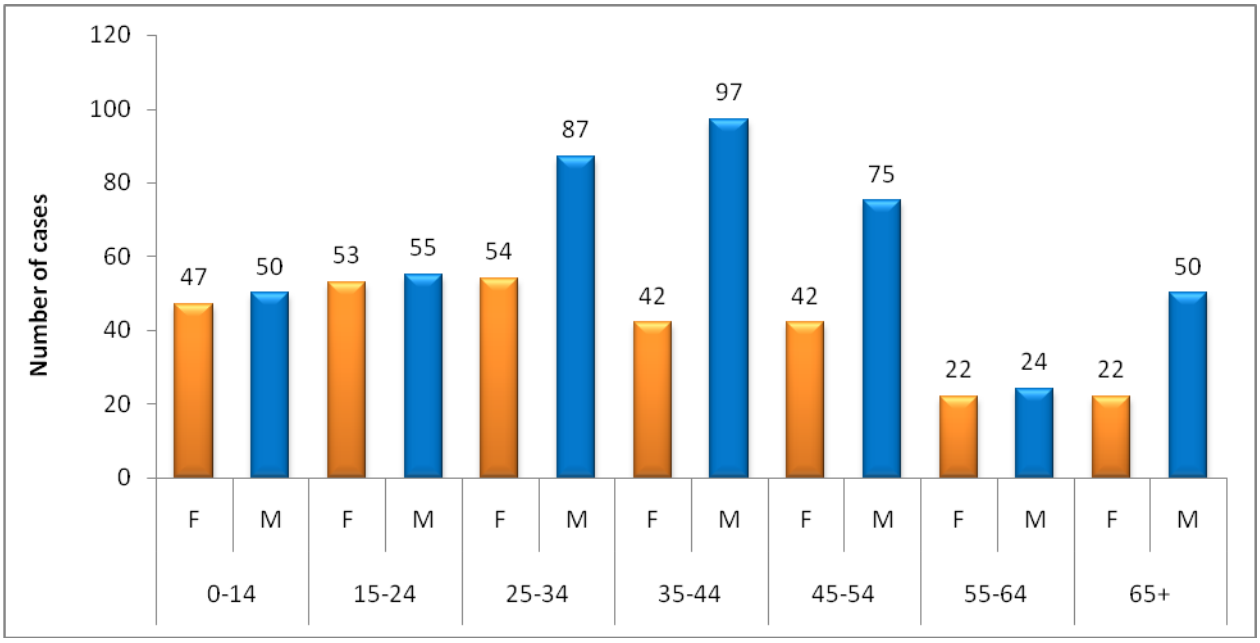
In 2016, a total of **723** cases of all forms of TB cases were notified and registered from health care facilities with **13.4%** being children below 15 years. The number of notified cases has decreased from **855**in 2015 to **723** in 2016; this might be contributed by low TB suspicious index among health care providers. Among the notified cases **384**(**53%**) were smear positive including **3** MDR-TB as shown in the table 4.1 below. Of all notified cases **13** were identified through contact tracing.

Table 4.1: TB cases notified by type of patient and category, Zanzibar, 2016

Type of patients	AFB+	AFB-	EP	Total
New	361	138	196	**695**
Relapse	13			**13**
Failure	3			**3**
Return to control	4			**4**
Others	0	5	0	**5**
MDR TB	3	0	0	**3**
Total	**384**	**143**	**196**	**723**

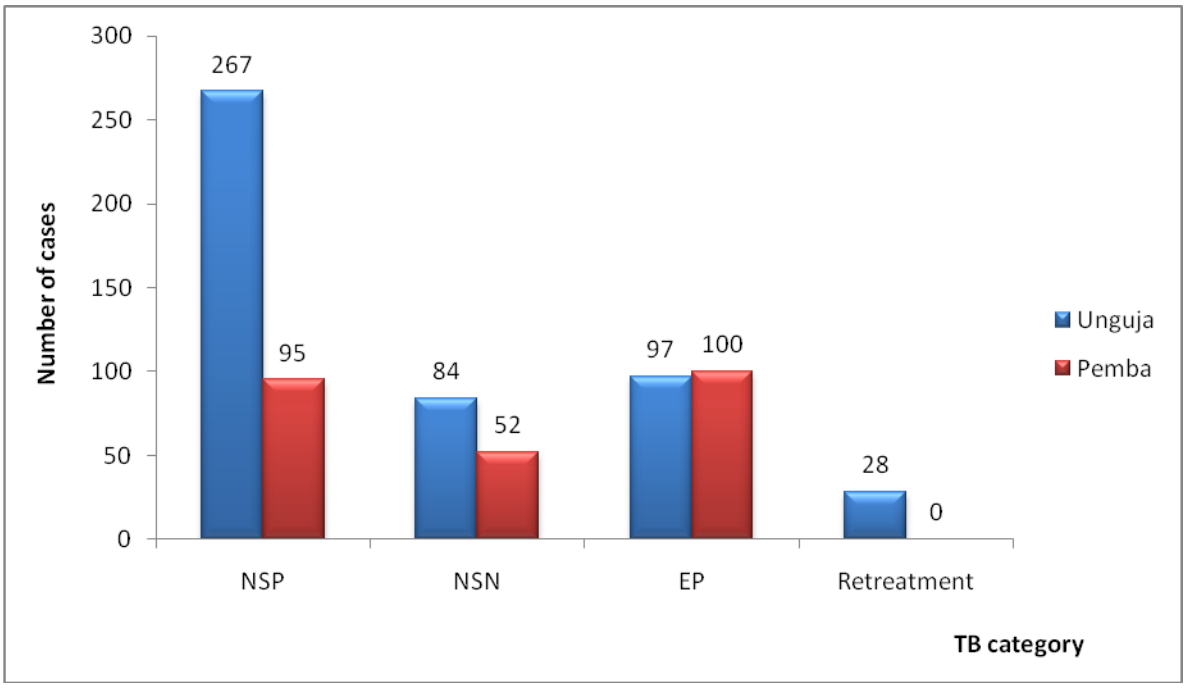
Among all patients notified in 2016, the most affected group is 15 – 54 years with male more affected then female.

Figure 4.1.: Age and sex distribution of all TB cases notified 2016



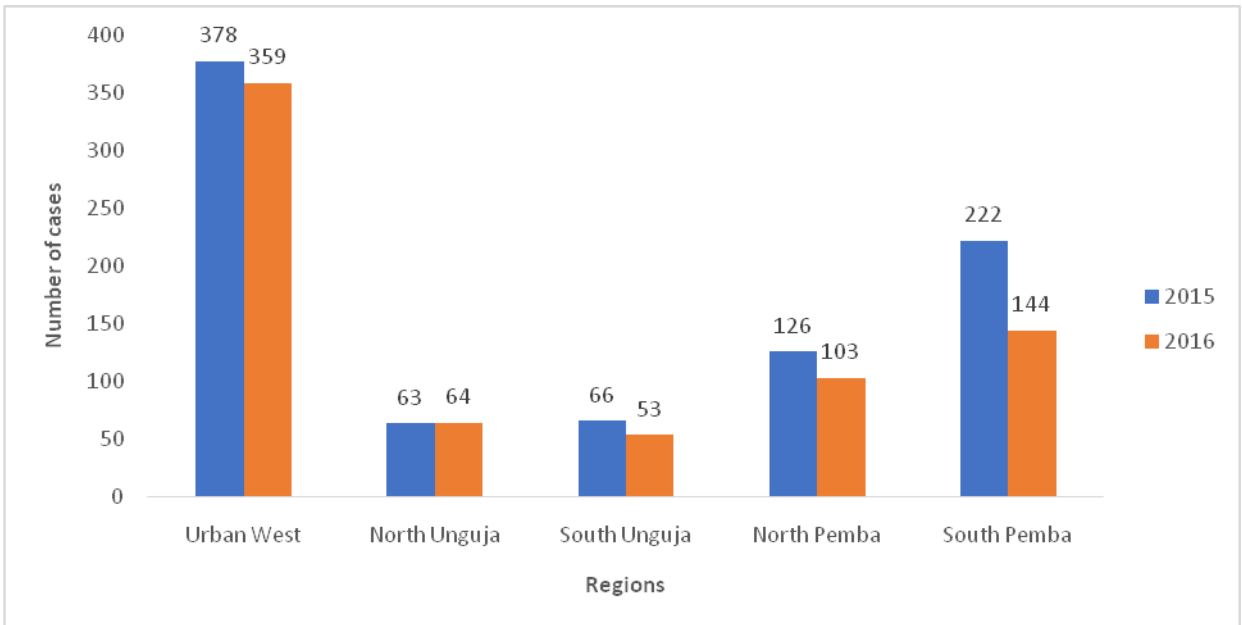
Among 723 patients notified in 2016, 476 (65.8%) patients were in Unguja and 247 (34%) in Pemba as seen in figure 4.2. below. However, Pemba Island reported higher number of extra pulmonary TB case (51%), especially in north Pemba.

Figure 4.2: TB case notification by category and Island, Zanzibar, 2016



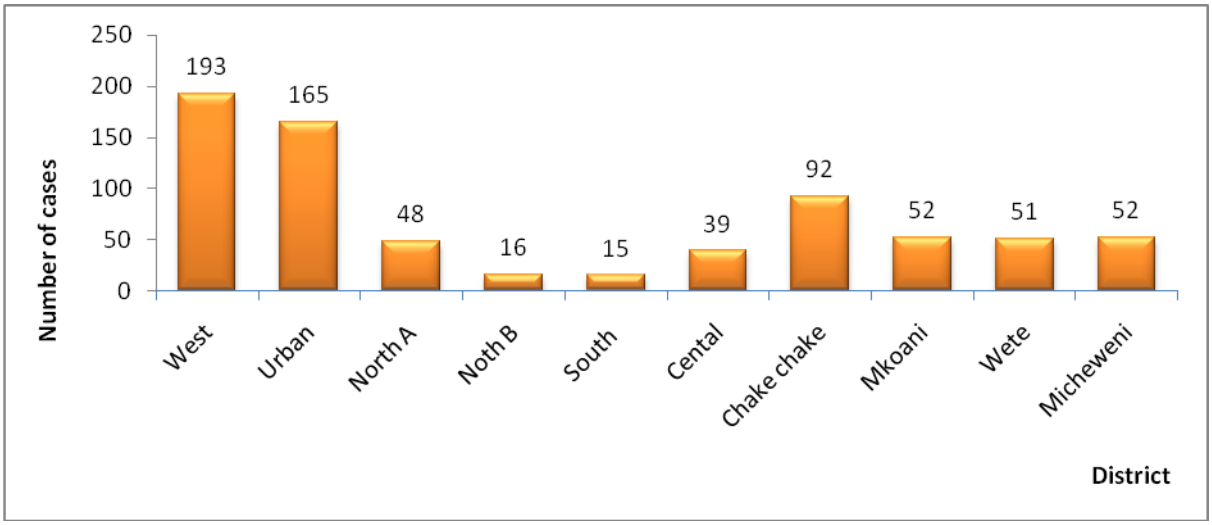
The number of notified TB patients is highest in Urban West region which was 359 (50%), followed by South Pemba 144 (19%). South Unguja region reported least number of TB cases notified 53 (7%). There is a decrease in number of TB cases notified in 2016 most the regions compared to the number of case reported in 2015 (see figure 4.3. below). In addition, North and South regions of Unguja notified the least number of TB cases in both 2015 and 2016 as illustrated in the figure below.

