REVOLUTIONARY GOVERNMENT OF ZANZIBAR

MINISTRY OF HEALTH

ZANZIBAR INTEGRATED HIV, HEPATITIS, TUBERCULOSIS & LEPROSY

PROGRAMME

(ZIHHTLP)

ANNUAL REPORT

2018

Table of Contents

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
DDM	District Data Manager
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
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

EXECUTIVE SUMMARY

This 2018 annual report is the eighth 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. In addition, 2017 mark the mid-term implementation of the National TB and leprosy strategic Plan 2015 -2019. The report also includes highlights of HIV/AIDS and TB research being done in Zanzibar. The following have been achieved regarding the services in the country.

HIV Counselling and Testing Services: The number of Counselling and Testing sites offering HIV Counselling and testing services was 141 including 13 sites provide VCT services alone, 79 provide PITC services alone and 49 provide both PITC and VCT services. A total 261,399 of individuals from the general population were counselled and tested for HIV in 2018 compared with 161,002 clients in 2017. Among the clients tested, 57% were females and 43% were males.

Prevention of Mother to Child Transmission services: The Prevention of Mother to Child Transmission services with treatment as "TREAT ALL" approach. A total of 63,663 pregnant women were tested for HIV which is 93.7% of all estimated pregnant women, wherein 394 (97.3%) HIV positive pregnant women out of 405 estimated HIV positive pregnant women were initiated on ART. A number of infants born to HIV positive mothers who received HIV antigen test (DNA PCR) within 2 months of birth were 258/405 (64%) and all were started on Cotrimoxazole within two months of birth.

Key Population services: About 6,045 of key population including 2,933 FSWs, 1,557 MSMs and 1,555 PWIDs were tested for HIV. The proportion of HIV infected KPs receiving ART was 85.2% for MSM, 19.7% FSW and 18% PWIDS. As of December 2018, a total of 16.3% (521/3,200) clients were enrolled and currently receiving MAT services in Unguja. Percentage of PWIDS who were on Methadone services for at least six months was 70.4% (367/521).

STI/RTI Control and Prevention Programme: In 2018, a total of 13,335 STI cases reported and managed which is a decrease from 8,354 episodes reported in 2017. There was an increase in STI cases diagnosed compared to 2016.

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 2018, a total of thirteen ART clinics were providing care and treatment services with 6,208 patients who received care in CTCs of whom 5,915 (86.6%) are receiving ARVs at these facilities. About 72.2% 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%.

Home Bases Care services: During 2018, a total of 3,328 compared to 3,158 patients in 2017. Among those received services 1,234 were People living with HIV where 828 Female and 406 were male.

Tuberculosis and Leprosy control services: A total number of all registered TB cases were 944, where number of new smear-positive TB cases was 334(37%). TB success rate was 95%. For TB/HIV collaborative activities, 934 TB patients tested for HIV and 122 (13%) were positive for HIV. Eighty-eight percent (96%) of the co-infected patients started ART through under one roof service. The number of new leprosy cases registered in 2018 was 82 cases of whom 70% 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, 18% were children, 2% had disability grade 2.

Laboratory Services: The laboratory services are key components of quality health care services, 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 13 laboratories (9 Unguja and 4 Pemba) which support monitoring of HIV care and treatment services. Furthermore, laboratory supports includes 141(92 Unguja49 Pemba) HTS sites, 158 (92 Unguja 66 Pemba) PMTCT sites, 56(38 Unguja 18 Pemba). Also, diagnostic performance increased There was an increase of sputum samples transported to Gene Xpert

testing sites from 57.6 % (3,627/6,280) in 2017 to 91 % (7,991/8751) in 2018. All 56 TB diagnostic sites performs sputum examination by microscopy technique, however MnaziMmoja in Unguja and Chake Chake in Pemba are using both Gene Expert and microscopy examination for diagnosis.

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 2018, the programme conducted bi-annual meeting with ACSM group to coordinate involvement of CSO's and NGO's in TB and Leprosy control. Also, sensitization meeting with key community leaders on importance of male involvement in ANC services, Also, different IEC/BCC materials on HIV, TB and Hepatitis, radio and TV spots were developed, printed and distributed and aired. In addition, develop TB Advocacy, Communication and Social Mobilization (ACSM) Strategy.

Strategic Information Management: Some of the key achievements during 2018 are surveillance among pregnant women who attended ANC and prevalence study on TB among high-risk groups (diabetic and Prisons). Also, rapid assessment among KP was conducted in Pemba to determine the feasibility of doing IBBSS. Also, the unit in collaboration with Measure Evaluation managed to develop the third health HIV M&E plan.

CHAPTER 1: GENERAL INSTITUTIONAL BACKGROUND INFORMATION

1.1 Introduction

Zanzibar Integrated HIV, Hepatitis, TB and Leprosy Programme (ZIHHTLP) 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 the provision of services for two interrelated diseases and efficiently utilize resources.

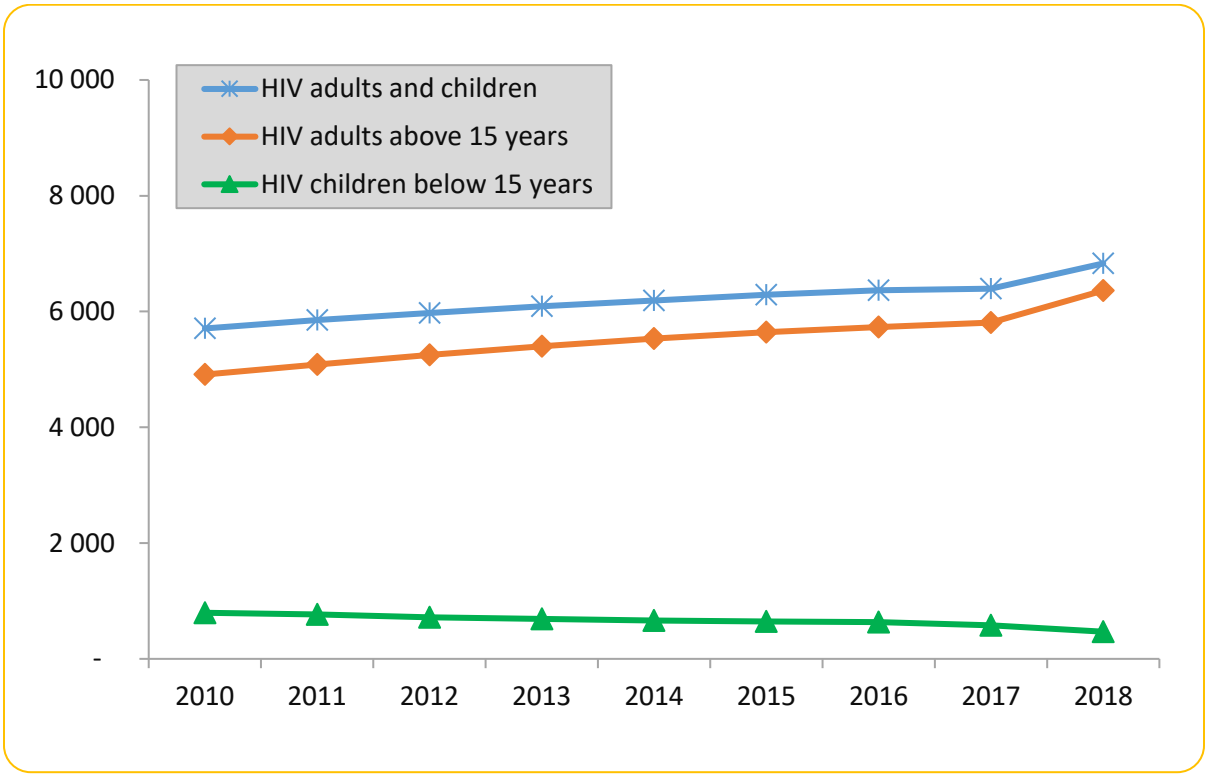
1.2 The burden of diseases (HIV, Hepatitis, TB and Leprosy)

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 by 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.

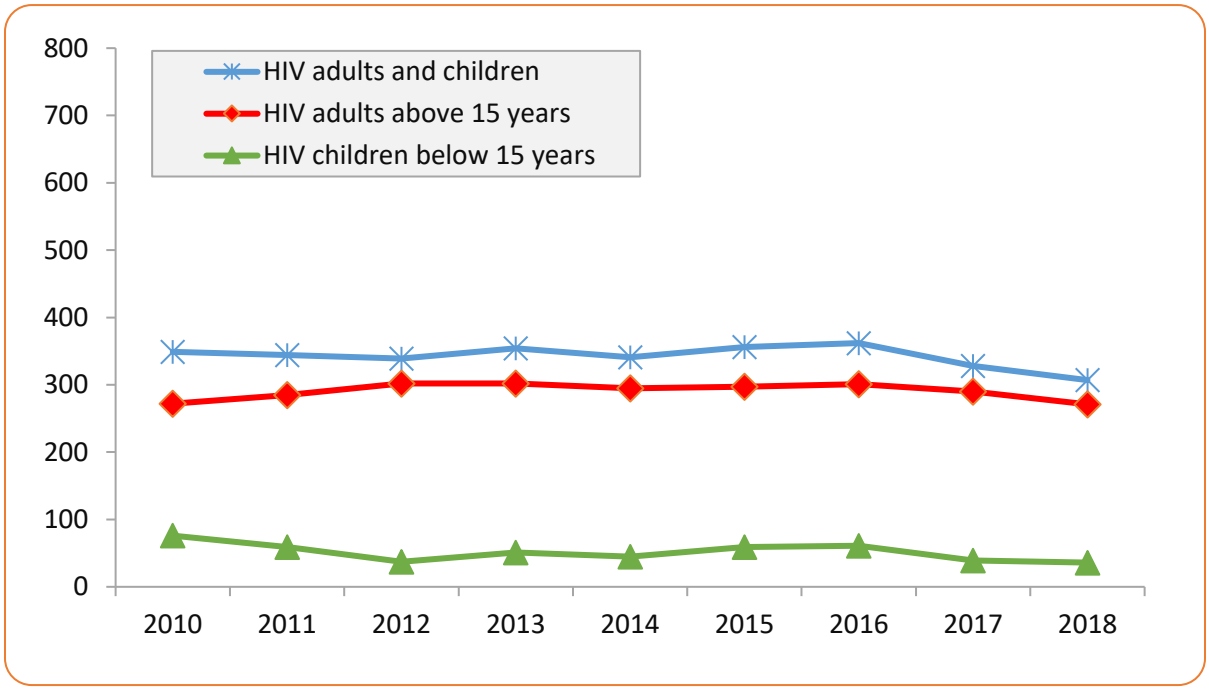
Based on the spectrum data, it is estimated that an average of 6,830people including adults and children will be living with HIV in 2018 in Zanzibar. Among them, 93% (6,362) will be people in the age group of 15years and above and 7% (469) are children less than 15 years of age. The population of people living with HIV (PLHIV) has been steady from 2010 to 2018as 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 the health outcome of PLHIV.

Figure 1. 1: Population estimates of people living with HIV, 2010 – 2018, Zanzibar



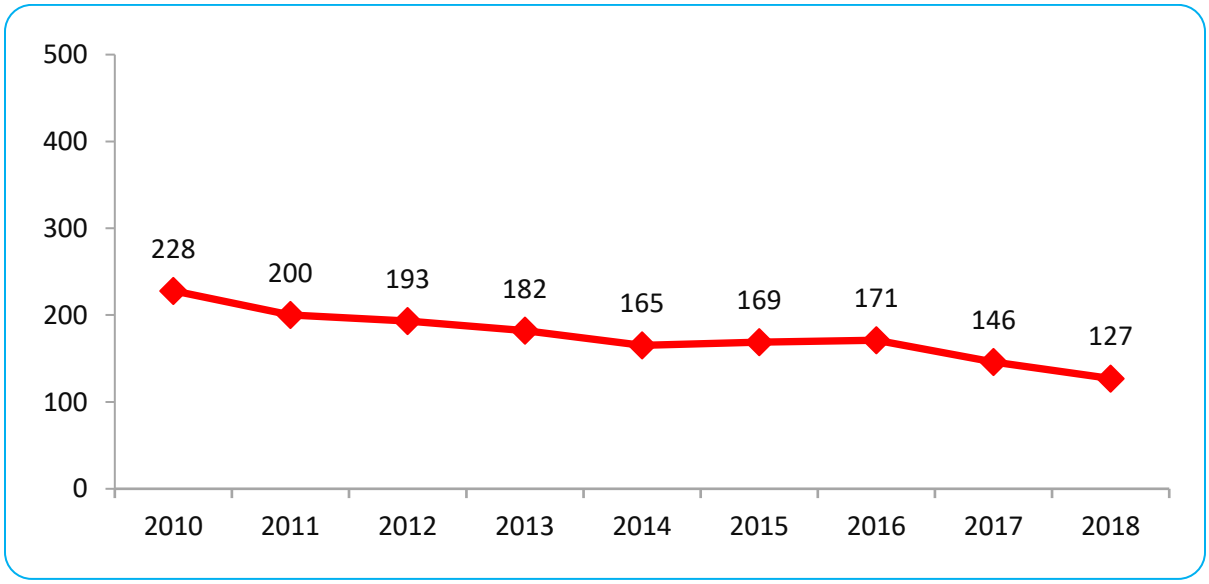
The number of new HIV infections from 2010 shows a downward trend across all age groups (figure 1.2). In 2018, 307 new cases are estimated whereby 12% (36) are children less than 15 years. The decline of new HIV cases indicates that HIV prevention and treatment interventions are fruitful.

Figure 1. 2: Trend of new HIV infection from 2010 – 2018, 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 2010 to 2018 in Zanzibar

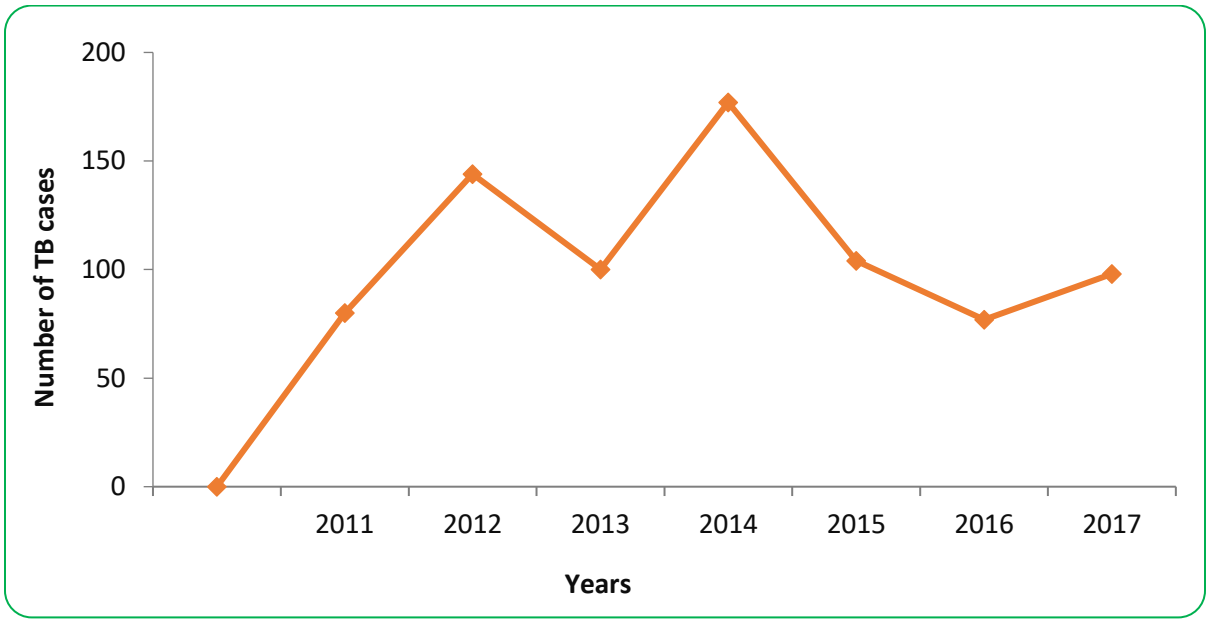


1.2.2 TB situation

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 449 in 2010 to 948 in 2017. However, a slight decrease was observed in 2016, whereby 723 cases were notified. The increase in the notification was largest in the group of bacteriologically confirmed TB cases between 2014 and 2018 (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 the notification of all forms of TB in the past years (Figure 1.4), it is still below the estimated number of the existing TB cases. According to the 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 TB case detection is far below the expected cases.

Figure 1. 4: Number of TB cases from 2010-2017, Zanzibar



In 2017, a total of 948 patients were diagnosed of whom 927(98%) were newly diagnosed. Among the newly identified, 511 (54%) were bacteriologically confirmed, 212 (22%) clinically diagnosed and 225 (24%) were extra pulmonary TB patients. A total of 15 re-treatment patients registered during 2017, among them 7 (47%) were a relapse, 3 (20%) were a failure and 5 (33%) were return to control.

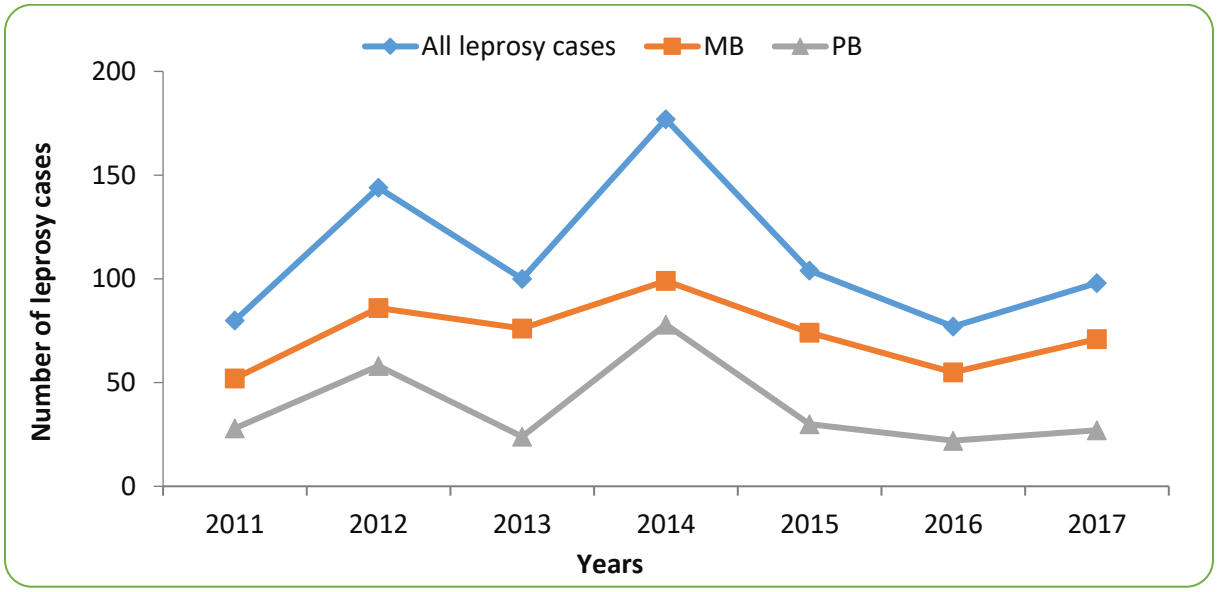
MDR-TB cases remain low in Zanzibar. The Drug-Resistant Survey (DRS) done in Tanzania in 2007 indicated that the MDR-TB burden in Zanzibar was 1.1% among new cases and 3.9% among retreated cases. The first case of MDR-TB in Zanzibar was diagnosed in 2009 in Pemba. Since then between 1 to 2 MDR-TB patients are diagnosed annually. In 2017, 3 MDR-TB cases were notified.

1.2.3 Leprosy situation

The main objective of Leprosy control is the 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 the Annual Report of 2017, the total number of Leprosy cases registered was 98, began to increase from 77 cases in 2016. The case detection rate was slightly less than 1 per 10,000 populations.

The trend of newly registered Leprosy cases has been fluctuating in the last 10 years (figure 1.5) with a 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 a high prevalence of Leprosy above WHO targets including South, Urban and West districts.

Figure 1. 5: Number of cases by type of Leprosy from 2010-2017 in Zanzibar



1.3 The Vision

Zanzibar free of new HIV, infection, people infected or affected by HIV are not stigmatized or discriminated against and key populations accessing HIV information and services

1.4 The Mission

To provide technical leadership and collaboration with other sectors and actors in ensuring that there are access availability and equity of quality HIV and AIDS services for general key population

1.5 The Goal

- To prevent the spread of new HIV infections among general and key population
- To Reduce morbidity and mortality related to HIV/AIDS

1.6 Program's Core Functions

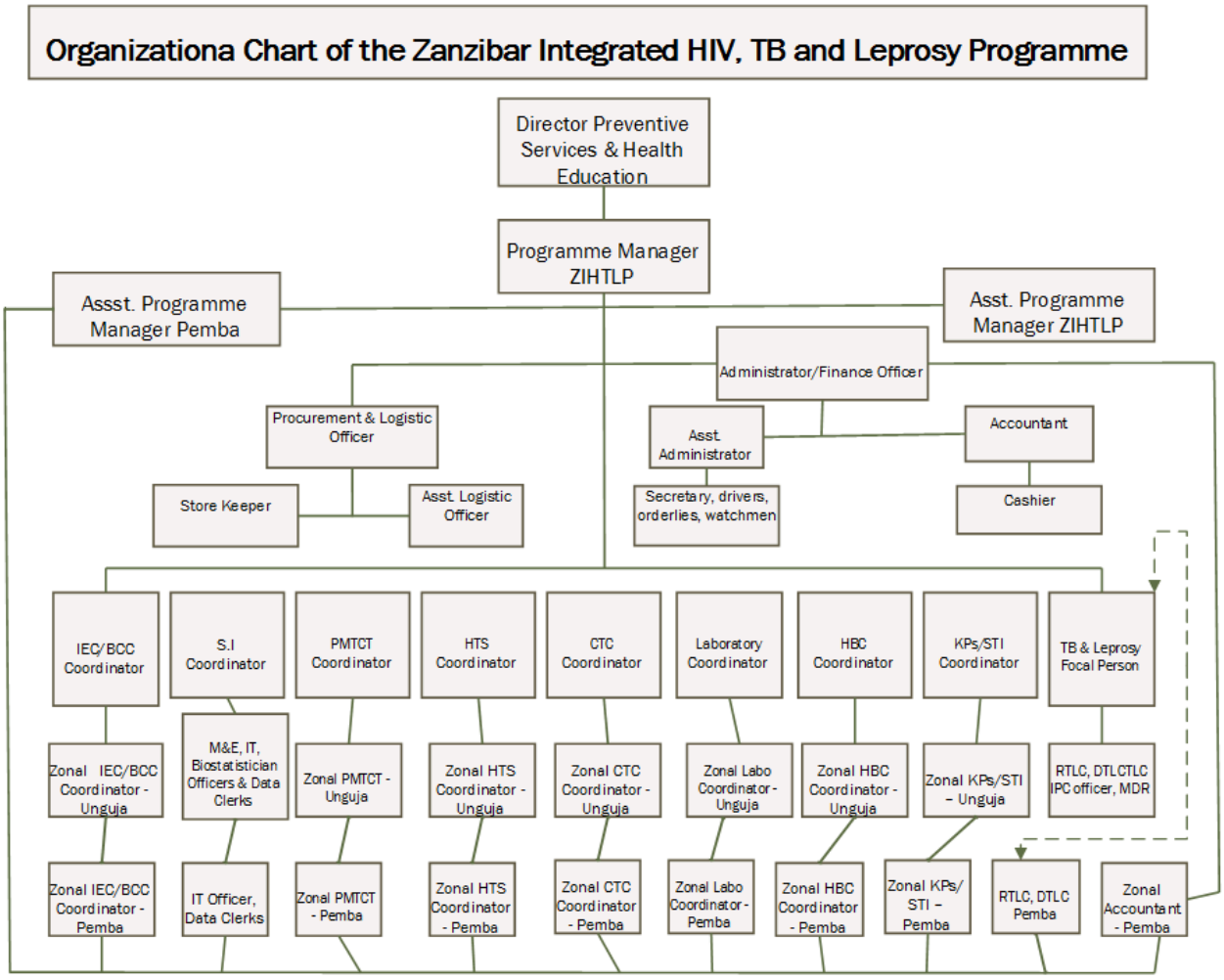
The ZIHHTLP coordinates all activities pertaining to HIV, Hepatitis, TB and Leprosy control in the country. It is also responsible for advising and guiding the MOH on health issues related to HIV, Hepatitis, TB and Leprosy, building capacity of health care workers (HCWs) on the management of the three diseases, monitoring the 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, Hepatitis, 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. ZIHHTLP 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 the 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, Hepatitis, 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 the previous year (2018) recommendations

Recommendations		Implementation status
HTS		
1	To liaise with CHMTs and hospital managers to include HTC training for newly employed staff in their budget plan	This recommendation was not implemented by CHMT and hospital managers in the past year, but the unit continues to lobby. However, in collaboration with development partners, capacity building on PITC services provision for HCW was done through PITC training and CME
2	To liaise with CHMTs and hospital managers to strengthen PITC services.	Some CHMT and hospital managers strengthen PITC services by collecting weekly report, discussing PITC issues in their quarterly meeting with service providers and identify special service providers for offering PITC services. Hence, there is an increasing number of people provided with PITC services in most of the major sites as compared with last year
PMTCT		
1	Strengthen tracking mechanisms for mother-infant pairs	• Close follow up of mother mentors and using phones were done to track mother-infant's pairs • Communication linkage between RCH and CTC were strengthened • Regular supportive supervision and clinical mentorship of service providers were performed