Figure 4.3: TB case notification by region, Zanzibar, 2015 – 2016



The number of notified TB patients is highest in Urban and West Districts. North B and South Unguja notified the least number of TB cases in 2016 as shown in the figure 4.3 below.

Figure 4.4 TB case notifications by Districts, Zanzibar, 2016



2. Percent of new bacteriological confirmed TB (New smear positive)

There is decrease in proportion of new bacteriological confirmed TB from 56% (479/855) in 2015 to 50% (361/723) in 2016. This may be contributed by frequent shortage of falcon tubes and cartage. The most affected group are adults between 35 to 44 years which was 93 (22%). Men were more affected (61%) than women (38.7%) as shown in table 4.2 below.

Table 4.2: Age and sex distribution of new bacteriological confirm TB, Zanzibar 2016

Age Category	Male	Female	Total
0-14	0	8	**8**
15-24	41	38	**79**
25-34	48	36	**84**
35-44	69	24	**93**
45-54	33	18	**51**
55-64	12	10	**22**
65+	18	6	**24**
Total	**221**	**140**	**361**

3. Treatment success rate bacteriological confirmed TB cases

A total of **508** bacteriological confirmed TB patients started TB treatment in 2015; among them **458** were cured and **3**treatments complete. Therefore, treatment successes rate of bacteriological confirmed TB cases was **91%** which is slightly lower compare to the target of **93%** for this year. As shown in table 4.3

4. Treatment success rate–-all new TB cases

Treatment success rate for all new TB cases registered and started treatment in 2015 was **93%** (754/814). The success rate for all new TB cases is almost the same with the reported 2015 which was **92.5%** (**571/617**). The program needs to make more effort to reach the set target of **95%** by 2017.

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

Type	Notified	Cured	T. comp	Failure	Died	Loss to follow up	Not evaluated	Total
S. positive	479	435	2	5	20	4	13	**479**
S negative	140		133		5	1	1	**140**
Ext. pulm	195		184		9	0	2	**195**
Relapse	19	15	1	2	0	0	1	**19**
Failure	4	3	0	0	0	0	1	**4**
Return	6	3	0	0	2	1	0	**6**
Others	10		8		0	0	2	**10**

5. Percentage of patient who had HIV test result recorded in the TB register

Among the **723** TB patients registered in 2016,**718** (**99.3%)** patients were tested for HIV and result recorded in the TB register. The proportion of TB patient tested for HIV has increased from **93%** in 2015 to **99.3%** in 2016. The achievement was within the national target. This might be due to strengthening of Provider Initiating Counselling and Testing services through training and supportive supervision.

6. Proportion of registered new and relapse TB patients with documented HIV positive status

Among the **718** TB patients tested for HIV, **110** (**15%**) identified positive. There is an increase in proportion of patients who were diagnosed with TB/HIV co-infection as compared to 2015 (**14%**). Among them **66%** (73) were from CTC and **44%** were patients from TB clinics. See figure 4.5 below.

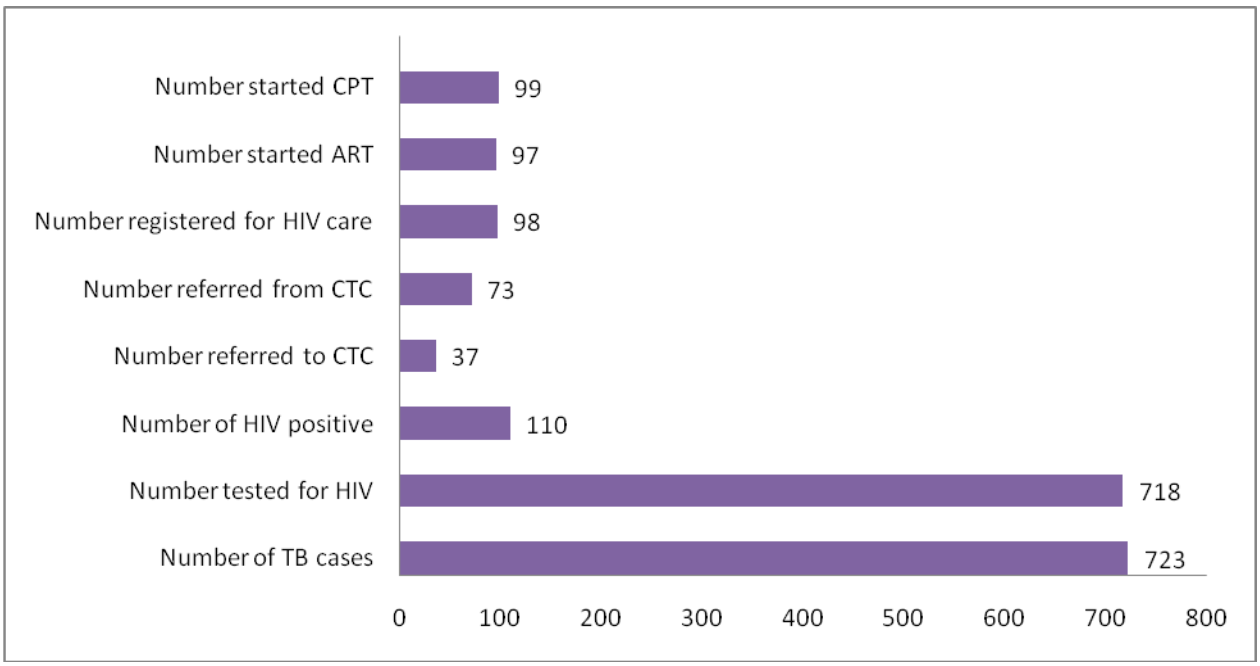
7. Percent of HIV positive TB patient initiated on ART

In 2016, among **110** TB/HIV patients diagnosed, **97** (**88%**) started ART (figure 4.5). There is an increase of **2%** compared to the previous year. The proportion is still low compare to the set target of **93%**. More effort is needed to reach the set target.

8. Percent of HIV positive TB patient on CPT

The percentage of TB/HIV patient started CPT is **90%** (99/110), the proportion of TB/HIV patient who started CPT has decreased from **98%** in 2015. There is a need to strengthen preventive services for co infected patient through early provision of CPT to reach sated target of **97.5%.**

Figure 4.5: TB/HIV notification, Zanzibar, 2016



9. Number of bacteriological confirmed drug resistant TB cases

Number of bacteriological confirmed drug resistance TB cases in 2016 was **3**; the number is low compare to target of **9** cases. This is due to in adequate capacity of health care workers to suspect and make follow up of MDR suspects and risk group.

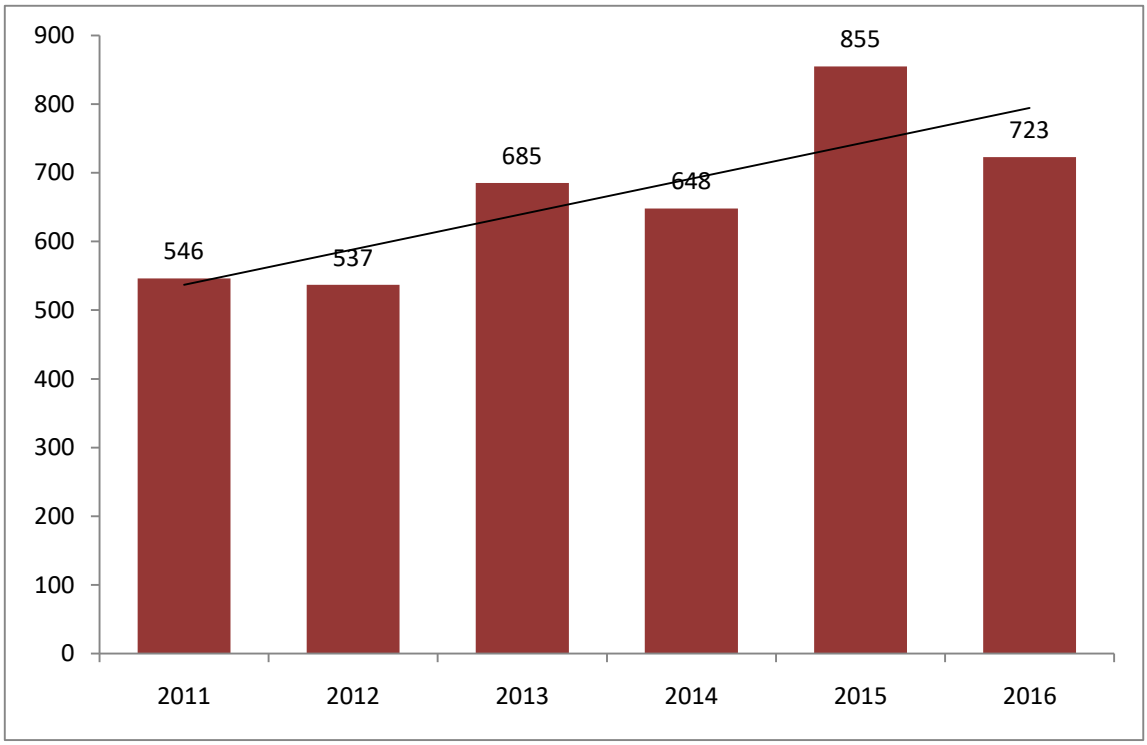
10. Number of cases with drug resistant TB that began second-line treatment

Among **3**MDR cases notified in 2016, one patient began second-line treatment. The rest were not initiated as one died before starting treatment and the other one refused to start treatment, however health care providers continue with counselling sessions.