2	Strengthen collaboration with private health facilities to integrate PMTCT services at RCH clinics.	• Private services providers participated on PMTC refresher training • Regular supportive supervision and mentorship of service providers were done
KP		
1	Promote and strengthen peer support programme conducted by NGOs	Two motorcycles (one for Pemba and one for Unguja) have been provided to Zonal KPs Coordinator to support monitoring and follow up of outreach and other KPs services provided by peer educators. Regular peer supportive meetings have been conducted in Unguja and Pemba
2	Strengthen KP friendly services	Regular MAT – TWG meeting conducted to discuss a technical issue that will improve the provision of MAT services in Unguja. Regular MAT – steering Committee meetings conducted to discuss administrative and other support issues that will improve the provision of MAT services.
3	Conduct study to determine factors contributing to lost to follow up of MAT services among the clients so as to help in solving this problem.	This study has not been conducted due to lack of funds
STI		

1	Timely procurement and distribution of STI drugs	The discussion has been conducted between Director for Central Medical Store and Coordinator for STI services on the importance of timely procurement and distribution of these drugs. It was agreed that STI drugs will be procured and distributed through government systems.
2	Conduct routinely supportive supervision to all health facilities providing STI/RTI services	Each health facility (public) has been supervised once in a year. Efforts to mobilize funds are still going on to facilitate more frequent supportive supervision (quarterly)
HBC		
	Engage expert patients and CHBCs in follow up of and trace back defaulted CTC clients	This was not implemented because still no active linkage between expert patients and CHBCs to trace the defaulters
TB and Leprosy		
1	Review and strengthen implementation of contact investigation among all infectious TB patients	The contact investigation was reviewed whereby health facility staff has been included in the team. The investigation also includes bacteriologically confirmed patients from a previous quarter so as identify hidden cases in the community.
2	Conduct active case finding (ACF) to all TB vulnerable group (IDUs, under-five, TB diabetes, prisoners and elderly people)	Active case findings were conducted to all risk groups and TB screening through community sensitization meetings and the following patients were diagnosed through active case finding. PLHV - 95 patients

		Prisoners - 5 patients Contact tracing of all age - 40 patients
3	Train health care provider from different health facilities on leprosy management.	The training is not conducted due to inadequate funds however it has been budgeted under the government fund of the year 2019
HIV/TB Laboratory		
1	Installation and training of laboratory staff in performing HVL in Zanzibar	Three Gene Xpert machines were installed two at MnaziMmoja and one at Chake Chake. A total of 33 laboratory technician were trained and perform analysis using the Gene Xpert machine
2	Feedback meeting after proficiency testing should be conducted in order to improve testing services	The meeting was not conducted after proficiency however a mentorship was conducted for those sites which had unsatisfactory results
IEC/BCC		
1	Capacity building for IEC/BCC professional staff	This intervention hasn't been implemented due to lack of funds.
Program management, Procurement and Finance		
1	Delays disbursement of Fund from Funders	These challenges still exist
2	Long Process of Approval of the activity	The process of approval did not change, however, the Coordinator of all Unit was required to issue the request in 2 weeks before the activity date.

CHAPTER 2: HIV PREVENTION

HIV TESTING SERVICES

2.1.1 Background

HIV testing and counselling (HTC) services were established in 1988 in five (5) public hospitals. Access to knowledge of one's HIV status has mainly been through VCT. In 2018, HIV Testing Services were provided in 141 sites in Zanzibar. These services were offered through two main approaches including Client-Initiated Counselling and Testing (CITC)/Voluntary Counselling and Testing (VCT) and Provider Initiated Testing and Counselling (PITC). Among 141 established sites, 13 sites provide VCT services only, 79 provide PITC services only and 49 provide both PITC and VCT services**.**

2.1.2 Goal

To increase utilization of quality HTS to the general population, Key Population (KP), Youth and Adolescents.

2.1.3 Objective

1. The increased proportion of people living with HIV who know their status by 95%.

2.1.4 Program Implementation

2.1.4.1 Capacity Building

During this period, six days' training on PITC services to **27** (22 Unguja and 5 Pemba**)** health care workers from different hospitals and primary health facilities were conducted. The objective was to equip health care workers with the required knowledge and skills on the provision of quality HIV counselling and testing services.

In addition, three days' training on HIV Testing and counselling targeting KP and youth to **25** (20 Unguja and 5 Pemba**)** counsellors from the public, private facilities and NGOs was conducted. The objective was to enhance the capacity of health providers working in CITC/VCT sites on proper counselling skills which enhance identification of KP attending in HTC sites and manage them according to the guideline.

Furthermore, one-day Continuing Medical Education (CME) on PITC services was conducted to 100 (40 Unguja and 60 Pemba) health providers. The objective was to bridge the gap of shortage of PITC service providers.

2.1.4.2 Service Monitoring

Annual supportive supervisions to **128** (84 Unguja and 44 Pemba) sites providing HTC services were conducted. The objectives were to monitor the progress of HTS and support providers to improve their performance. There were **13** HTC sites newly established in 2018 and hence, were not supervised during the same year. Apart from supportive supervision, monthly follow up visit was conducted for HTC sites, which provide an opportunity for supervisors to oversee the services provision and provide on-site feedback.

In addition, one-day coordination meeting with **25** management staff of Mnazi Mmoja hospital was conducted. The objective was to discuss the progress of PITC uptake and to generate strategies for sustainability of PITC services. The followings are the agreed strategies in order to ensure the sustainability of PITC services: director of nursing services committed to being overall PITC focal person, allocation of special nurses trained on PITC in each department to improve PITC services and overall nurse-in-charge to ensure availability of HIV test kits and commodities.

2.1.5: Trends of HIV Testing Services from 2016 to 2018

Indicator	**Year**		
	2016	**2017**	**2018**
1. Number and percentage of health facilities providing HTS services	123	120	141/280 (50.4%)
2. Number and proportion of people who were tested for HIV and received their results within the past 12 months	94,507	161,002	261,399 (16.1%)
➢ Individuals identified as HIV positive	1,064	1,557	1,840

1. Number of sites offering HTS

The percentage of health facilities providing HTS services in 2018 was **141/280** (**50.4%**) i.e. **126** Government facilities, **5** NGOs, **3** FBOs and **7** Private hospitals (90 Unguja and 51 in Pemba). This figure was slightly higher than the 2018 M&E target set of achieving at least 50%. The number of sites offering HTC services has been increased from **120** in 2017 to **141** in 2018. This increase was due to several reasons including capacity building of health care providers through PITC training, CME as well as mentorship in the facilities where trained personnel were relocated.

Table 2.1.1: Number of HTS site by ownership type, Approach and districts, Zanzibar 2018

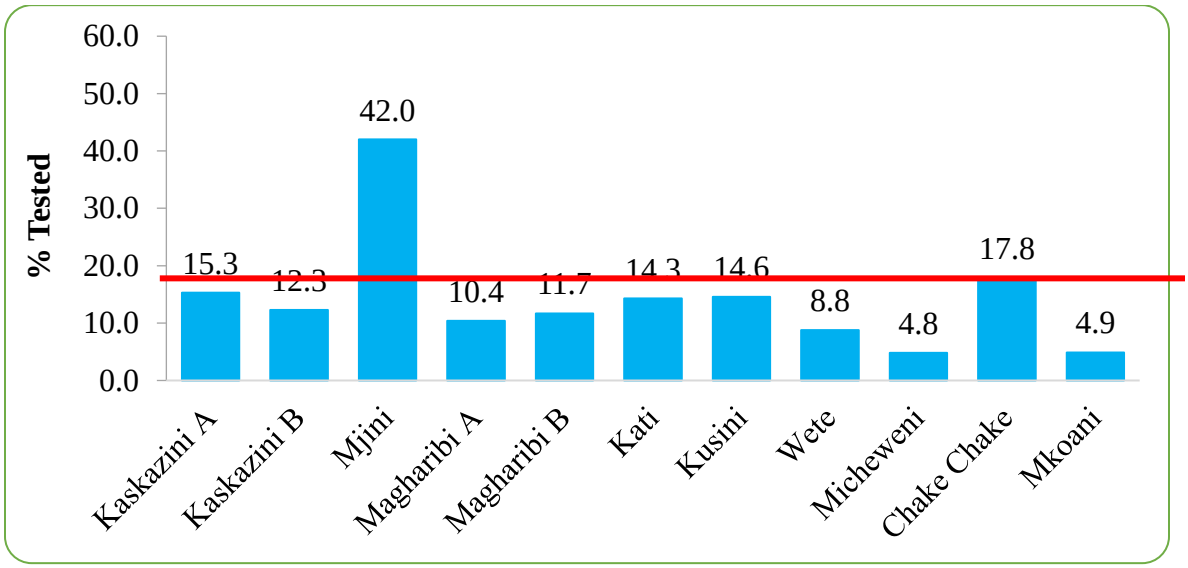
District name	PITC	VCT/CITC	PITC& CITC	Total	Government	Private	NGOs	FBO
Mjini	7	5	7	19	13	5	1	0
Magharibi “A”	4	0	3	7	7	0	0	0
Magharibi “B”	6	2	3	11	10	0	1	1
Kati	9	2	11	22	19	1	0	1
Kaskazini 'A'	8	1	2	11	10	0	1	0
Kaskazini 'B'	6	0	5	11	10	0	0	1
Kusini	8	1	2	11	10	0	1	0
Wete	8	0	4	12	12	0	0	0
Micheweni	7	0	6	13	13	0	0	0
ChakeChake	9	1	3	13	12	1	0	0
Mkoani	7	1	3	11	10	0	1	0
Total	**79**	**13**	**49**	**141**	**126**	**7**	**5**	**3**

2. Number and proportion of people who were tested for HIV and received their results within the past 12 months

The proportion of people who were tested for HIV and received their results in Zanzibar was **16.1%**. Hence, the M&E target of testing at least 16% of people in Zanzibar was achieved. The number of people who were tested for HIV and received their results has increased from

161,002 in 2017 to **261,399** in 2018. This achievement was contributed by consistent availability of HIV test kits, increased number of HTC sites and improving commitments of hospital managers to promote and monitor PITC services especially in major hospitals. Other measures that were taken is to set a target of client tested per site and support for non- employed medical personnel who provide PITC services in high yield sites.

Figure 2.1.1: Percent of the population received HTS by district, Zanzibar, 2018.



The figure above shows the proportion of people counselled and tested by district, where Mjini district had the highest proportion (**42.0%**) while Micheweni had the least (**4.8%**). The following districts did not achieve the M&E target of testing 16% of the population: all districts of Pemba and Kaskazini A and B of Unguja as indicated in figure 2.1.1. The districts which achieved the M&E target was contributed by a high number of facilities that provide HTS and in other districts, people were reached through outreach services conducted by NGOs.

Table 2.1.2: HIV proportion among clients tested by district of residence, Zanzibar 2018

District	Number Tested for HIV	Number HIV Positive		% of HIV Positive
Kaskazini A	18,729	58		0.3
Kaskazini B	13,067	73		0.6
Mjini	57,898	445		0.8
Magharibi A	30,980	263		0.8
Magharibi B	69,037	533		0.8
Kati	21,178	201		0.9
Kusini	8,116	69		0.9
Unguja	**219,005**	**1642**		**0.7**
Wete	9,313	32		0.3
Micheweni	6,995	15		0.2
Chakechake	17,488	57		0.3
Mkoani	6,854	13		0.2
Pemba	**40,650**	**117**		**0.3**
Missing	483	7		1.4
Outside Zanzibar	1,266	74		5.8
TOTAL	**261,404**	**1,840**		**0.7**

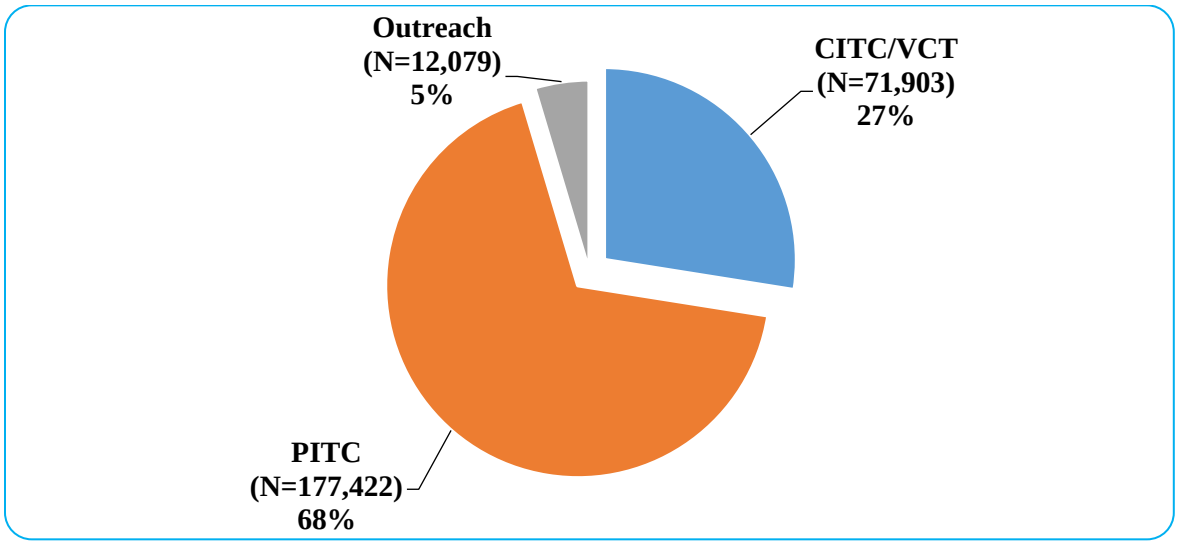
The overall proportion of HIV positive cases among tested was **0.7%** (**1,840/261,404**). HIV positivity rate was highest in client tested residing outside Zanzibar (5.8%). Kati and Kusini had the highest positivity rate (**0.9%**) and Kaskazini "A" had the least (0.3%) for Unguja while Micheweni and Mkoani districts had the least in Pemba (**0.2%**). Positivity rate was higher in Unguja (**0.7%**) as compared to Pemba (**0.3%)** as indicated in table 2.1.2.

Table 2.1.3: HIV proportion among clients tested by age and sex, Zanzibar, 2018.

Age Group (Years)	Female			Male			Total		
	Tested HIV	HIV positive	% positive	Tested HIV	HIV positive	% positive	Tested HIV	HIV positive	% positive
<1	2,438	6	0.2	2,545	7	0.3	4,983	13	0.3
1-4	9,038	18	0.2	9,309	9	0.1	18,347	27	0.1
5-9	3,459	13	0.4	3,631	13	0.4	7,090	26	0.4
10-19	20,172	46	0.2	9,844	24	0.2	30,016	70	0.2
20-24	33,746	195	0.6	18,694	55	0.3	52,440	250	0.5
25-49	70,665	815	1.2	57,885	428	0.7	128,550	1243	1.0
50+	9,979	107	1.1	9,999	104	1.0	19,978	211	1.1
Total	**149,497**	**1,200**	**0.8**	**111,907**	**640**	**0.6**	**261,404**	**1,840**	**0.7**

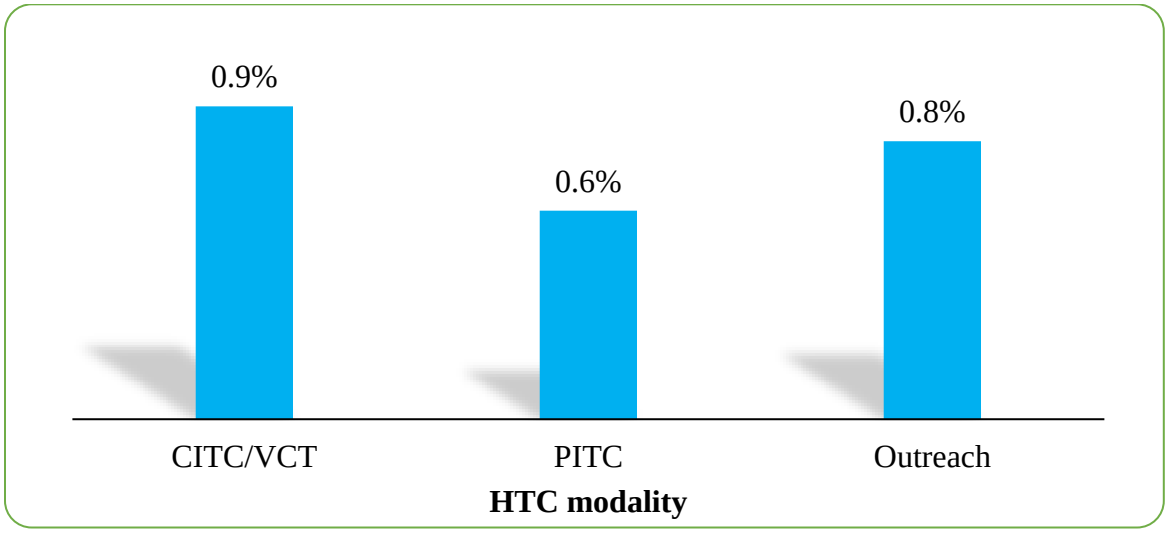
Out of all people **(261,404)** received HIV testing and counselling services, more than half **149,497 (57.2%)** were females. Moreover, most of those who tested HIV and received results (128,550) had ages between 25 and 49 years. Regarding the testing results, females had higher positivity rates (0.8%) than their males' counterparts (0.6%). Moreover, HIV positivity was higher with increasing age as indicated in the table 2.1.3.

Figure 2.1.2: HIV testing modality, Zanzibar, 2018



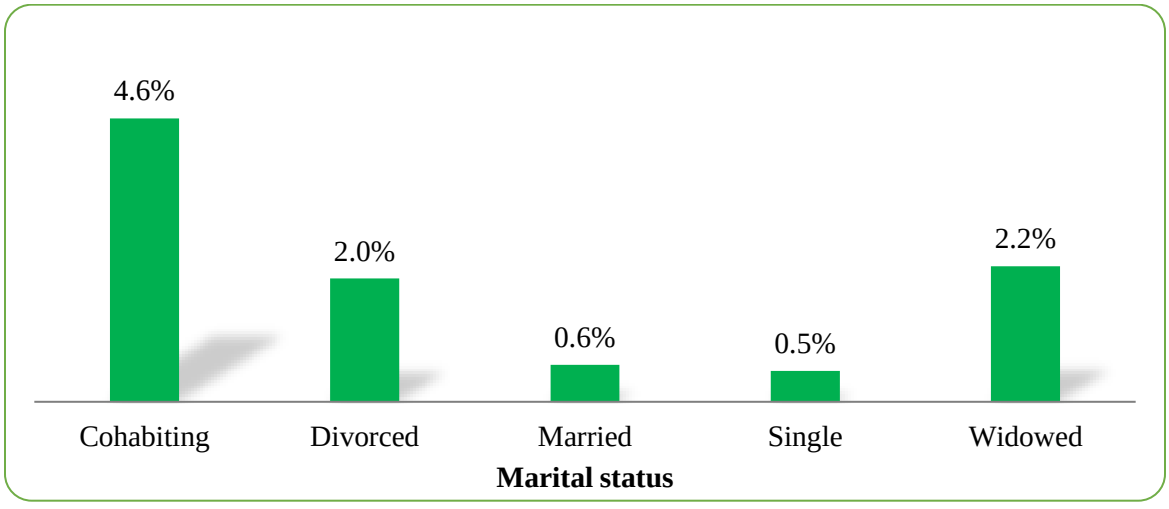
The figure above shows that **68%** were reached through PITC approach in 2018 which is higher as compared to **47.4%** in 2017. CITC/VCT decreased to **27%** in 2018 compared to **46%** in 2017 as indicated in figure 2.1.2. Promotion for people to test HIV voluntarily will continue so as to provide an opportunity for individuals' to learn more about HIV knowledge and to assess their own risk behaviour of HIV transmission.

Figure 2.1.3: HIV proportion among tested by HTS modality, Zanzibar, 2018



In 2018, HIV positivity rate was high among clients who were reached through CITC/VCT approach **(0.9%)** while it was low (**0.6%)** among individual tested through PITC services as indicated in figure 2.1.3

Figure 2.1.4: HIV proportion among individual tested by marital status, Zanzibar, 2018



HIV positivity rate in 2018 was highest among clients who were cohabiting. This was higher in 2018 (4.6%) compared to 2017 (**3.5%**). Nevertheless, those who were single had the lowest HIV positivity rate (**0.5%)** as indicated in figure 2.1.4.

Figure 2.1.5: Number of people who were tested for HIV and received their results from 2014 to 2018, Zanzibar

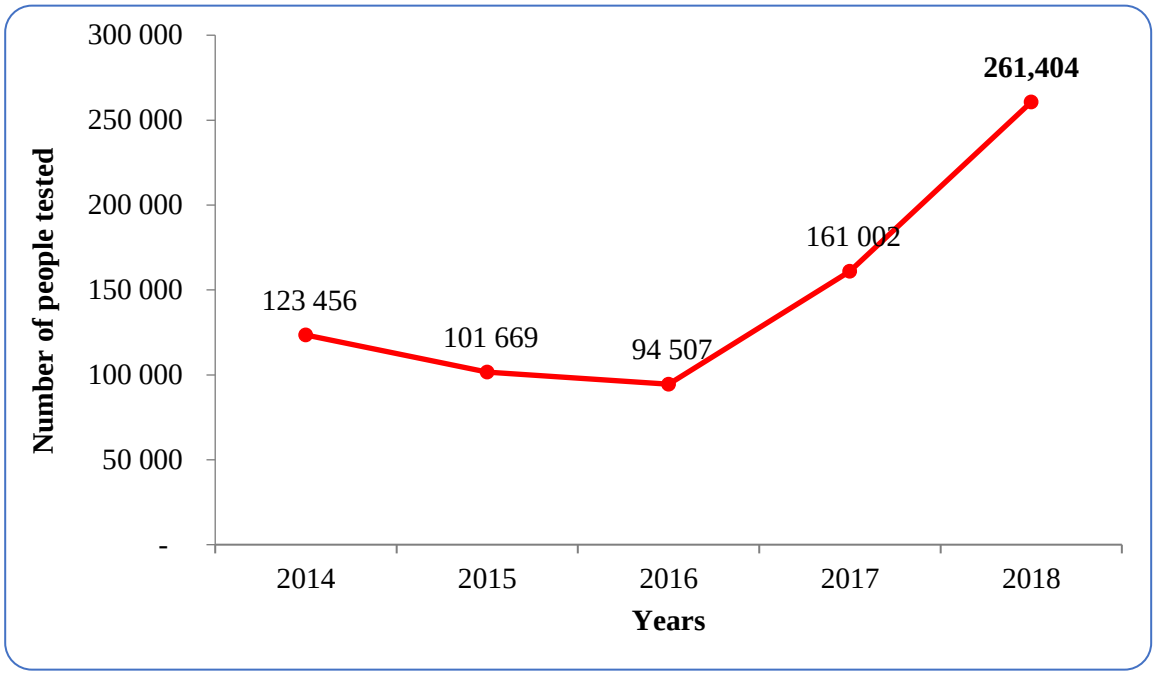


Figure 2.1.5 indicates the number of people who received HIV testing services and received their results from 2014 to 2018. This shows that, the number of people who received HIV testing services and received their results has been decreasing from 2014 to 2016; but increasing from 2016 to 2018 due to reasons highlighted above.

2.1.6 The Best practice of the uptake of PITC service among HTC sites.

Objective: To increase HIV testing by 60% among OPD attendees and 80% among admitted patients. HTS unit was achieved to increase the number of people tested for HIV and received their result from 161,002 in 2017 to 261,399 in 2018. The success comes after met with implementing partner (THPS) and discuss on how we can improve the uptake of PITC especial in their supported sites, and come up with the idea of involving hospital management team and DHMT in the PITC program management. So the first step was to conduct sensitization meetings with the hospital management team, DHMTs, facility in charge and some HCPs. The

aim was to motivate stakeholders, promote PITC service and increase the uptake of HTC service among hospital attendees. After discussion we come up with the following strategy;

- Sensitization of the HCPs at OPD, and IPD.
- Close follow up both physical and phone calls to the facility in-charges 9
- Daily check of the availability of HIV test kits
- Daily data target setting
- To send a weekly report of client tested to selected hospital manager and DHMTs

Apart from these strategies, but whenever we come across a new strategy was developed according to the presented challenge like those mentioned in the coordination meeting activity. The unit, mobilizing fund from implementing partner for conducting meetings with different key stakeholders. Management of Mnazi Mmoja referral hospital was given the opportunity to organize and to propose a meeting agenda regarding PITC services progress and uptake in their respective areas. Furthermore, appreciation of the work done was considered for those who reach the target (HCP and Managers) by inviting in the THPS data review meeting to share their success with others and this was encouraged them to increase ownership of it and the fruitful results. Therefore, as a unit, we learn that full involvement of Hospital management team /stakeholders in the program management and motivation among HCPs; increase their spirit of ownership and the fruitful results.

2.1.7 Challenges

1. Some identified positive clients refused to be linked to HIV care and treatment possibly due to inadequate counselling skills, stigma and previous knowledge of HIV positive status.
2. Low uptake of PITC services in PHCUs.
3. Some private facilities are providing HTC services without official authorization.

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

2.2.1 Background

PMTCT services include HIV testing for pregnant women and their partners, lifetime use of antiretroviral therapy (ART) for HIV-infected pregnant and breastfeeding women, safe delivery practices and safe infant feeding. Early infant diagnosis (EID) is a component of PMTCT services that entails early identification of infants born to HIV-infected mothers (HIV-exposed infants) for provision of prophylaxis (ARV at birth and cotrimoxazole 4 weeks after birth). In addition, the HIV antigen (DNA PCR) test is performed at 4-6 weeks after birth and 6 weeks after complete cessation of breastfeeding to confirm HIV infection among HIV-exposed infants for prompt management. Currently, the services are provided at 168 (100 Unguja and 68 Pemba) Reproductive and Child Health (RCH) clinics, across all eleven districts of Zanzibar.

2.2.2 Goal

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

2.2.3Objectives

1. To increase access and utilization of PMTCT services
2. To increase the involvement of male partners in PMTCT services
3. To integrate PMTCT services with other common co-morbidities
4. Increase access to HIV diagnosis and treatment for HIV exposed and infected infants.