4.6 Trend of TB case notification from 2011 to 2016

For the last six years, the number of notified TB cases has gradually increased from 546 in 2011 to 723 cases in 2016.However, the notification has slight decreased in 2016 as shown in figure 4.6 below.

Figure 4.6.: Trend of TB case notification from 2011 to 2016, Zanzibar



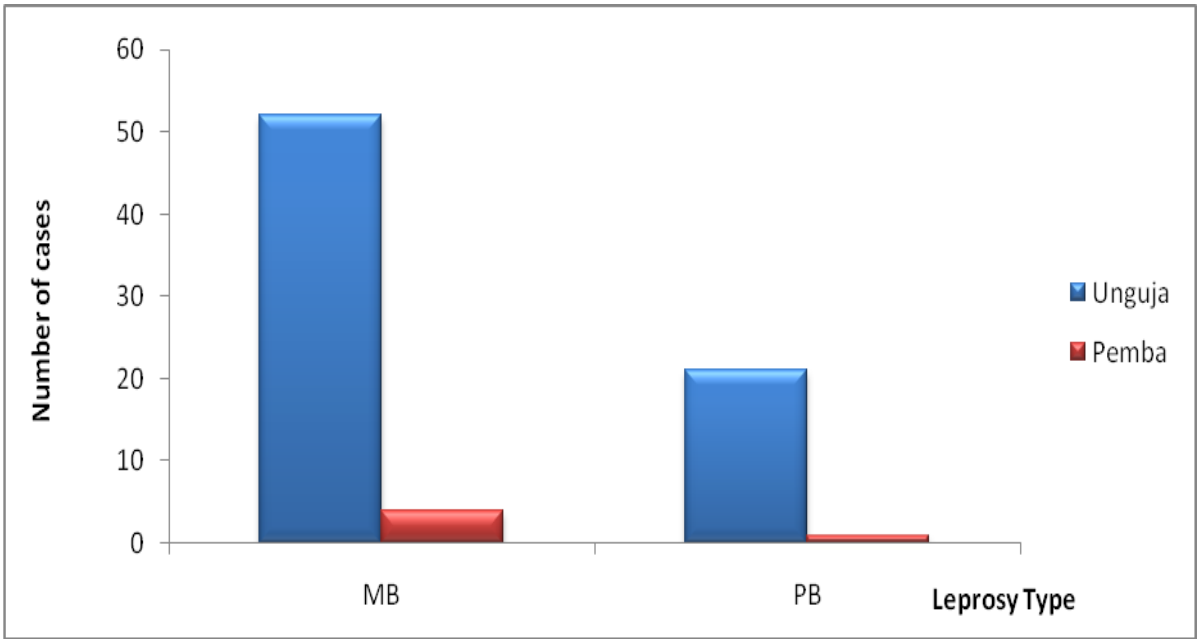
4.7 Leprosy services indicators and trend from 2014 to 2016

Indicators		Years		
		2014	2015	2016
1.	Number of all new registered Leprosy cases	177	104	77
2.	Percent of MB cases among all new cases	56	71	71.8
3.	Percent of children among new cases	19	16	19.4
4.	Percent of WHO disability grade 2 among new cases	3	5.8	9
5.	Rate of disability grade 2 per 100,000 population	0.4	0.01	0.4
6.	Percent of female patients among new cases	36	22	29
7.	Percent of MB Leprosy patients completing 12 months of MDT amongst those expected to complete their MDT (calculated for 1 year cohort intake)	96.5	97	98

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

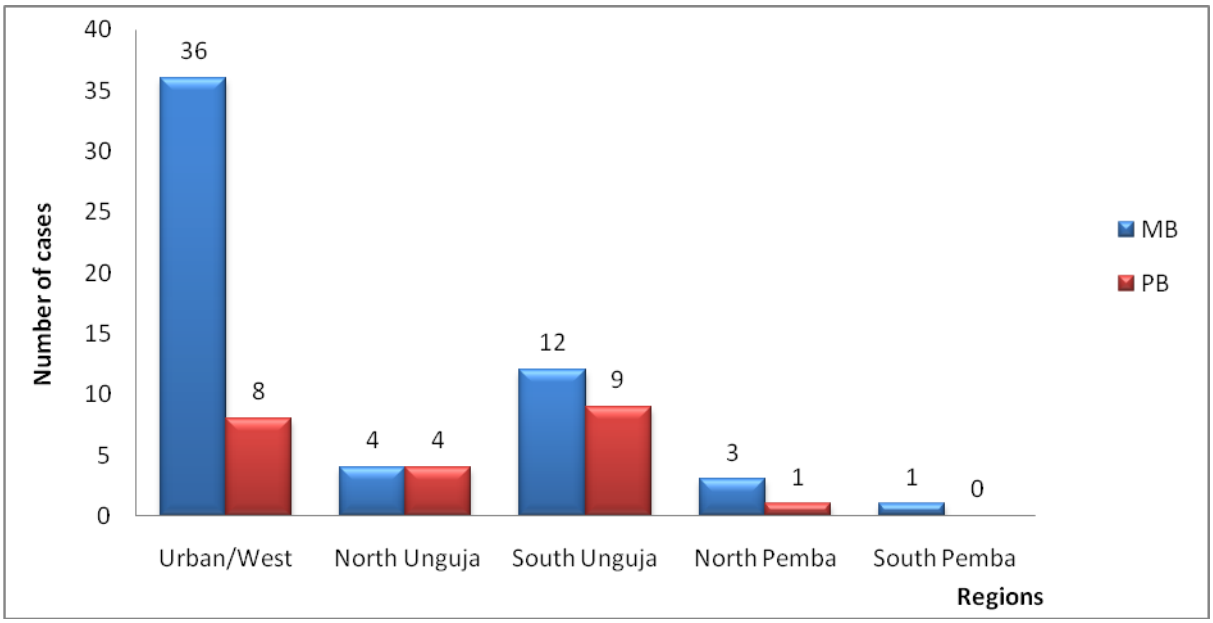
A total of **77** new leprosy cases were registered in 2016. Among them, **73** (**94. %)** were diagnosed in Unguja and **5** (**4%**) were diagnosed in Pemba, among diagnosed **56** were MB, **22** were PB as shown in the figure 4.7 below. The number of leprosy cases diagnosed has greatly decreased from **104** cases in 2015 to **77** cases in 2016. The decrease is more in South and North Pemba regions and North Unguja region. The decrease might be contributed by low knowledge and suspicious index among health care workers.

Figure 4.7: Number of all new registered Leprosy cases by type and Island, Zanzibar, 2016



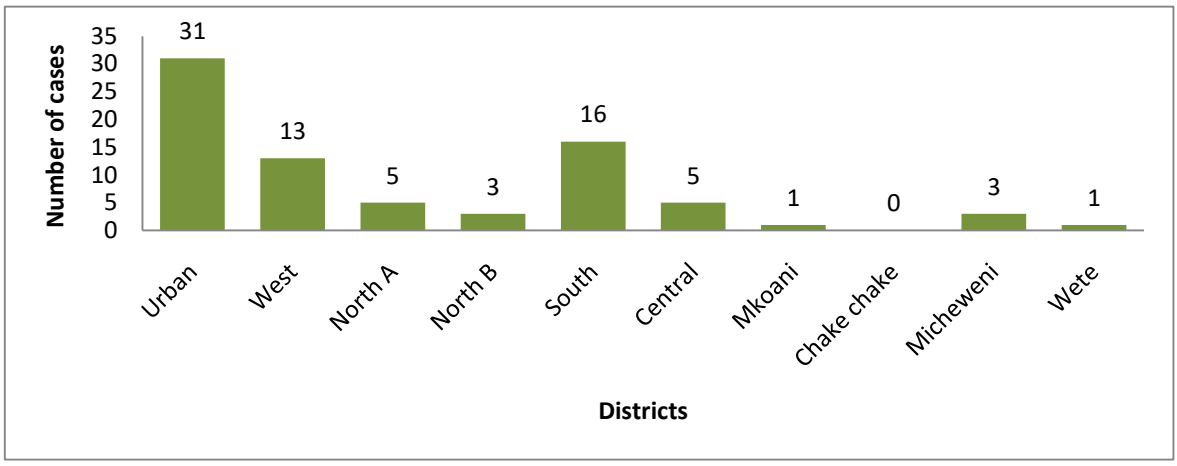
The figure 4.8 below illustrates the number of leprosy cases notified per region. Urban west region had **57%** all cases notified in 2016, followed by South Unguja which had **27%** of the cases. As explained above, both two regions of Pemba had reported low number of leprosy case with South Pemba reported the least number of cases **1**%.

Figure 4.8: Number of Leprosy notified case by region Zanzibar, 2016



The figure 4.9 below illustrates the number of leprosy cases notified per district whereby Urban district had**40%**of all cases notified in 2016, followed by South Unguja which had **21%** of the cases. Generally, Pemba had reported low number of leprosy cases, Chake chake reported zero throughout the year.

Figure 4.9 Leprosy notification by District Zanzibar 2016



Leprosy notification by age and sex

Among all new cases registered in 2016 (77 cases), all age groups and sex is affected by leprosy, male with the age group between 15- 44 are more affected compared to female of the same age. In addition to that male are more affected with MB type of leprosy which is more infectious as shown in table 4.4 below.

Table 4.4: Age and sex distribution and type of new leprosy cases registered during the year 2016, Zanzibar

Category	Age and Sex																GRAND TOTAL
	0-14		15-24		25-34		35-44		45-54		55-64		65+		TOTAL		
	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
MB	0	6	3	9	3	14	1	8	2	3	0	1	2	3	11	44	**56**
PB	5	4	0	2	2	2	3	1	0	1	0	0	1	1	11	11	**22**
TOTAL	**5**	**10**	**3**	**11**	**5**	**16**	**4**	**9**	**2**	**4**	**0**	**1**	**3**	**4**	**22**	**55**	**77**

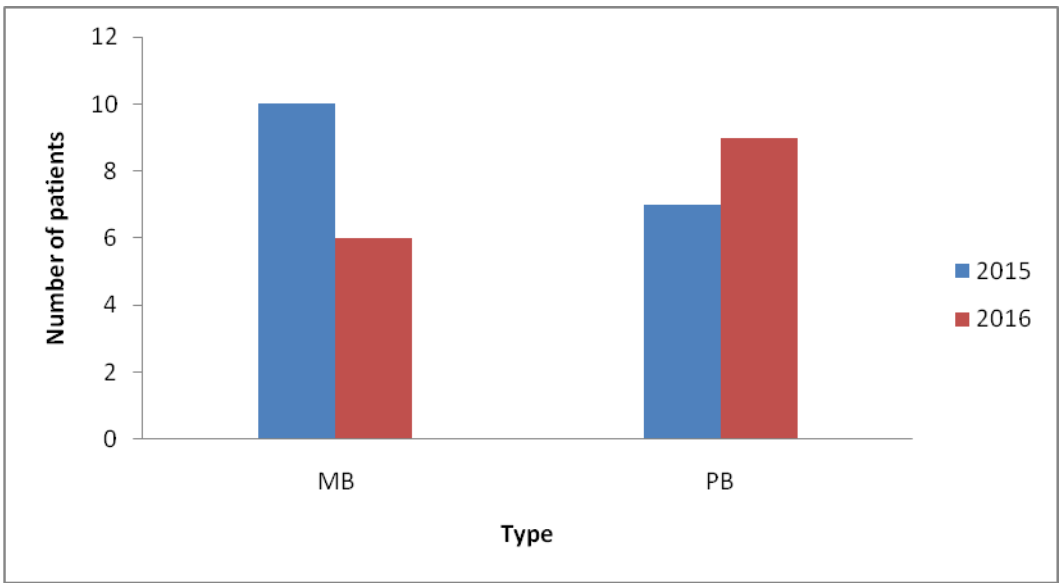
2. Percent of MB cases among all new cases

Out of **77** new cases registered in 2016, the percentage of multibacillary patients, which is the source of Leprosy transmission, has slightly increased from **71%** (**74/104**) in 2015 to **73%** (**56/77**). This shows that MB cases are still in the community and transmission among the community members is still high, hence alerting 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 **15** children were diagnosed and registered in this reporting year which is equal to **19.4%** (15/77) in 2016 of all new cases. There is an increase in proportion of children diagnosed in 2015 which was **16%** (17/104) this might be due to increase of infectious leprosy cases as explained above. This higher proportion of children diagnosed with leprosy is an alarming of the infection in the community. The figure below shows the trend of leprosy notification among children.

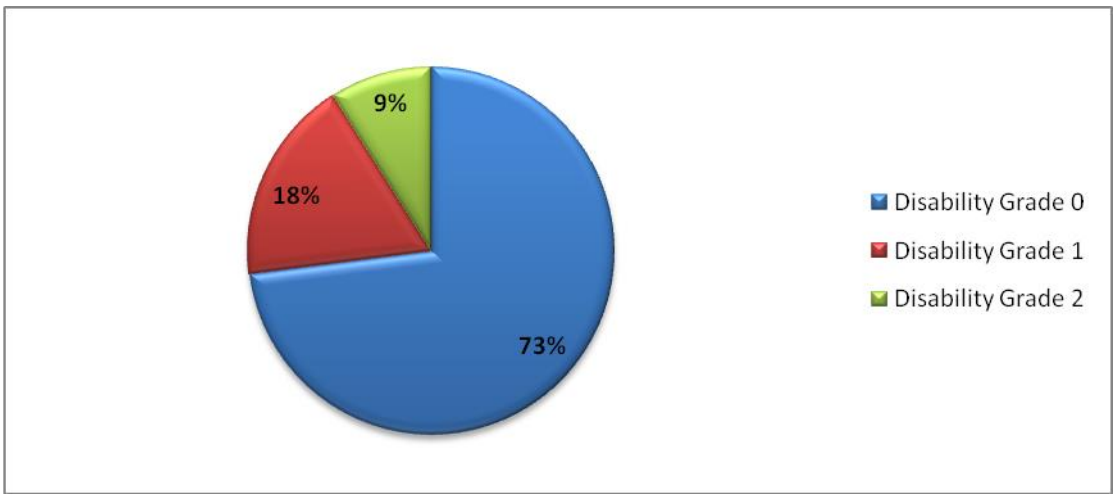
Figure4.10: Leprosy notification among children from 2015 -2016 by leprosy type, Zanzibar.



4. Percent of WHO disability grade 2 among new cases

In 2016, among **77** new Leprosy cases diagnosed, **14**(**18.1%**) patients had disability grade **1** and seven **7**(**9%**) had disability grade 2. The percentage of Leprosy cases with disability grade 2 has increased from **5.8 %** in 2015to **9%** in 2016 (figure 4.11 below). Among factors contributing to this was delay in diagnosing of Leprosy among HCWs due to inadequate knowledge and low awareness of leprosy among the community. One patient underwent reconstructive surgery.

Figure 4.11: Disability grading for newly diagnosed leprosy patients diagnosed in 2016



5. Rate of disability grade 2 per 100,000 population

The rate for disability grade 2 per 100,000 populations among new cases in 2016 is 0.4; the proportion is above the national target of 3.35. However due to the low suspicious index among the health care workers, there might be more cases with disability grade 2 within the community, that might increase the disability proportion. More intervention is needed to detect hidden cases within the community.

6. Percentage of female patients among new cases

Among Leprosy patients identified in this reporting year, the percentage of female patients was **29%.** This shows a slight increase of female patient detected in 2016 compared to **22%** in 2015.

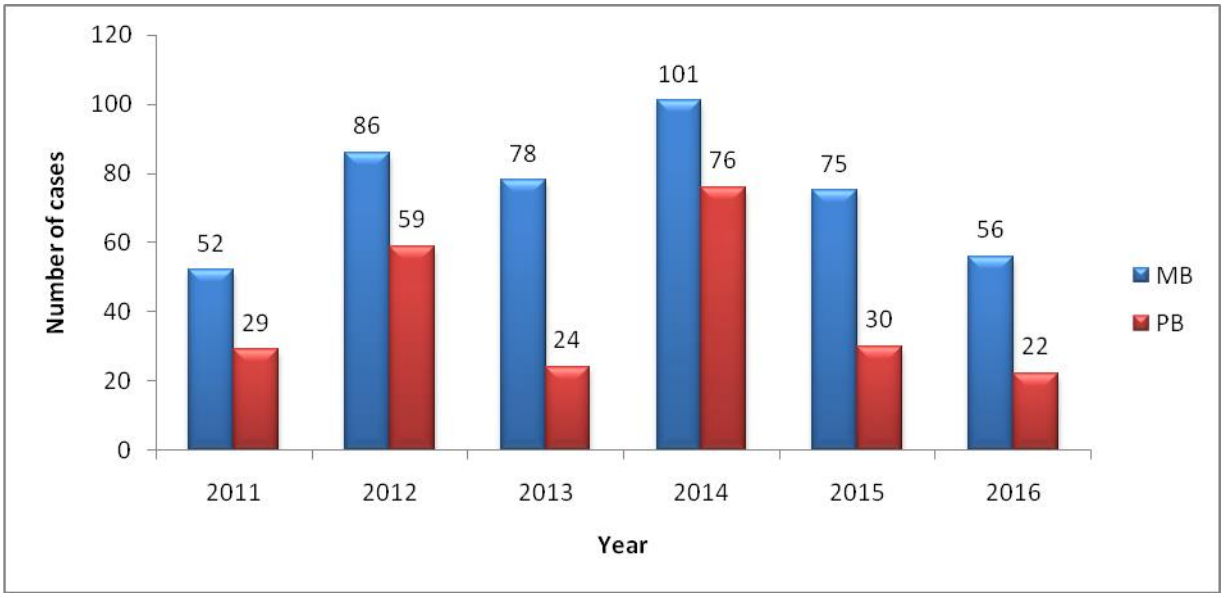
7. Percentage of MB leprosy patients completing 12 months of MDT amongst those expected to complete their MDT (calculated for 1-year cohort intake)

In year 2014a total of **102** MB leprosy patients started treatment, **100** (**98%**) completed their treatments and **2** (**2%**) were not evaluated. This shows the treatment completion rate has slightly increased compared to **97% in 2015**, however, out of 100 cases completed their treatment, **68** (**68%**) had no change in disabilities, **32** (**32%**) were improved.

4.8 Trend of Leprosy case notification from 2011 to 2016

Leprosy case notification is fluctuating from 2011 to 2016; higher numbers of cases were reported in 2014 but the number diagnosed is decreasing since 2014. The figure below shows the trend of leprosy detection from 2011 to 2016.

Figure 4.12: Trend of Leprosy cases notification from 2011 to 2016, Zanzibar



4.9 Challenges

Low case detection whose contributing factors are:

- Inadequate involvement of CSOs in TB and leprosy intervention
- Low suspicious index among HCWs in diagnosing both TB and Leprosy

CHAPTER 5: HIV AND TB LABORATORY SERVICES

5.1 Background

The laboratory services are key component of quality health care services. Laboratory unit is accountable for overseeing laboratories in HIV and TB services to ensure that tests performed and results generated are reliable, reproducible, timely and accurate. Currently there are twelve laboratories for HIV care and treatment sites (8 Unguja & 4 Pemba) 123 HTS sites (Unguja 83 & 40 Pemba), 168 PMTCT sites (100 Unguja & 68 Pemba) and 55 TB diagnostic sites in Zanzibar (35 Unguja &20 Pemba). In addition, Public Health laboratory (PHL) in Pemba serves 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:

Two days orientation training on HIV rapid test for 100 HCWs (60 in Unguja & 40 in Pemba) was conducted. The training was conducted in two sessions in each Island with the aim of updating HCWs from testing sites on new HIV testing algorithm

Three days training to 42 health care workers (27 participants Unguja and 15 Pemba) on how to perform proficiency testing from sites that were not performing well, the objectives of the training were to build their capacity on; Quality Assurance for HIV Rapid testing, DTS

Proficiency Testing, as an EQA method and Standardized HIV Logbook and tracer form for PT data recording and analysis.

A five days training on rational use and quantification of TB drugs and laboratory commodities, involving 35 health care workers (30 Unguja & 5 Pemba) from different heath facilities. This training was conducted in collaboration with central medical stores department, TB and PMU units. The aim was to impart knowledge and skills on Stores management, forecasting, quantification process, proper request and report of TB commodities.

5.4.2 Service monitoring

Proficiency testing for HIV rapid test performance was conducted to 31 sites (17 Unguja & 14 Pemba). Proficiency testing was done by distribution of known samples to measure the quality of testing services at the testing sites. Out of 31 distributed panels, 27 results were submitted timely (87%) while four sites (12. 9%) were not submit due to shortage of staff and reagents at the testing site. The results showed that the performance rate for 25 providers was above 98% which is acceptable performance rate while 2 had an unacceptable rate. On job training was conducted to those sites which did not perform well.