2.2.4 Program Implementation

2.2.4.1 Capacity Building

Three sessions of PMTCT refresher training on integrated guideline were conducted to **88** (56 Unguja and 25 Pemba) health care providers including nurses, medical and clinical officers as well as laboratory technicians. The objective was to build their capacity in providing quality and comprehensive PMTCT services according to Zanzibar National Guidelines for the Prevention and Treatment for HIV and AIDS, 2017.

In addition, one session of refresher training on counselling skills for **30** (23 Unguja and 7 Pemba) health care providers was conducted. The objective was to equip them with knowledge, skills and attitudes to effective counselling skills to prevent, diagnose and properly manage for HIV positive pregnant women, partners and their exposed infants.

2.2.4.2 Service monitoring

Supportive supervision was conducted to service providers in 150/158 (88 Unguja and 62 Pemba) PMTCT sites. Other facilities were not visited due to hard to reach areas especially those facilities in Islands. The objectives were to monitor the implementation of PMTCT services and enhance the capacity of service providers. This is to ensure HIV-free survival of infants, improved health outcomes for HIV-infected pregnant women, their partners and family. PMTCT services have improved the number of pregnant women tested for HIV increased. But major issue was poor documentation of mother-infant follow up the register. Clinical mentorship and continued supportive supervision are needed.

Data review visits were conducted in **23** (13 Unguja and 10 Pemba) sites. The objectives were to monitor data quality and to determine the overall reliability of data collected. The visits focused on verification of the accuracy of the reports submitted to the national level from health facilities via district. It was observed that healthcare workers lack knowledge on interpreting and analyzing PMTCT data and documentation of mother-infants follow up register is inadequate.

In addition, bi-annual feedback meeting with **41** (35 Unguja and 6 Pemba) participants including mother mentors and health care workers was conducted. The objective was to share the performance of mother mentors and discuss the effective ways of achieving their responsibilities in implementing PMTCT services. Tracking of HIV-infected pregnant women, breastfeeding mothers and their infants who missed appointments or dropped out of PMTCT care cascade were conducted in Unguja and Pemba. A total of 18HIV-infected mothers were returned to continue with PMTCT services and escorted to CTC for initiation of ARVs. Furthermore, 16 out of 18 HIV-exposed infants of these mothers were resumed to the services, the remaining two could not be traced as one died and one was lost to follow up.

2.2.5 PMTCT services indicators and trend from 2016 to 2018

S. N	Indicator	2016	2017	2018
1	Percentage of pregnant women with known HIV status	43,937/61,147 (72%)	59,004/66,417 (89%)	63,663/ 67,941 (93.7%)
2	Percentage of pregnant women living with HIV who received ART to reduce the risk of mother-to-child transmission of HIV	197/423 (47%)	336/383 (87.7%)	394/405 (97.3%)
3	Percentage of pregnant women attending ANC whose male partner was tested for HIV during pregnancy	2,286/61,147 (3.7%)	6,410/66,417 (9.7%)	21,734/62,877 (34.6%)
4	Percentage of pregnant women who were tested for syphilis	TBD	TBD	13,344/62,877 (21.2%)
5	Percentage of HIV-exposed infants who started on ARV prophylaxis	TBD	262/383 (68.4%)	258/405 (63.7%)
6	Percentage of HIV-exposed infants receiving a virological test for HIV within 12 months of birth	146/232 (63%)	197/280 (70%)	334/405 (82.4%)
	ercentage of infants born to HIV ositive mothers who receive HIV ntigen test (DNA PCR) within 2 onths of birth	146/232 (63%)	197/361 (55%)	258/405 (64%)
7	Percentage of HIV-exposed infants receiving a test for HIV 6	TBD	TBD	67/405 (16.5%)

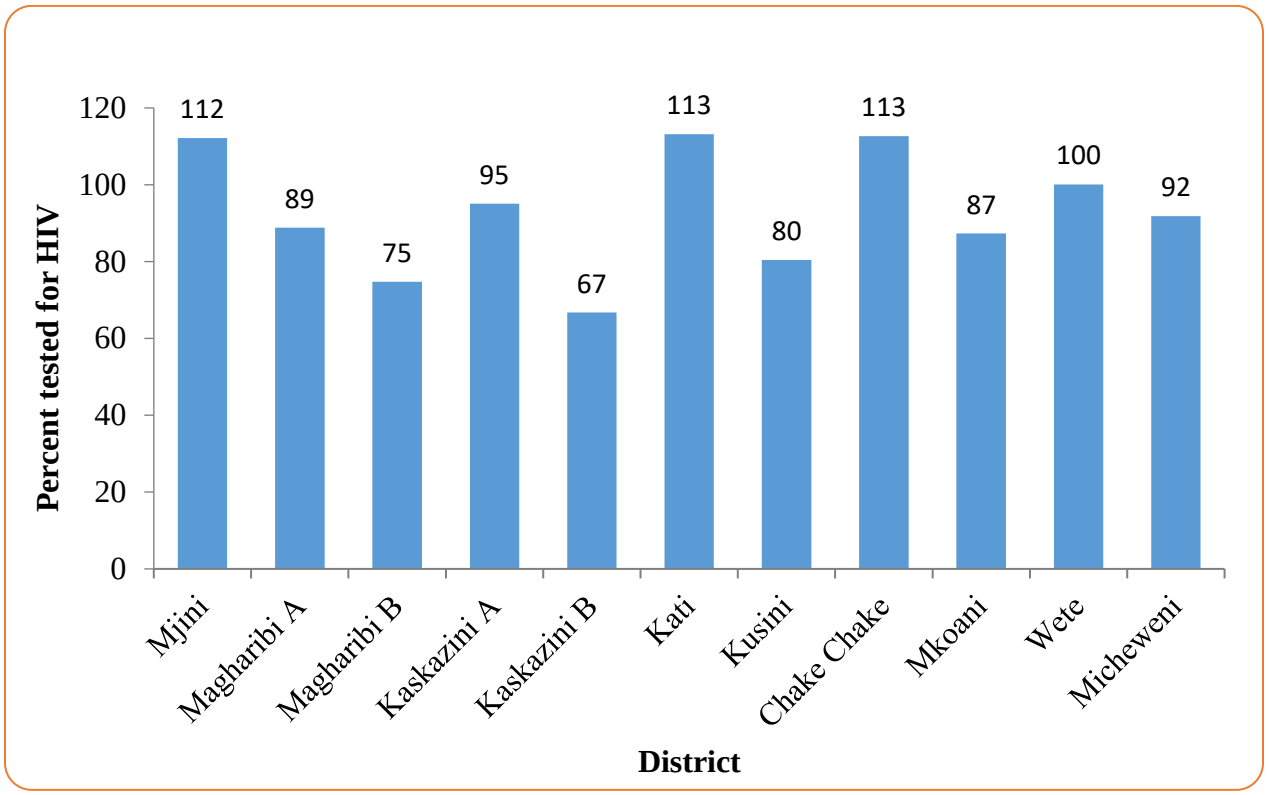
	weeks after cessation of breastfeeding			
8	Percentage of HIV-infections among HIV-exposed infants born in the past 12 months	(10/221) 4.5%	15/361 (4.1%)	9/334 (2.7%)
9	Percentage of HIV-exposed infants started on CTX prophylaxis within 2 months of birth	146/232 (63%)	208/361 (57.6%)	261/405 (64.4%)
10	Percentage of identified HIV positive infants who started on ART by 12 months of age	4/10 (40%)	14/15 (93.3%)	8/9 (89%)

1. Percentage of pregnant women with known HIV status.

The proportion of known positive pregnant women increased from **89% (59,004/66,417)** in 2017 to **93.7% (63,663/ 67,941)** in 2018 of the expected pregnancy. This performance was above the target (90%) set in Monitoring and Evaluation Plan III, 2017-2022. This was due to ongoing supportive supervision, staff commitment and community sensitization on PMTCT services.

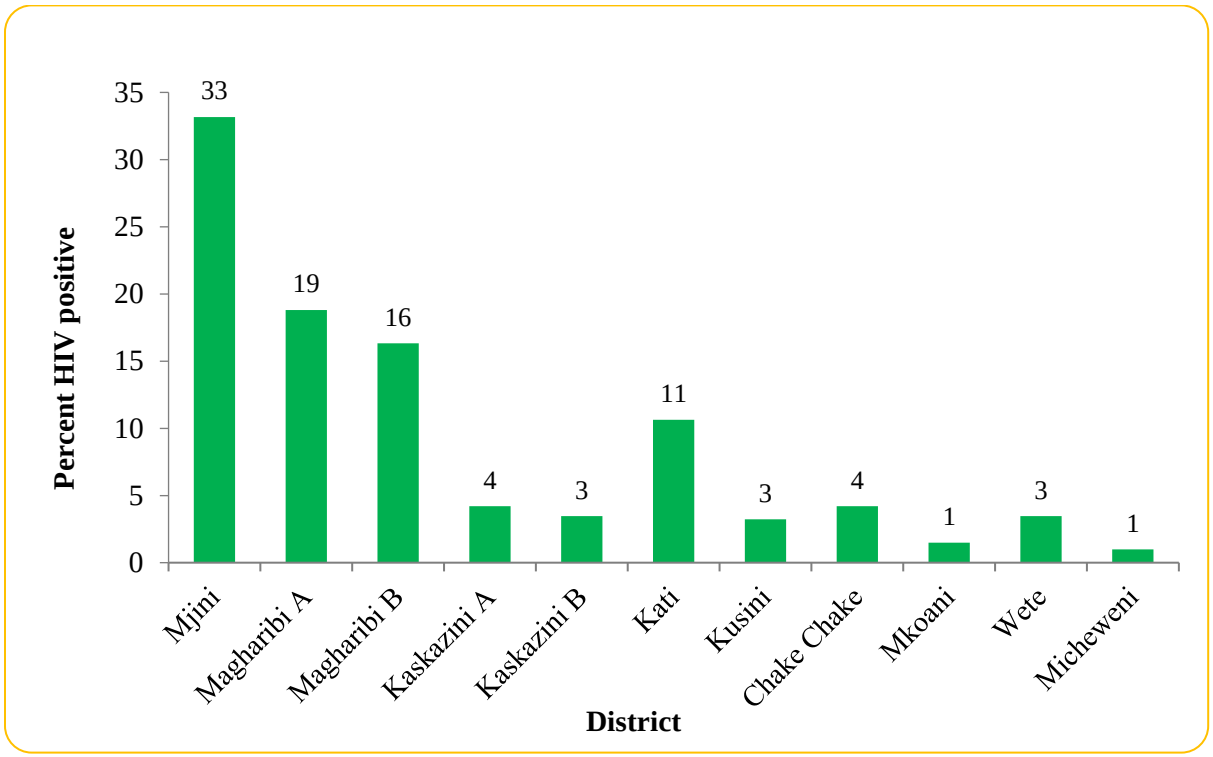
Among all clients who attended ANC services, Kati and Chake Chake district had the highest proportion of ANC clients tested for HIV (**113 %)** by of district projected population, followed by Mjini district **(112%)**. The lowest districts reported were Kaskazini B **(67%)** and Magharibi B (75%) of ANC clients tested for HIV as indicated in figure 2.2.1 below.

Figure: 2.2.1 Proportion of ANC clients tested for HIV by district, Zanzibar, 2018



Knowledge of HIV positive status among pregnant women has increased from **94% (361/383)** in 2017 to **99.7% (404/405)** in 2018. Among HIV positive pregnant women, **65.8% (266/404)** were previously known and **34.2% (138/404)** were newly tested positive at ANC and maternity. Majority of cases reported were from Mjini district **(33%)** followed by Magharibi A **(19%).** Few HIV cases were reported from Kaskazini A and B, Kusini districts Unguja and all four districts of Pemba as shown in the figure 2.2.2 below.

Figure: 2.2.2 Percentage of known HIV Positive Pregnant Women Identified by District, Zanzibar, 2018



2. **Percentage of pregnant women living with HIV who received ART to reduce the risk of mother-to-child transmission of HIV**

The proportion of HIV-infected pregnant women who started ART to reduce the risk of mother-to-child transmission of HIV has increased from **87.7%(336/383)** in 2017 to**97.3% (394/405)** in 2018 which is above the target of **90%** as per Monitoring and Evaluation Plan III, 2017-2022. This achievement was contributed by improved counselling skill of healthcare workers, continuing clinical mentorship and good communication between RCH and CTC clinics and improved follow up of mother mentors to infected pregnant women.

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

Pregnant women attending ANC whose male partner was tested for HIV during pregnancy showed an increase from **9.7% (6,410/66,417)** in 2017 to **34.6% (21,734/62,877)** in 2018 as compared to the target of **10%** as per Monitoring and Evaluation Plan III, 2017-2022. This

achievement was due to strengthened health education session at ANC and ongoing efforts of community sensitization made by different districts in both Islands.

Furthermore, the highest proportion of male partner testing for HIV among the women attended at RCH was ChakeChake **(72.6%)** while the least proportion was from Kaskazini B **(10.4%)** as shown in the table 2.2.1 below.