Quarterly External Quality Assurance for TB diagnosis was done in 42 diagnostic sites (28 Unguja & 14 Pemba) using the approach of blinded rechecking of sputum slides from the site by the first reader District Laboratory Technician (DLT). The performance showed that 97.6 % of the sites had concordant results while one site (2.7%) had a discordant result. On job training was conducted to health care workers at this site.

Supportive supervision for Early Infant Diagnosis (EID) services was conducted in 44 sites (22 Unguja and 22 Pemba). The purpose of this supportive supervision was to support EID service delivery, identify challenges, and provide guidance on the provision of EID services in order to improve services.

Supportive supervision in TB diagnostic sites was conducted in three quarters in Unguja and Pemba. The aim was to support TB diagnostic services delivery, identify challenge and provide guidance on TB diagnosis. Out of 55 diagnostic sites, 42 (28 Unguja& 14 Pemba) sites were functioning, while 13 (7 Unguja &6 Pemba) sites were not functioning due to shortage of staff and poor infrastructures. Majority of the sites were not performing internal quality control regularly and had poor infection prevention control procedures.

Three workshops were conducted in the year 2016 as follows: -

- A five day's workshop to 33 HCW (30 Unguja & 3 Pemba) from health facilities providing TB services to update TB testing algorithm to include Gene expert. The outcomes of the workshop were availability of new version of TB testing algorithm including two approaches for the sequence of provision of TB diagnosis using gene expert.
- A five day's workshop to develop training material for gene expert analysis. A total of 18 (15 Unguja & 3 Pemba) heath care workers attended. Participant manuals and facilitator guide were developed which will be used for the trainings for end users of gene expert machines.
- A five day's workshop to establish sputum transportation system to GenExpert MTB/ Rif site. A total of 18 participants (15 Unguja, 3 Pemba) attended. The aim of the workshop was to establish sputum transportation system from peripheral facilities, so as to enhance utilization of Gen Expert MTB/Rif to increase TB case detection.

5.5 Laboratory services indicators and trend from 2014 to 2016

Indicator	**Year**		
	2014	**2015**	**2016**
1. Number of laboratories with capacity to perform clinical laboratory tests for HIV care and treatment services	**6** out of **11**	**6** out of **12**	**6** out of **12**
2. Number of HIV testing sites participating in proficiency testing for HIV testing	212 (56 HCT&156 PMTCT)	84 (37 HTC & 47 PMTCT)	31 (17 PMTCT &14HTC)
3. Percent of laboratory performing smear microscopy showing adequate EQA performance according to EQA guidelines	100%	100%	97.6%
4. Number of health facility performing TB diagnosis using microscopy and or new technology	53	53	55
5. Percent of sputum samples transported to gene expert for TB diagnosis	745/5392 (13.8%)	1517/5934 (25.5%)	2737/4914 (55.6%)

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. Other 5 CTC laboratory have capacity to perform some of the clinical analysis but do not include CD4.These sites have system for transportation of samples to nearby health facility. These sites include Micheweni and Mkoani Hospital for Pemba, Al-Rahma, Makunduchi, ZAYEDESA and MAT CTCin Unguja.

Table 5.1 below shows the number of HIV clinical tests performed from 2011 to 2016 by site. The performance of testing was increasing with each subsequent year; 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 progress of the disease. Furthermore, chemistry tests including ALT and AST are done at base line and after every three months depending on the condition of the patient. However, for the Year 2016 there was a decrease of samples which were analysed due to shortage of all type of reagents for monitoring of HIV clients.

Table 5.1: Number of clinical tests performed disaggregated by site and year, Zanzibar, 2011-2016

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
2016	19550	1114	701	1506	270	656

A total of 222 samples for EID was received from PMTCT sites and transported to Muhimbili National Hospital, Dar es Salaam. The number of samples received from PMTCT sites decreased compared to the last two years. The data shows that there was an increase of HIV positive infants, 6 infants (2.3%) in 2015 to 10 infants (4.5%) in 2016. The detailed data is shown in the table below:

Table 5.2: Number of DBS samples transported for HIV DNA PCR testing by year, Zanzibar, 2011-2016

Year	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%)
2016	222	221	10 (4.5%)

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

There was a decrease in number of sites, from 84 in 2015 to 31 sites 2016 that participated in proficiency for HIV rapid test. The main challenge was shortage of staff and lack of HIV testing reagents in some of the testing sites

3. Percent of laboratory performing smear microscopy showing adequate EQA performance according to EQA guidelines.

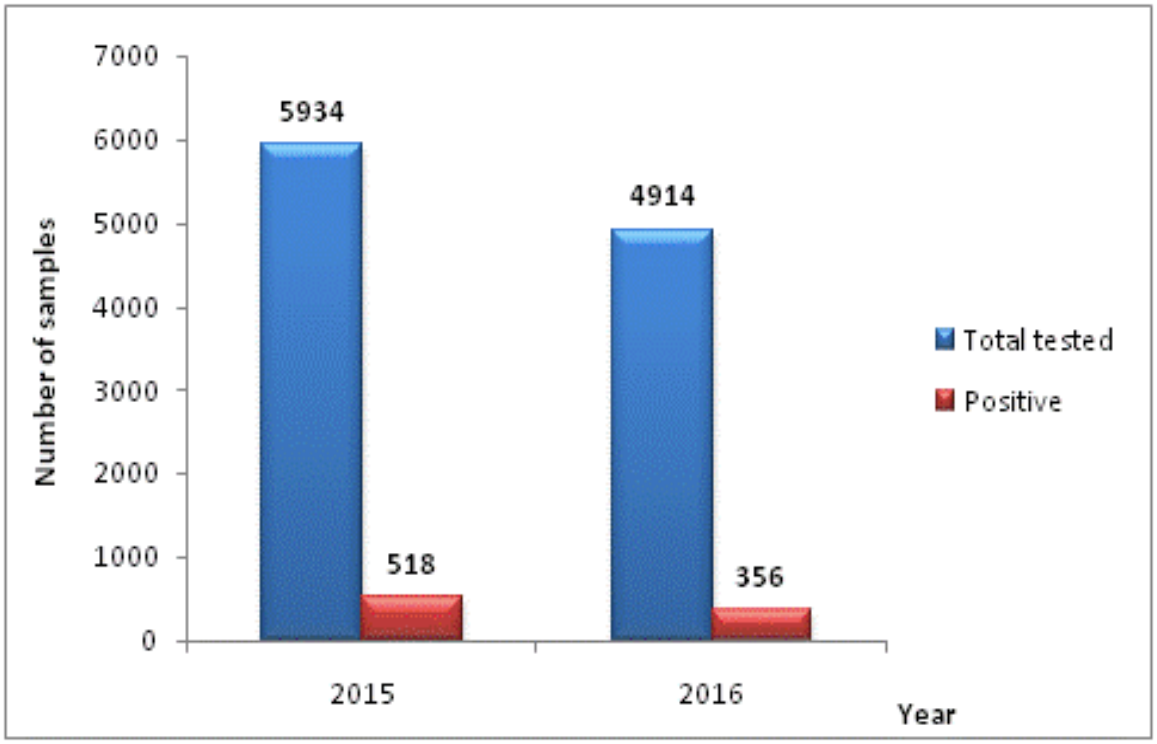
A total of 42 out of 55 (76.3%) TB diagnostic sites participated in proficiency testing according to EQA guidelines for TB smear microscopy. The performance rate was 97.1% (41/42) for TB sites one site did not perform well.

4. Number of health facility performing TB diagnosis using microscopy and or new technology

In 2016, number of diagnostic sites with capacity to perform AFB examination increased from 53 to 55 in Zanzibar. However diagnostic performance decreased from 5,934 samples

(2015) with 518 positives to 4,914 with 356 positives in 2016. This decrease was due to shortage of staff and poor infrastructure in some of the diagnostic facilities. All 55 TB diagnostic sites are performing sputum examination by microscopy technique with the exception of one site (Mnazi Mmoja) that uses both Gene Expert and microscopy examination.

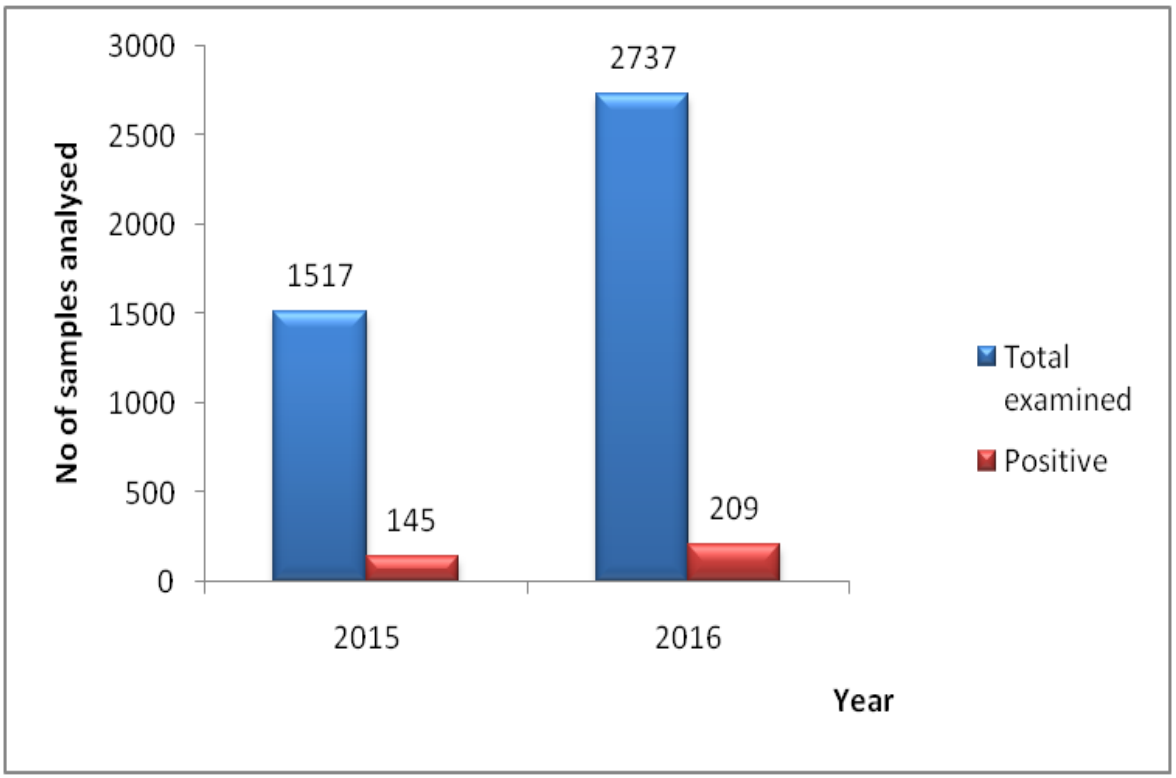
Figure 5.2: Sputum examination using Microscopy examination by year, Zanzibar, 2016



5. Percent of sputum samples transported to gene expert for TB diagnosis

There was an increase of samples transported for gene expert from 25.5% **(1517/5934) in 2015 to 55.6% (2737/4914) in 2016**.This technique is specific and sensitive in diagnosis including MDR cases, for 2016 detected 2 cases of MDR among samples performed.

Figure 5.3: Sputum Examination using Gene Expert by year, Zanzibar, 2016



5.7 Challenges

- Lack of PCR in Zanzibar, results in delay to identify HIV status of exposed infants
- Irregular availability of laboratory reagents and supplies for HIV and TB patient diagnosis and monitoring

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 Program Implementation

1. Workshop to develop IEC/BCC materials for TB/HIV and leprosy

A five days' workshop to develop TB/HIV and leprosy IEC/BCC materials was conducted. A team of 22 (17Unguja and 5 from Pemba) technical persons from TB, HIV and Health Education Unit participated in the workshop. These materials will be used to sensitize TB screening among HIV patients and HIV testing among TB patients.

At the end of the workshop, the following materials were developed:

Three types of pamphlets namely

- "Ufuasi mzuri wa dawa za ARV naTB",
- "Uhusiano kati ya TB na UKIMWI", "
- "Fahamu kuhusu ugonjwa wa Ukoma"
- "Zuwia unyanyapaa kwa wagonjwa wa Kifua kikuu, Ukoma na UKIMWI";

One sticker titled

- "Zuwia unyanyapaa kwa wagonjwa wa Kifua kikuu, Ukoma na UKIMWI"

One poster titled;

- "Fahamu Kuhusu ugonjwa wa Ukoma".

2. Develop IEC/BCC materials on PMTCT services targeting pregnant mothers and their infants

A five days' workshop to develop IEC/BCC materials on PMTCT services was held at Unguja. A total of **28** participants (20 Unguja and 8 from Pemba) participated in the workshop. The aim of this workshop was to develop new IEC/BCC materials on PMTCT services reflecting option B+ including ARVs adherence materials for PMTCT mothers and their infants. Participants were able to develop four types of pamphlets, four types of posters and three types of stickers that targeted pregnant mothers, male partner involvement, Health Care Workers and General Population.

The titles of IEC materials developed were:

A) Pamphlets

- "Mama Mjamzito Tumia Dawa Za Kupunguza Makali Ya VVU Kwa Usahihi"
- "Baba Na Mama Mkingeni Mtoto Dhidi Ya Maambukizi Ya VVU"
- "Tambua Huduma Za Kumkinga Mtoto Na Maambukizi Ya VVU"
- "Epuka Unyanyapaa Kwa Mama Waja Wazito Wenye VVU"

B) Posters

- "Tumia Dawa za ARV kwa usahihi"
- "Baba Na Mama Mkingeni Mtoto Dhidi Ya Maambukizi Ya VVU"
- "Pata Huduma Ya Kuzuia Maambukizi Ya VVU Kwa Mtoto Katika Kliniki Ya Afya Ya Uzazi"

C) Sticker

- "Matumizi Ya ARV Kwa Mama Mjamzito Mwenye VVU Huboresha Maisha Ya Mama Na Mtoto"

3. Conduct workshop to develop IEC/BCC materials on TB Infection, Prevention and Control(IPC)

A five day's workshop to develop IEC/BCC materials on TB Infection, Prevention and Control was conducted. A total of **22** participants from Unguja were involved. Objective of the workshop was to develop IEC/BCC materials on TB, TB/HIV and Infection Prevention and Control for health care providers, community and policy/decision makers.
At the end of the workshop, the following materials were developed;

1. Brochures: Titled;

- " UKWELI KUHUSU UGONJWA WA KIFUA KIKUU"
- " JIKINGE NA MAAMBUKIZI YA TB KWENYE SEHEMU YA KAZI"

2. Poster: Titled;

- " USIAMBUKIZE WENGINE UGONJWA WA KIFUA KIKUU"
- "Je wewe una dalili hii"

3. **Wall sheet:** Titled;
    - "HATA WEWE"
4. **Fact sheet:** Titled;
    - "Wajibu wa viongozi"

5. TB/HIV sensitization meeting to the community

The program conducted TB HIV sensitization meeting in 20 Shehias of Unguja. The aim was to create awareness on TB and HIV in the community. During these meetings, people were mobilized to test for HIV and screen for TB. A total of **2,095** people attended; among them **156** were TB suspects and **3** were found positive. Total tested for HIV were **1,167** and **3** were found HIV positive.

6. Health Education for TB to the community

TB health education sessions and screening were conducted in the community in9 Shehias with reported cases of TB**,** and place where stones bricks are manufactured in Pemba. The aim was to raise awareness on TB prevention in the community. A total of **670** attended of which **22** presumptive were identified, **2** patients diagnosed with TB. At the end of each meeting IEC materials were distributed.

7. Conduct sensitization meetings on Leprosy to the community

Program in collaboration with community leaders and community Leprosy committees, leprosy sensitization meetings within community were conducted which was coupled with leprosy screening. The 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 **1,327** people (**586** people from **6** Shehias in Pemba and **741** from 9 Shehias in Unguja) were sensitized and screened. During these meetings, a total of **7** presumptive were identified and **3** were confirmed to have Leprosy (2 MB grade 0 and 1 with MB grade 2). At the end of each meeting IEC materials were distributed.

8. Commemorations of the World AIDS, TB and Leprosy Days

The Programme participated in commemoration of Worlds AIDS day on 1st December, 2016 which was organized by Zanzibar AIDS Commission and the theme was "**KIJANA KATAA UKIMWI**".

The programme also commemorated World TB day on 24th March, 2016. This year theme was **"Find TB. Treat TB. Working together to eliminate TB".** Various activities were done before the climax day, including 3 TB community sensitization meetings in the Shehia of Urban West with the aim to create awareness and to identify hidden cases from the community and send them for investigation and treatment. Also, two radio programs were aired.

The World **Leprosy** Day was marked on 31 January 2016, and the Theme was **"To live is to help to live"**. Also, two radio programs concerning awareness on Leprosy were aired.

9. Conduct health education at Correction facility on TB and HIV

A total of 201 students at Kilimani correctional facility were sensitized and screened for TB and HIV. All 87 students of correction facility who were tested for HIV and all 24 who were screened for TB were found negative.

10. School health education program on TB

TB health education sessions and screening were conducted in 9 secondary schools (2 in Unguja, 7 in Pemba). A total of **1,208** students were screened and **9** presumptive cases were identified but none of them was found with TB.

11. Sensitization meeting to key community leaders on importance of Male involvement in ANC services

Ten days community sensitization meeting to key community leaders was conducted in all ten districts. A total of 300 key leaders, 30 from each district participated including Shehas, religious leaders, traditional healers, etc. The main objectives of the meeting were to create awareness on importance of male involvement in ANC services and to involve them in scale up male participation at community level.

12. Sensitization meeting to key community leaders on mother mentor program

One day sensitization meeting to key community leaders was conducted in all ten districts. A total of 250 leaders, 25 from each district participated. The participants included religious leaders, Shehas and health Care Providers. The objectives of the meetings were to create awareness on importance of establishing mother mentor program and to fully engage them in

improving community uptake and retention among HIV-infected pregnant women, breastfeeding mothers and their infants, across PMTCT care cascade.

MAT services sensitization meeting to key community leaders

The program conducted MAT sensitization meetings to key community leaders. The meeting was conducted in 3 sessions each for 2 days with 35 participants. The objective of this activity was to create awareness on the importance of Methadone Assisted Treatment (MAT) in Zanzibar so as to create ownership in providing these services.

13. Workshop to create TB awareness among non -health Sectors

One day workshop to create TB awareness among non-health sectors was conducted in two sessions. A total of 70 participants (35 Unguja, 35 Pemba) were sensitized. The aim of this workshop was to establish collaboration with employer and employees from government, private and informal sectors to expand TB services at work place as well as in the community.

6.5 Challenges

- Absence of TB, HIV and leprosy ACSM strategy.
- Low knowledge of TB and leprosy in the community resulting into low health seeking behaviour.

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 data management 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 2016, the programme has managed to implement **11** 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. Strategic information unit 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. These 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 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 S.I officers within the program.

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

HIV, STI, TB and Leprosy data verification was conducted in **34/253** (13.4%) health facilities (**9** in South Region and **29** in Urban West Region) Unguja. 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, reporting forms, and few health facilities did not have updated PMTCT, STI, HBC, PEP and TB registers and guidelines.
- Most of the reports are being submitted to DHMT instead of district surveillance officer collecting the report from the facility. Because of this; data checking and verification before collection was not done.

- Most of the service indicators were not 100% accurate in reporting, 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.

The outcome of verification exercise was shared with staff of the visited health facilities, issues were identified and strategies to improve the challenges discussed.

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.

7.4.3.1 Training for Data collectors on Formative assessment for KP

Partners from University of California San Francisco in collaboration with ZIHTLP facilitated four days training on formative assessment which targets three groups namely SW, PWID and MSM was conducted in Unguja. The objective of the training was to orient data collectors, on formative assessment methods including focus group discussion, observation, census and enumeration. A total of **33** research team members participated in the training.

7.4.3.2 Data collection for TB KAP study

Three days data collection training was conducted for enumerators. The aim of this training was to orient enumerators on the use of ODK software in collecting data for TB KAP study. A total of 30 participants from 10 districts participated in the training (three from each district). During this training, tool review was done and participants exercised on data collection using tablets. At the end of the training data collectors were equipped with skills and competencies on how to use ODK software in data collection and these staff participated in KAP study.

7.4.4 Component 4: M&E Partnership

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 development of KP and MAT tools and database which are still in process.
- MDH provided technical assistance on updating CTC2 database
- MEASURE EVALUATION provided technical assistance on data demand and information use.
- UNAIDS provided technical assistance in updating 2016 spectrum file for HIV estimates and projections.
- PATHFINDER provided technical assistance on finalization of HBC monitoring tools.