Table: 2.2.1 Percent of male partners tested for HIV in the last 12 months per district, Zanzibar, 2018

District	Partners tested	Women tested	Percent Male involvement
Mjini	4,939	12,361	40.0
Magharibi A	1,684	7,438	22.6
Magharibi B	3,289	8,513	38.6
Kaskazini A	1,322	5,078	26.0
Kaskazini B	305	2,927	10.4
Kati	608	4,351	14.0
Kusini	183	1,706	10.7
ChakeChake	3,978	5,476	72.6
Mkoani	2,517	4,576	55.0
Wete	2,202	5,498	40.1
Micheweni	707	4,953	14.3
Total	**21,734**	**62,877**	**34.6**

4. Percentage of pregnant women who were tested for syphilis.

The percentage of women tested for syphilis was **21.2% (13,344/62,877)** in 2018; this was low compared to the target of **50%** in Monitoring and Evaluation Plan III, 2017-2022. This was due to a shortage of syphilis test kits in the health facilities. However, some districts in Unguja include syphilis test kits in their Council Health Management Team (CHMT) work plan and budget and hence are able to procure and distribute to respective sites, but Pemba has not done so.

5. Percentage of HIV-exposed infants who started on ARV prophylaxis

The proportion of HIV-exposed infants started on ARV prophylaxis was **63.7% (258/405)** in 2018, which is a below-set target (**75%)** in Monitoring and Evaluation Plan III, 2017-2022. The challenge is pregnant women who deliver at home and do not return at a health facility for PMTCT and postnatal services. Hence there is a need to educate and counsel HIV pregnant women on the importance of adherence to PMTCT care cascade. Also to strengthen tracking of mother-infant pair by mother mentors, Community Home Based Care providers and Community Health Volunteers. In addition, some of the delivery sites do not stock Nevirapine syrup for prophylaxis.

6. Percentage of HIV-exposed infants receiving a virological test for HIV within 12 months of birth

The proportion of infants born to HIV positive mothers who received HIV antigen test (DNA PCR) within 12 months of birth increased from **70% (197/280)** in 2017 to **82.4% (334/405)** in 2018 and above the target of **75%** in Monitoring and Evaluation Plan III, 2017-2022. This achievement was contributed by improved counselling and health education in health facilities, community sensitization and improved tracking system of mother-infant pairs. Out of the **334** HIV-exposed infants tested using HIV antigen test (DNA PCR), **258/405** (**64%**) were tested between 1-2 months after birth and **76/405**(**18.8 %**) were tested between 3-12 months of age as shown in the table 2.2.2.

7. Percentage of HIV-exposed infants receiving a test for HIV 6 weeks after cessation of breastfeeding.

The proportion of HIV-exposed infants receiving test for HIV 6 weeks after cessation of breastfeeding is still low **16.5% (67/405)** in 2018 compared to the target of **20%** in Monitoring and Evaluation Plan III, 2017-2022. This attributed to loss of follow up of mother-infant pair after the first test, poor documentation in mother-infant follow up the register and the EID lab register does not accommodate appropriate documentation of the first and second PCR test.

8. Percentage of HIV-infections among HIV exposed infants born in the past 12 months

HIV positivity rate among exposed infants born in the past 12 months is **2.7% (9/334)** in 2018. Coverage of HIV testing for pregnant women and ART initiation for infected women has increased which contribute to lower the positivity among HIV exposed infants. However, more effort is needed to ensure compliance of mother-infant pair to PMTCT care cascade towards the achievement of elimination target.

Table: 2.2.2 Number of exposed infants born and tested for HIV and their results, by quarter, Zanzibar, 2018

Period	Number of infants received virological test of HIV after birth by age		HIV-exposed infants receiving test for HIV 6 weeks after cessation of breastfeeding	Number of infants tested HIV positive by age after delivery		% Positive		
	1-2 month	3-12 month		1-2 month	3-12 month	2 month	3-12 month	6 weeks after cessation of breastfeeding
Jan - Mar	52	24	10	0	3	0	0	**0**
Apr - June	53	16	20	1	0	1.9	0	**0**
July - Sept	89	12	22	2	0	2.2	0	**0**
Oct - Dec	68	24	15	2	1	2.9	0	**0**
Total	**258**	**76**	**67**	**5**	**4**	**55.5**	**44.4**	**0**

10. **Percentage of HIV-exposed infants started on cotrimoxazole prophylaxis within 2 months of birth**.

The proportion of HIV-exposed infants started on cotrimoxazole prophylaxis within 2 months of birth increased from **57.6% (208/361)** in 2017 to **64.4% (261/405)** in 2018. However, it has not reached the target of **75%** in Monitoring and Evaluation Plan III, 2017-2022. This is due to attrition of mother-infants pair from PMTCT care cascade, stigma/disclosure among infected pregnant women, poor documentation as well as low male involvement.

Best practice:

Participation of male at RCH clinics was increased from **9.7%** in 2017 to **34.6%** in 2018, due to the effort made by PMTCT program on community sensitization on the importance of male involvement in PMTCT services through public and private media (TV and Radio). In addition, healthcare workers made a big effort in counselling and health education to pregnant women on the importance of partner participation during ANC visits. Whereby, all health facilities gives first priority for those pregnant women attended with their partners at ANC.

2.2.6 Challenges

1. Inadequate tracking system for mother-infant pairs which leads to attrition from PMTCT care cascade
2. Shortage of syphilis test kits at health facilities.
3. Poor documentation in PMTCT monitoring tools at site level including EID register
4. Lack of resources to integrate viral hepatitis in PMTCT services (capacity of service providers, HBV reagents and supplies)
5. Low uptake of Nevirapine syrup by HEI

2.3 INTERVENTION TARGETING KEY POPULATIONS, ADOLESCENTS AND YOUTH

2.3.1 Background

Key Populations (KPs) are populations that are at higher risk of being infected by HIV, Viral Hepatitis and other STI/RTI infections such as syphilis. In Zanzibar, three groups of people have been documented in Zanzibar Health Sector HIV Strategic Plan III (SHSHSP III) as well as Zanzibar National HIV Strategic Plan III (ZNSP III) to be at higher risk of acquiring HIV infection, these are Men having Sex with other Men (MSM), Sex Workers (SW) and Peoples who inject drugs (PWID).

To date, there are three KPs friendly services centres located at MnaziMmoja Hospital, ZAYEDESA and Methadone Assisted Treatment (MAT) clinic at KidongoChekunduUnguja. There are a number of local NGOs and one National which in collaboration with other KPs stakeholders, continue to implement KPs interventions in Zanzibar.

2.3.2 Goal

The goal is to reduce new HIV and other Sexually Transmitted Infections and provide care, treatment and support to KPs.

2.3.3 Objectives

1. To reduce risky behaviours among Key populations by 15%
2. To increase services utilization among Key populations to 90% by 2022.
3. To increase the use of HIV /AIDS, sexual and reproductive health (SRH) by young people.

2.3.4 Program Implementation

2.3.4 .1 Capacity building

Five days Training of Trainers (ToT) on national comprehensive guidelines on HIV interventions for KPs was conducted to **25** (18 Unguja and 7 Pemba) participants from health facilities and NGOs working with KPs. The objective was to strengthen the capacity and skills of participants so as to facilitate in the subsequent training.

Moreover, training on the use of national comprehensive guidelines on HIV interventions for Key populations (KPs) was conducted to **30** (20 Unguja and 10 Pemba) services providers from

NGOs and health facilities implementing KP interventions. The objective was to strengthen capacity in the provision of quality HIV related services to key populations in Zanzibar.

In addition, five days training on programmatic and financial components related to Sub Recipients (SR) and Sub Sub Recipients (SSR) of GFATM funds implementing KP interventions was conducted. A total of **30** (20 Unguja and 10 Pemba) participants attended. The objective was to enhance the capacity of SR and SSR on effective programmatic interventions and financial management targeting KPs in Zanzibar.

Six sessions of one-day sensitization meeting were conducted to the key community, government, influential and religious leaders on Needle and Syringe Program (NSP) and Methadone Assistant Therapy (MAT) services to people who inject drugs. A total of **102**participants from seven (**7**) districts in Unguja attended the meetings. The objective was to create awareness on the importance of implementing NSP and provision of MAT services to PWIDs so as to provide support in the process towards the behaviour change of the clients.

Moreover, three days of training on HIV counselling and testing services to **35** (25Unguja and 10 Pemba) community youth counsellors from all district youth councils were conducted. The objective was to build the capacity of the participants in providing quality HIV related community outreach services to youth in Zanzibar.

In addition, four days high-level study tour involved two ministers, principal secretary, a representative from ZGFCCM and senior program Officer on Methadone services and Needle and Syringe Programme at Mombasa was conducted. The objective was to learn the quality of MAT and NSP services provided to clients in Mombasa that will help in improving the same services in Zanzibar. After the visit participants committed to advocating fellow leaders to provide support toward the implementation for these interventions once they returned to the country.

2.3.4.2 Service monitoring

Quarterly supportive supervision to SR and SSR (NGOs) implementing KP interventions was conducted. A total of **11** (7 in Unguja and 4 in Pemba) sites were supervised. The objectives were to assess the quality of HIV and other related services provided to key populations as per the guidelines as well as to support services providers in improving the quality of services to clients. Main challenges observed were inconsistence recording and reporting of KPs data,

inadequate follow up of KPs who have initially reached but also in the adequate linkage of tested positive KPs to other services points.

Following youth HTS training; supportive supervision for youth councils 'educators and counsellors was conducted; a total of **11** (4 Pemba and 7 Unguja) youth district councils with **40** counsellors and youth council educators were visited. The objective was to assess the progress and quality of services provided to targeted populations. It was noted that more follow up are needed to engage youth in HIV interventions.

Furthermore, a bi-annual stakeholders meeting was conducted to **51** (30 in Unguja and 21 in Pemba) participants from NGOs implementing KPs interventions. The objectives were to strengthen coordination, share experiences and provide feedback on services implementation. Among the key issues discussed were inadequate supports to NGOs implementing KP interventions and insufficient skills of service providers which reduced efforts of service provision to KPs in Zanzibar.

In addition, quarterly MAT Technical Working Group meetings were conducted. A total of **15** experts from ZIHHTLP, Commission for National Coordination and Drug Control (CNCDC), MAT clinic and Sheha of KidongoChekundu attended the meeting. The objective was to discuss technical issues on the provision of comprehensive MAT services in Zanzibar. Poor adherence was discussed as the main challenge hence it was suggested to revive family therapy and involvement of all relevant stakeholders.

Moreover, quarterly MAT steering committee meetings were conducted. A total of **15** members attended. The objective was to discuss technical and administrative issues on the provision of MAT services. A major issue discussed was strengthening multisectoral collaboration between government and other sectors in Zanzibar.

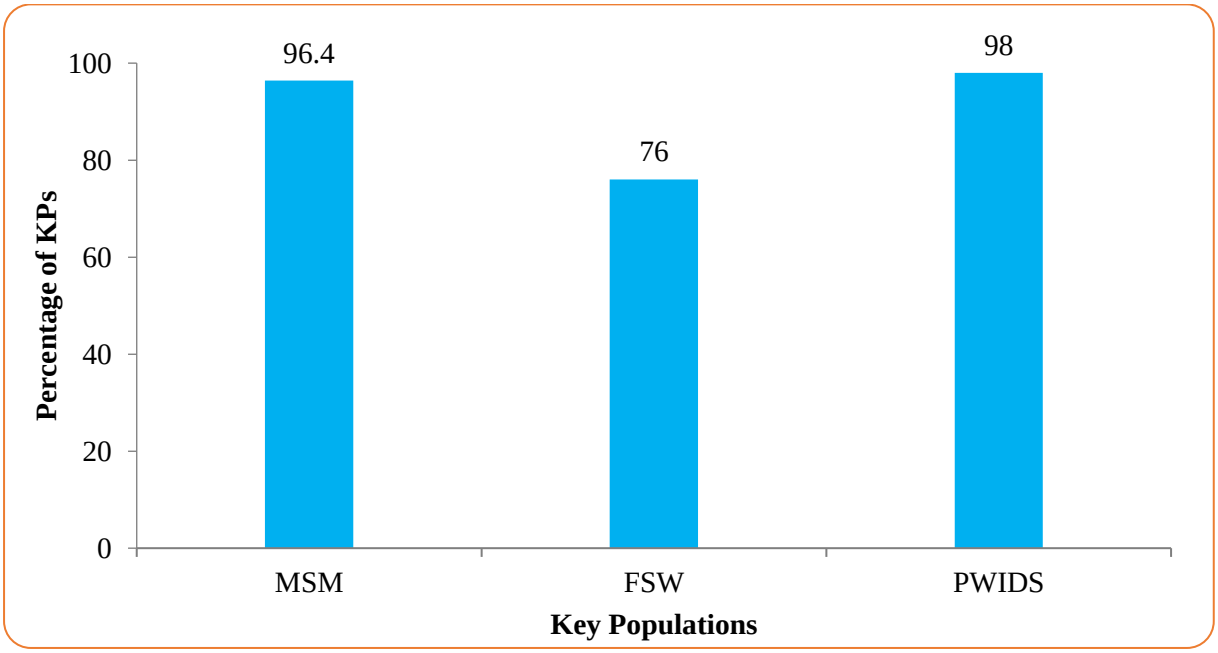
2.3.5 KP services indicators and trend from 2016- 2018

SNO	Indicators		2016	2017	2018
1	Percentage of KPs reached with individual or small-group level HIV prevention interventions designed for the target population	ISM	NA	105.1%	96.4%
		SW	NA	81.1%	76.0%
		WIDs	NA	74.3%	98.0%
2	Percentage of KPs tested for HIV and received their results in the past 12 months	ISM	NA	69.1%	56.2%
		SW	NA	54.2%	61.0%
		WIDS	NA	49.0%	48.7%
3	Proportion of HIV-infected KPs receiving ART	• MSM	NA	92.0%	85.2%
		• FSW	NA	93.7%	19.7%
		• PWIDS	NA	100.0%	18.0%
4	Percentage of people who inject drugs receiving OST		8.8%	14.2%	16.9%
5	Percentage of PWID receiving OST for at least 6 months		69.0%	53.6%	70.4%
6	Percentage of young men and women ages 15–24with comprehensive knowledge of HIV/AIDS		NA	NA	27%
7	Number of adolescents and youth who receive HIV testing services (HTS) and receive their test results				76,559

1. Percentage of KPs reached with individual or small-group level HIV prevention interventions designed for the target population

Percentage of KPs (MSM, FSW and PWIDS) reached with different HIV and STI interventions were reported to be above the set target of 60% per KPs categories. The highest category was MSM 96.4% followed by PWIDS 98% and the lowest was FSW 76% as indicated in figure bellow. These achievements were due to increasing number of outreach sessions conducted by NGOs implementing HIV/STI interventions targeting KPs in Unguja and Pemba.