7.4.5 Component 5: Monitoring and Evaluation Plan/Framework

The programme has developed TB M&E plan for 2015/2016-2019/2020 that aimed at measuring the level of implementation of Zanzibar TB and Leprosy Strategic plan II. However, HIV M&E plan ended this year and therefore the programme is on the process to develop new M&E framework.

7.4.6 Component 6: Survey and surveillance

Periodic survey and surveillance were conducted to track the trend of HIV and TB infections. This was done so as to provide information for programme planning. In 2016, the programme has managed to do the following:

7.4.6.1 TB KAP Study

7.4.6.1.1 Protocol development for TB KAP study

Protocol for TB KAP study was developed and one day meeting with Technical working group was done with the aim of reviewing protocol and receiving comments before submission for ethical clearance. Thereafter comments received were incorporated and submitted to ZAMREC for approval.

7.4.6.1.2 Data collection

Twelve (**12**) days field data collection was done in all **30** selected Shehias (21 in Unguja and 9 in Pemba). A total of 3,204 community participants (2,273 in Unguja and 931 in Pemba),

and 233 HCWs (149 in Unguja and 84 in Pemba) participated in the study. The target was to interview 2,808 community participants and 180 HCWs.

7.4.6.1.3 Data cleaning and analysis for TB KAP study

Five days' data cleaning and analysis workshop was conducted. The aim of the workshop was to do data analysis and produce results ready for dissemination to various stakeholders. The workshop involved 10 participants, 8 from Unguja and two consultants from Ifakara Health Institute. At the end of the workshop preliminary results were produced.

7.4.6.4 Formative assessment for KP

Protocol for this assessment was developed and then submitted to ZAMREC for ethical clearance and finally was approved; this was followed by data collection training. The objective of the assessment was to collect data which will help and guide preparations for the coming third round of IBBSS study for KP in Zanzibar.

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 services. The main goal is to produce timely and high-quality routine programme monitoring data.

The programme has monitoring tools for all services. Patients/client forms/cards; registers, reporting 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 database. 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

S.I unit in collaboration with PMTCT, HTS, HBC, STIs, TB and Leprosy units conducted a **5**daysworkshop of tool review. The objective of this activity was to review the existing monitoring tools based on additional new indicators that are required by the programme to report on different reporting cycles for the government and other key stakeholders.

7.4.7.2 Strategic information indicator trends

On tracking routine programme services, data is entered into DHIS2 database. Report for three years (2014-2016) was generated from DHIS2 database to show the trends of completeness and timeliness of the HIV/TB and Leprosy data.

Table 7.1: Strategic Information Indicator and Trend, 2014 - 2016

Indicator	Measurement	2014	2015	2016
Percent of facilities submitting complete and timely reports	**Completeness**	**85**	**88**	**75**
	Timeliness	**37**	**50**	**47**

The completeness of reports collected from health facilities has decreased from **88%** to **75%** from 2015 to 2016. Less than fifty percent **(47%)** of the reports were entered into the DHIS2 database timely. Among contributing factors for this decrease was lack of support on supervision and mentorship to DSOs at DHMTs, also may be due to lack of commitment of DSOs. Timeliness and completeness of reports still needs to be improved in the coming years. (For detailed reporting summary on HIV, TB and Leprosy services, **see appendix I.**

7.4.8 Component 8: National M&E databases

The HMIS of MoH maintains a DHIS2 database as a national M&E database which houses majority of data across all health sector programmes including HIV, STI, TB and Leprosy service data. This database is regularly updated based on the need of the programme. ZIHTLP staff has access to the DHIS2 database through a web-based interface. Despite of programme data being integrated into HMIS, the programme 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 software version 3.5.4. 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 office.

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 goal is to disseminate and use data from the M&E system to guide policy formulation and programme planning and improvement.

7.4.9.1 Data dissemination

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

- Preparation and sharing of quarterly, semi-annual and annual narrative progress and detailed indicators performance based reports for tracking HIV, TB and Leprosy interventions has been done and submitted to MOH and other relevant stakeholders.
- Oral presentation on program key interventions and financial performance for the year 2015 was presented on February 2016 during the Annual Health Sectoral Reform meeting organised by MOH.

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 2016, the programme has used data for various activities including the following:

- Tracking patients on HIV care and treatment who were lost to follow up
- Following up HIV positive pregnant women and their exposed infants who were lost to follow up
- TB and Leprosy contact tracing
- Establishment of quality improvement plan for HIV, TB and Leprosy services
- Weekly programme services review meeting

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, programme managers, programme staff and other stakeholders. Commitment to M&E activities exists within ZIHTLP whereby it is well reflected in national strategic plans and 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. M&E system information products are largely disseminated within the health care system and insufficiently to the public. Dissemination of information to the public need to be strengthened through program website and newsletters.

7.4.11 Component 11: Evaluation and Research

This component involves identification of key questions for research and evaluation; coordinate studies to respond to identified needs and promote the use of evaluation and research findings.

This year, the programme developed TB & Leprosy research agenda (2016/2017-2019/2020) that direct TB, Research and Evaluation. The Agenda has been prioritized based on strategies from TB and Leprosy strategic plan II. The overall goal of the TB & Leprosy research agenda is to guide researchers, policy makers, program implementers, academic institutions, health development partners and other stakeholders on research priorities for TB and Leprosy in Zanzibar.

7.5 Challenges

- Inadequate fund for supportive supervision at district and data verification at health facility levels
- Absence of data quality assessment guidelines
- 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 other programme units to implement technical roles by ensuring availability of necessary requirements to execute their duties effectively. In addition, it 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

Programme Management Unit is responsible for the following areas: a) Policy guidance; b) Planning and budget; c) Human resource management; 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 staff and all HIV, TB and leprosy implementers on the processes and procedures that are necessary to ensure implementation and accountability of services. In this reporting period, the programme released circular for “test and treat” to all implementers providing HIV Care and Treatment services. The programme also prepared plans for end term review of the HIV Health sector strategic plan 2012/2016 and development of the new Strategic plan.

8.3.2 Planning and budget

Every financial year, the programme prepares a comprehensive work plan and budget that includes Government and various HIV, TB and Leprosy partners. The Government financial year runs from July to June, however some of the partners’ budgets have different financial years. 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. In addition, reprogramming of the planned activities is done where there is low chance of implementation of the activities. For this year, reprogramming and extension request was done for GF activities whose implementation delayed due to late disbursement of funds. Also, the programme convened a meeting with THPS to prioritize activities that will be supported by them through PEPFAR funds.

8.3.3 Human resource management

Majority of ZIHTLP staff are employees of 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 2016, a total of **92** staff (84 Government and 8 on contractual basis) with different specialties were working in the programme. In addition, the programme was in process of recruiting 4 additional staffs including Biostatistician, Accountant, MDR Coordinator and MAT Psychologist.

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. These include the following:

- National and International Meetings and Conferences
    - 9th International AIDS Society Conferences in Durban
    - 47th Union World Conference on Lung Health in Liverpool
    - HIV Cascade analysis workshop in Croatia
    - Meeting to establish formal link with Supranational Laboratory in Italy
    - QPR, SAPR, APR and EA meeting organized by CDC Office Dar es Salaam
- Training
    - MDR TB Training in Rwanda (2 participants)
    - Master in Applied Epidemiology (1 participant)
    - MSc in Health System Management (1 participant)
    - Global Fund PPM Training in Dar es Salaam (2 participants)

8.3.5 Inter and Intra Coordination

ZIHTLP has continued to collaborate with development partners to support implementation of HIV, TB and Leprosy activities at all levels. Outlined in table 8.1 below are the partners providing technical support to ZIHTLP during the year 2016.

Table 8.1: ZIHTLP Technical Support by Partners, Zanzibar, 2016

NAME OF PARTNERS	TECHNICAL SUPPORT PROVIDED
1. Pathfinder International	• Revision and training of HBC monitoring tools
2. François Xavier Bagnoud (FXB)	• Support meeting of Technical Working Group to review PMTCT Training Package
3. KNCV	• Support in strengthening TB and TB/HIV data quality
4. UN agencies	• Provide technical assistance in Guidelines review
5. Measure Evaluation	• Data demand and information use assessment

8.3.6 Procurement and provision of logistics

The programme uses Procurement Unit of the Ministry for major procurement (above 10,000 USD) and minor procurements are done through the programme. However, starting from this year, for GF Procurement support, all health commodities will be procured through Pooled Procurement Mechanism (PPM). In this mechanism, the Global Fund facilitates the procurement process. Through PPM USD **511,204.44** was used to procure ARVs and HIV test kits during 2016.

8.3.7 Financial Management

Finance unit supports other technical unit in the areas of financial management, budget and reporting according to financial regulations 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.

The following is the overview of the financial position for ZIHTLP for the calendar year ended December 2016. Included in this overview is analysis of ZIHTLP Asset and Liabilities, Budget, Outflow and Inflow of the financial resource.

a. Asset and Liabilities

Asset and Liabilities are prepared under cash basis of accounting, whereby revenues and expenses are recognised at the time physical cash is actually received or paid out. Asset, expenses, liabilities and revenue are measured using current value except fixed assets are stated at historical cost.

Fixed Asset

During 2016, the Program planned to procure assets such as computers, motor vehicles and motor cycles but due to the delay in procurement procedure, the Program didn't acquire any of these assets for the calendar year ended December 2016. These assets are expected to be received next year. The Program has Asset Register for all Program assets which is updated every year. No disposal of asset was done during 2016.

b. Budget

In this reporting period, program planned to receive funds from different sources for the implementation of HIV, TB and Leprosy interventions. The major planned support was 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). Table 8.2 illustrate the sources of funds and the area supported in 2016.

Table 8.2: Source of funds from the Government and development partners and area supported, 2016

	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 • Strengthening Strategic Information System and • Program management
2.	Global Fund HIV/TB grant	Enhancement of HIV and TB Prevention, Diagnosis, Treatment and Care among Key and General Populations in Zanzibar	• Prevention of Mother To Child Transmission of HIV • HIV Care and Treatment • Home Based Care services • HIV prevention services for KPs and General population • TB prevention, diagnosis and treatment • HIV/TB • MDR TB • HIV/TB laboratory services

			• Information Education Communication and Behaviors Change • Strategic Information • Program management
3.	Tanzania Health Promotion Support	Provision of Comprehensive Care and Treatment Program in Zanzibar	• Strengthening of HIV Care and Treatment, PMTCT, HTS, HBC and Laboratory services • Key Population activities including MAT service • Gap filler to support Laboratory reagents and supplies
4.	United National Development Program – Tanzania (UNICEF)		• Provide bridge support on HIV health sector interventions including PMTCT, Key Population and Care and Treatment
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.