Figure: 2.3.1 Percentage of KPs reached for HIV prevention services by categories in Zanzibar, January to December, 2018



2. Percentage of KPs tested for HIV and received their results in the past 12 months

Percentage of KPs who received HIV test in the past 12 months and know their results is reported to be above the set target of 50% for MSM (75.5%), and FSW (61%). However, it was below the set target for PWIDS which was reported to be 48.7% see figure 2.3.2 The achievements for MSM and FSW were due to increasing number of service provider working at different health facilities trained on quality of HIV/STI services to KPs using the current guidelines but also willingness for these groups to undergo counseling and testing services. In addition, the underachievement for PWIDS was to majority of PWIDS changed their original hotspots and hard to reach.

Majority of the KPs tested (71%) were Adult aged 25+ years compared to 29% of youth KPs. Those tested who aged 25+ were found with high HIV positive (80.3%) as indicated in table 2.3.1 bellow.

Figure 2.3.2: Percentage of KPs tested for HIV and received their results in the past 12 months by categories in Zanzibar, 2018

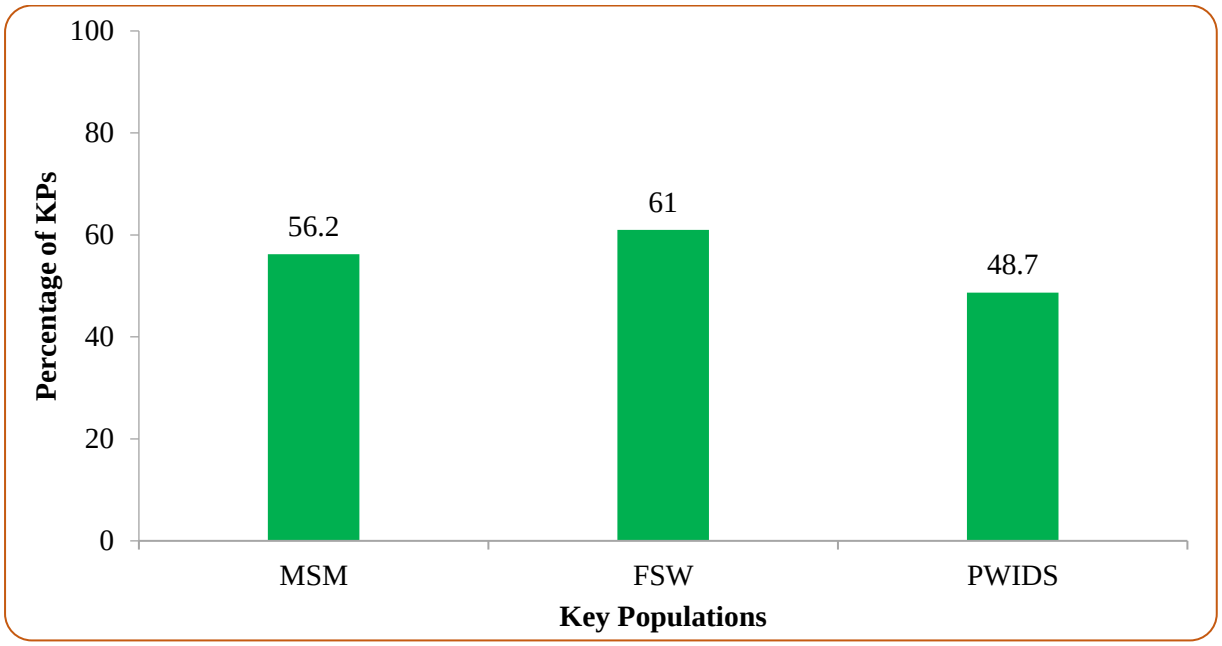


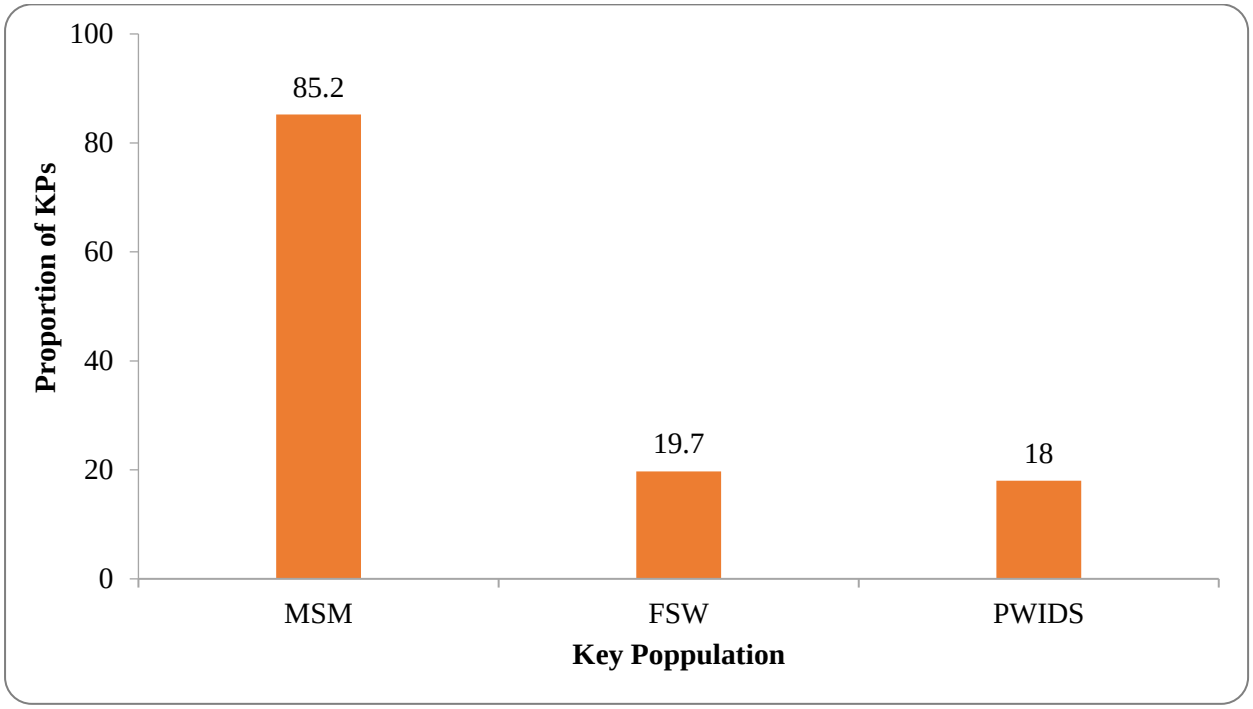
Table 2.3.1 KPs who received HIV testing services by type of category, Zanzibar, 2018

KP category	HIV TESTED			HIV POSITIVE		
	Age group			Age group		
	15- 19	20- 24	25+	15- 19	20- 24	25+
MSM	157	378	1,022	3	12	36
PWID	41	183	1,331	-	3	27
FSW	234	760	1,939	3	24	121
Total	**432**	**1,321**	**4,292**	**6**	**39**	**184**

3. Proportion of HIV infected KPs receiving ART

The proportion of HIV infected KPs receiving ART was 85.2% for MSM, 19.7% FSW and 18% PWIDS as illustrated in the figure below. These achievements are below the set target of 100% each. This under achievement was due to false identification FSW and MSM provide wrong information regarding their sexual status and considered as general populations. It was noted that PWIDS who are continuing with injecting drugs most of the time when they are on high stage or absence of heroin were not in the position to adhere to the services hence, defaulted or lost to follow up.

Figure 2.3.3: Proportion of HIV positive KPs started ART in Zanzibar, Jan to Dec. 2018



4. Percentage of people who inject drugs receiving OST

As of December 2018, a total of 16.3% (521/3,200) clients were enrolled and currently receiving MAT services in Unguja which is above target of 15%, of whom 93.9% were male. This achievement was due to the increasing number of sessions conducted by NGO implementing MAT related services to PWIDS in Unguja but also frequent supportive meeting with community outreach workers on the improvement of service provision targeting PWIDS in Unguja.

5. Percentage of PWID receiving OST for at least 6 months by December 2018

Percentage of PWIDS who were on Methadone services for at least six months is70.4% (367/521) which is above the target of 70%in 2018 as indicated in table below 2.3.2. Most of these clients (95.9%) were above 25 years old. Moreover, it has been noted that 98% of them were male clients. This achievement was contributed by the frequent provision of tailored psychosocial and behavioral change sessions to clients.

Table 2.3.2 Number of heroin users enrolled and received MAT services at Kidongo Chekundu MAT clinic in Unguja, Zanzibar, 2018

ITEM	Male	Female	Total
Client ever enrolled	649	53	702
Lost to follow up (Excluding death)	135	20	155
Death of patients, ever registered	25	1	26
Client on Methadone (Current on care)	489	32	521
Current on Treatment for at least six months	344	23	367

6. Number of adolescents and youth who receive HIV testing services (HTS) and receive their test results

Percentage of young men and women ages 15–24with comprehensive knowledge of HIV/AIDS is reported to be 27% which is below the set target of 50%. This has been contributed to limited number of youth friendly sites where they can get relevant information.

7. Percentage of young men and women ages 15–24 with comprehensive knowledge of HIV/AIDS

Number of adolescents and youth who receive HIV testing services (HTS) and receive their test results was 76,559 which is above target of 50,000. Among them 24,119 were the ages of 15-19, while 52,440 were the age of 20-24. Majority of them (50,592/76559) were female, whereby Mjini has reported with high number (17,667) and the lowest (2,344) was Mkoani district as indicated in the table below.