The total budget for each support depends on the financial year of the particular partner. Every partner has got its own accounting period. Table 8.3 shows financial year and budget allocated for mentioned partners.

Table 8.3: ZIHTLP budget from different sources per fiscal year 2015-2016

FUND SOURCE	FINANCIAL YEAR	BUDGET 2015 USD	BUDGET 2016 USD	% CHANGE
Government	July to June	59,101.65	50,403.23	**-14%***
PEPFAR	April to September	2,967,890	2,552,039	**-14%**
Global Fund	July to June	4,336,776	3,694,042.00	**-14%**
UNICEF	July to June	80,575	26,196.35	**-67%**
THPS	October to September	80,000	19,845	**-75%**
GLRA	January to December	12,614	9,162.42	**-27%**

*The budget was the same in 2015 and 2016. The shown decrease is due to the exchange rate used to convert the currency (exchange fluctuation). The actual budget was 100,000,000 Tshs each year.

The table above shows that PEPFAR and Global Fund support declined by 14% while UNICEF, THPS and GLRA declined by 67%, 75%and 27% respectively. For the prior reporting period the support from Global Fund was under the name of GF R10 which ended in September 2015. ZIHTLP signed a new contract with Global Fund under the grant name HIV/TB NFM for the period of 3 years starting October 2015 to December 2017 but implementation of this new grant started in April 2016 due to delayed disbursement of funds.

c. Inflow and outflow of financial resource

Cash Inflow /Income

During this year, ZIHTLP received funds as a cash inflow from various sources as mentioned above, the total amount received was USD 4,378,110.50. The following is a summary of cash inflow received (Table 8.4).

Table 8.4: Summary of ZIHTLP funds received from various sources 2014-2016

SOURCE OF FUND	2014	2015	2016
Government	1,165	0	23,234.20
PEPFAR	2,449,376.84	2,008,104.69	564,045.23
GF	0	276,057.81	3,750,042.80
UNICEF	0	0	17,142.49
THPS	16,936.75	59,100.78	14,483.36
ICAP	31,456.93	0	0
GLRA	12,690.82	12,614.00	9,162.42
UNDP	23,293.87	0	0
TOTAL	**2,534,920**	**2,355,877.28**	**4,378,110.50**

Cash outflow/expenditures

Out of USD 4,378,110.50 that ZIHTLP received in 2016, Programme managed to absorb USD 1,991,906.96 (45%). However, 20% of the funds was committed in procurement in which its process is ongoing. The following table 8.5 indicate the absorption rate per each partner for the year 2016.

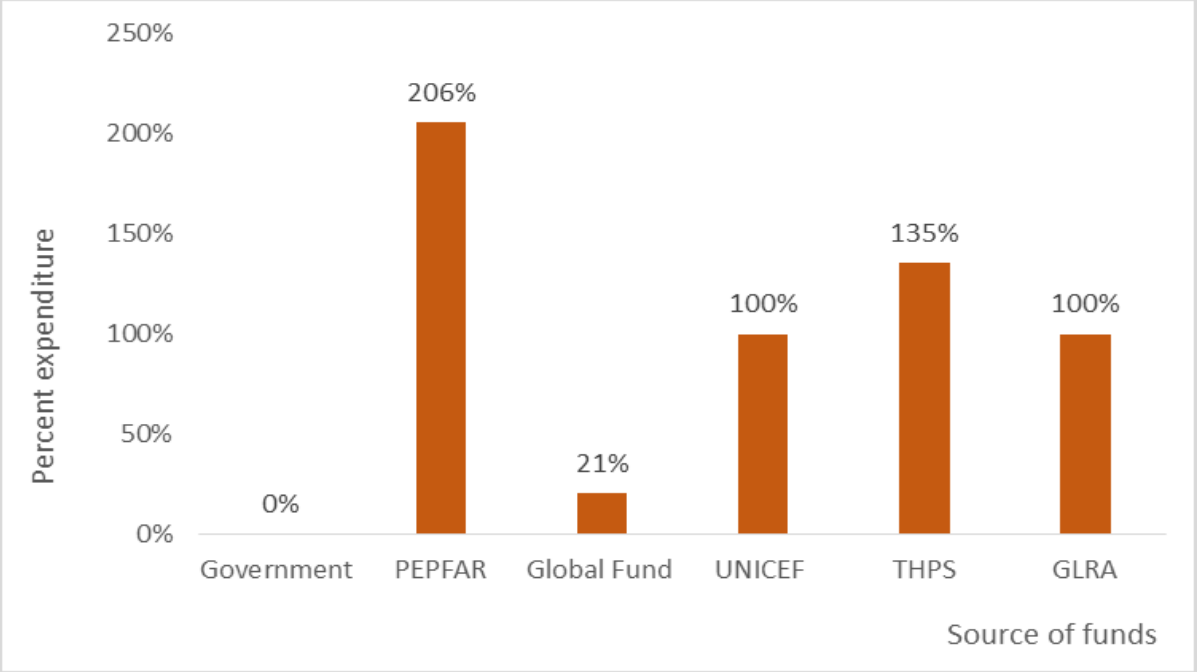
Table 8.5: Summary of expenditure of ZIHTLP funds from various sources, 2014-2016

SOURCE OF FUND	2014	2015	2016
Government	1,165	0	0
PEPFAR	2,118,037.13	1,171,411.35	1,160,524.04
GF	596,136.43	332,490.00	773,864.61
UNICEF	0	0	17,142.49
THPS	0	64,447.36	19,596.40
ICAP	31,456.93	0	0
GLRA	12,690.82	12,614.00	9,162.42
UNDP	23,293.87	0	0
TOTAL	**2,782,780.18**	**1,580,962.71**	**1,980,289.96**

The figure below shows that the programme spent more funds than it received from PEPFAR and THPS for the current year. This is because the accounting period for these partners started in the previous year (October 2015 to September 2016) and therefore there were some funds received from PEPFAR and THPS in 2015 but were spent in 2016.

Absorption rate for funds received from Global Fund was low, mostly because there was delayed disbursement (29 March 2016) and funds received was for implementation of two accounting years starting October 2015 to June 2017. Most of the activities that were supposed to be conducted from October 2015 to March 2016 were not implemented timely and others were not implemented at all. Furthermore, there was no spending for the government funds in 2016; this is because the funds were received in December 2016 and hence will be spent starting January 2017.

Figure 8.1: Percentage of ZIHTLP expenditure by source of funds, 2016



I. Projection of budget for the year 2016/2017

The main support of the program for the coming year is from partners as indicated in the Table 8.6 below. However, PEPFAR support has phased out in this year; hence there is no projection for this partner in the coming year.

Table 8.6: Budget Projections from different sources for 2016/2017

SOURCE OF FUND	FISCAL YEAR	AMOUNT USD
GLOBAL FUND	July – June	3,694,042.00
THPS	October - September	170,705.77
UNICEF	July – June	26,196.35
GLRA	January - December	9000.00
GOVERNMENT	July – June	45,662.10

Challenges

- Delayed disbursement of fund from GF and THPS.
- Decreased financial support from partners (CDC-PEPFAR)
- Shortage of human resource at Programme level
- Lack of Procurement Plan

Recommendations

- Liaise with partners to ensure timely disbursement of funds.
- Mobilise resources from other partners.
- Hiring of staff
- Develop Procurement Plan

CHAPTER 9: RECOMMENDATIONS

Despite ZIHTLP having achievements in the year 2016; 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 2017:

- Build capacity of HTS providers on how to use report and request form for HIV commodities
- Liaise with Hospital management and DHMTs to integrate PITC services as a routine test for all who attend health facilities
- To set PITC target for health facilities and create motivation system for those who perform well
- Improve HIV test kits supply system and enhance its use among healthcare providers
- Strengthen follow up and tracking mechanisms for mother-infant pairs through phone calls, follow up by mother mentors and CHBC, data sharing with CTC and liaising with D-Tree program
- Follow up to improve EID system
- Strengthen current approaches, innovate other potential strategies and learn from other successful programs to improve male involvement inANC services.
- Promote and strengthen peer support programme conducted by NGOs
- Strengthen KP friendly services
- Timely procurement of MAT supplies and reagents
- Lobby for fund to various donors to support viral hepatitis interventions targeting KPs
- Procurement and distribution of STI drugs timely
- Conduct training to service providers (public and some private hospitals)
- Strengthening partner tracing through designing system to trace partner (partner tracing form, referral cards etc)
- Conduct study to identify factors that influence ART retention in Zanzibar
- Strengthen collaboration with community home based care providers, and peers in tracing of defaulters

- Conduct quarterly QI meeting to discuss retention of patients and progress on service provision
- Liaise with DHMTs and Mnazi Mmoja Hospital management for additional CTC staff
- Improve case detection through involvement of CSOs in TB and leprosy awareness and identification of symptomatic patients.
- Train health care workers on leprosy
- Strengthen mentorship to health care providers on TB and leprosy
- Procurement of PCR machine
- Liaise with GF to speed up procurement process
- Mobilize resources for developing ACSM strategy for TB, HIV and leprosy
- Conduct community mobilization sessions on HIV, TB and leprosy awareness so as increase uptake of HIV, TB and leprosy services
- Mobilize fund for supportive supervision at district and HIV/TB data verification at facility levels
- Develop Programme website
- Develop data quality assessment guidelines

Appendix I: Reporting summary for HIV, TB and Leprosy in 2016

Indicator	Percent of facilities submitting complete and timely reports				
	Completeness			Timeliness	
Services	Actual	Expected	Percentage	Report on time	Percentage on time
HTS	1020	1404	72.6	591	42.1
RCH	1990	2016	98.7	1359	67.4
Maternity	563	576	97.7	353	61.3
STI	2221	2712	81.9	1430	52.7
HBC	1625	1800	90.3	1000	55.6
TB notification	527	640	82.3	136	21.3
Leprosy notification	496	660	75.2	132	20.0
HIV Laboratory	109	120	90.8	63	52.5

Appendix II: 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	✓	✓	✓	✓	✓
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	✓	✓	✓	✓	✓
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	✓			✓	
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	✓	✓	✓	✓	✓
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	✓	✓	✓	✓	✓
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			✓	✓	