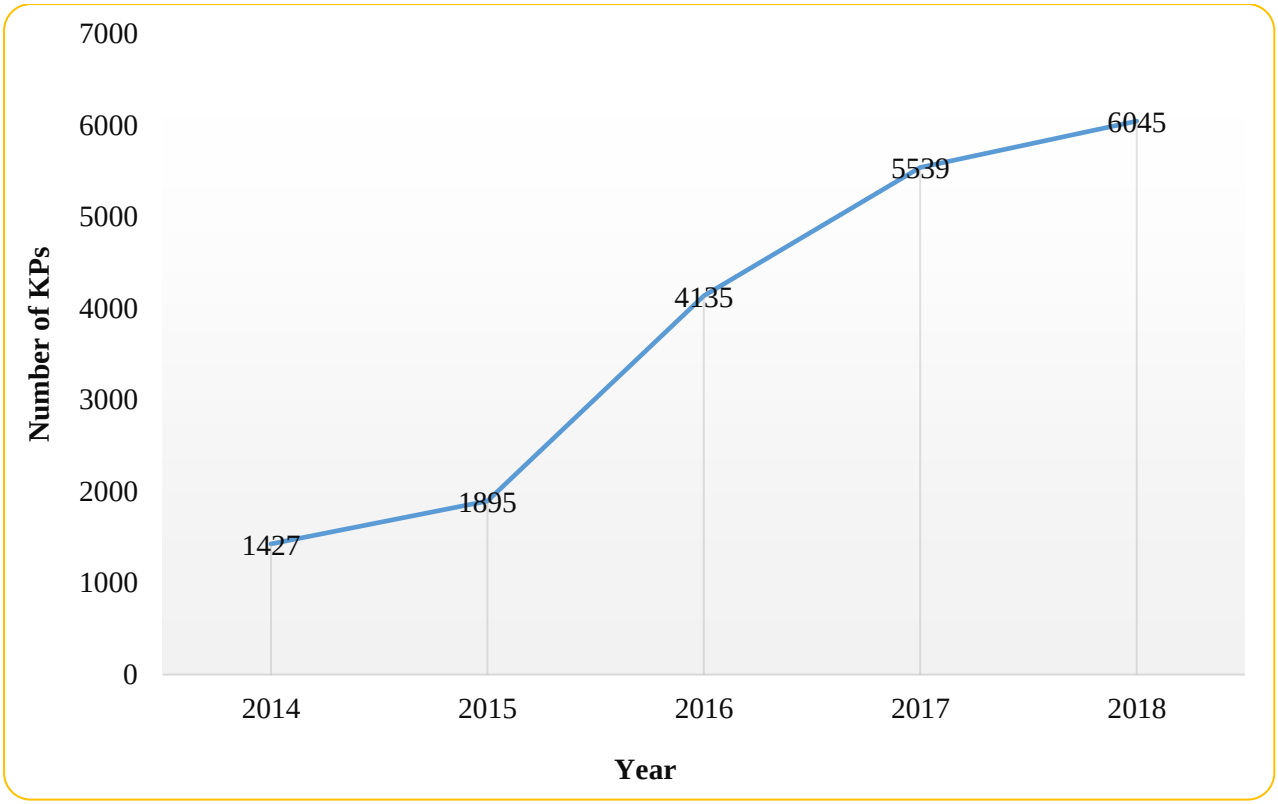
Table 2.3.3: Number of Adolescent and youth who received HIV testing services by sex, age and district Zanzibar, 2018

District	Age and Sex				Total
	15 - 19		20 - 24		
	Female	Male	Female	Male	
Kaskazini A	1,532	621	2,866	1,340	**6,359**
Kaskazini B	934	499	1,846	921	**4,200**
Mjini	3,189	1,648	8,098	4,732	**17,667**
Magharibi	5,458	2,272	11,769	6,114	**25,613**
Kati	1,184	580	2,655	1,469	**5,888**
Kusini	481	216	1,133	708	**2,538**
Wete	841	334	969	728	**2,872**
Micheweni	945	302	836	759	**2,842**
Chake	1,487	507	2,542	1,236	**5,772**
Mkoani	688	274	827	555	**2,344**
Outside Zanzibar	107	20	205	132	**464**
Total	**16,846**	**7,273**	**33,746**	**18,694**	**76,559**

2.3.6 Trend of HIV testing services among KPs from 2014 -2018

There was an increased number of KPs who received HIV testing services for the five years' period from 1,427 in 2014 to 6,045 in 2018 as indicated in figure number 2.3.4 below.

Figure 2.3.4 Trend of HIV testing services among KPs from 2014 – 2018, Zanzibar



2.3.7 Challenges

1. Low capacity of services providers in counseling and testing of KPs compare to KP reached.
2. Poor linkage of KPs to care and treatment services.
3. Inadequate pre-MAT sessions to PWIDS contributed to poor adherence of PWIDs to MAT services.

2.4 SEXUALLY TRANSMITTED INFECTION SERVICES

2.4.1. Background

Sexually Transmitted Infections (STIs) and other Reproductive Tract Infections (RTIs) services were established in 1987. The role of STI unit is to monitor and coordinate STI/RTI services in Zanzibar. STIs/RTIs services are provided in 280 (173 in Unguja and 107 in Pemba) health facilities.

2.4.2. Goal

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

2.4.3. Objectives

To increase utilization of STI/RTI services among Key and General population by 30%

2.4.4. Programme Implementation

2.4.4.1 Capacity building

Six day's STI/RTI training based on new guideline was conducted in two session to **90** (50 Unguja and 40 Pemba) services providers. The objective was to build capacity of service providers in delivering quality management of STI/RTIs according to national STI guidelines.

2.4.4.2 Service monitoring

Annual supportive supervision to health facilities implementing STIs services in Unguja and Pemba was conducted. A total of **120** (86 Unguja and 34 Pemba) health facilities were supervised. The objectives were to monitor the implementation of STI services and to enhance capacity of service providers. There is an increase in awareness and skills among services providers in managing STI cases in many health facilities.

Annual integrated feedback meeting on HIV and STI interventions was conducted. A total of **150** (100 Unguja and 50 Pemba) health care workers who provide HIV related (STI/RTIs, HTS, Lab and PMTCT) services from all districts attended. The objectives were to share the supervision findings and discuss on the best way in the provision of quality HIV/STI services. Major issues discussed were discrepancies of data in terms of recording and reporting and low commitment of service providers in delivering HIV/STI services. It was agreed to strengthen supportive supervision and mentorship as well as staff motivation and recognition for high performing providers and their respective facilities.

Condoms were distributed through various condom outlets in Zanzibar. A total of **1,691,697** (1,688,872 male and 2,825 Female) pieces of condoms distributed in various condom outlets as indicated in table 2.4.1The objective was to help in prevention of STI including HIV among general and Key Populations.

Table 2.4.1: Number of condoms distributed in different outlets in Zanzibar, 2018

Condom outlets	Pieces of Condom Distributed		
	Male	Female	Total
NGOs	478,352	1,325	479,677
Military camp	122,400	0	122,400
Hotel and Recreation Conferences	642,720	0	642,720
Health facilities	124,048	0	124,048
District Youth Councils	113,472	0	113,472
Different Institutions	92,680	0	92,680
Steaming seafood camp	17,280	0	17,280
Studies	97,920	1,500	99,420
TOTAL	**1,688,872**	**2,825**	**1,691,697**

2.4.5 STI/RTI services indicators and trend from 2016 to 2018

SNO	Indicators	Year		
		2016	2017	2018
1	Number of men and women diagnosed with and treated for STIs/RTI	8,354	11,533	13,335

1. Number of men and women diagnosed with and treated for a sexually transmitted / reproductive tract infection.

There was an increase in STI cases diagnosed from **11,533** in 2017 to **13,335** in 2018 which is below the target **14,993**.This under achievement might due to shortage of drugs in many of health facilities at all levels in Unguja and Pemba. Majority of the patients received STI services were female **9,977** (75 %) compared to **3,358** (25%) males, whereby the most diagnosed STI cases was Vaginal Discharge Syndrome **6,386** (48%) followed by Lower Abdominal Pain **2,799** (21%) as indicated in the table below.

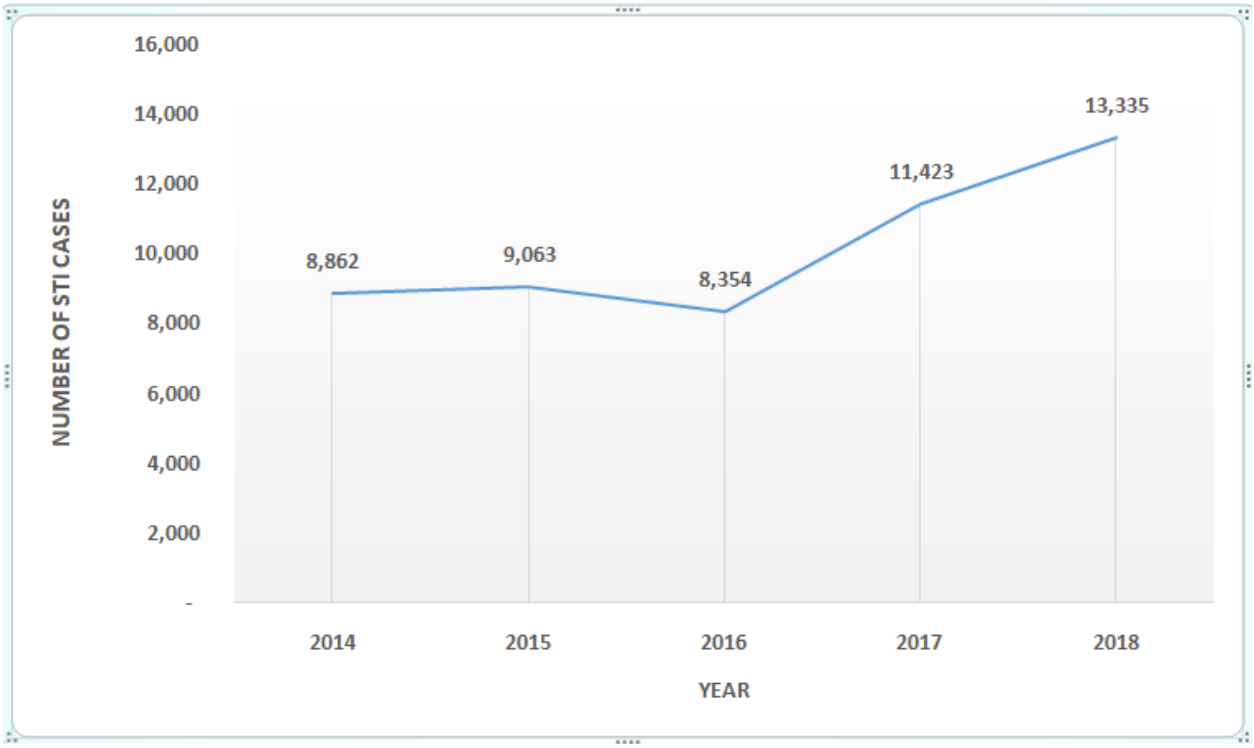
Table 2.4.2: Number of STI/RTI diagnosed by sex and age group, 2018, Zanzibar

Syndromic Diagnosis	Age (years) and Gender										Total
	Female					Male					
	0–9	10–14	15–19	20–24	25+	0–9	10–14	15–19	20–24	25+	
Genital Ulcer (GU)	1	5	53	83	105	6	5	31	57	94	**440**
Inguinal Bubo (IB)	4	-	-	-	3	16	-	1	5	12	**41**
Oral Pharyngeal (OP)	2	9	20	18	20	5	6	14	21	13	**128**
Anorectal (ARS)	-	-	16	21	10	-	-	1	6	7	**61**
Lower abdominal pain (LAP)	15	85	462	926	1,311						**2,799**
Vaginal Discharge (VD)	33	110	749	2,220	3,274						**6,386**
Urethral Discharge (UD)						41	5	110	493	1,857	**2,506**
Painful Scrotal Swelling (PSS)						2	2	18	37	114	**173**
Neonatal Conjunctivitis (0 – 28 days)	422					379					**801**
Total	**477**	**209**	**1,300**	**3,268**	**4,723**	**449**	**18**	**175**	**619**	**2,097**	**13,335**

2.4.6. Trend of Number of men and women diagnosed with and treated for STIs/RTI, 2014–2018

Number of men and women diagnosed with and treated for STIs/RTI has slowly declined from **8,862** in 2014 to **8,354** in 2016 but has increased from **8,354** in 2016 to **13,335** in 2018 as indicated in figure below.

Figure 2.4.1: Number of men and women diagnosed with and treated for STIs/RTI in Zanzibar, 2014 -2018



2.4.5 Challenges

1. Shortage of STI drugs in all levels of health facilities due to inadequate allocation of STI drugs from DDM
2. Insufficient frequency of supportive supervision at health facility due to shortage of funds

CHAPTER 3: HIV CARE AND TREATMENT SERVICES

3.1 HIV CARE AND TREATMENT SERVICES

3.1.1 Background

HIV care and treatment services were established in 2005 at Mnazi Mmoja Hospital. Currently there are 13 (9 Unguja and 4 Pemba) care and treatment clinics (CTCs) in Zanzibar. In addition, there are 3 ART refilling sites in Unguja. CTC services are provided in 11 public health facilities, 1 private hospital and 1 Non-Governmental Organization.

3.1.2 Goal

Reduction in morbidity and mortality related to HIV/AIDS by 2022

3.1.3 Objective

To Increased utilization of care and treatment services to 95% of PLHIV by 2022

3.1.4 Program Implementation

3.1.4.1 Capacity building

A five days training on advance adherence counselling was conducted to **30** (25 Unguja and 5 Pemba) CTC Providers. The objectives were to equip CTC Providers with knowledge and skills on Advanced Adherence Counselling (AAC), to understand better adherence opportunities and challenges for different ages and gender.

In addition, another five days training on Differentiated Services Delivery Models (DSDMs), viral load monitoring and Enhanced Adherence Counselling (EAC) for those with high viral load was conducted. A total of **40** (25 Unguja and 15 Pemba) health care workers participated. The objectives were to orient health care providers working in CTC on DSDMs, monitoring of patients using HIV viral load (HVL) testing and EAC for patients with high HVL.

3.1.4.2 Service monitoring

Quarterly supportive supervisions were conducted to **13** CTCs in Unguja and Pemba and 3 refilling sites in Unguja. The objective was to monitor the standards and quality of services provided in CTCs according to the Zanzibar National Guidelines for HIV Prevention and Treatment, 2017. Key finding is inadequate implementation of DSDMs which causes persistence of overcrowding of patients in high volume CTCs.

Defaulter tracing to CTC clients who were lost to follow-up were conducted by Community Home Based Care (CHBC) providers in collaboration with peers. A total of **736** (696 Unguja and 40Pemba) defaulters, out of them **353** were successfully returned into care. The rest did not return due to various reasons including deaths, continue with the services at other clinic without official transfer, provision of wrong addresses and travel with no information.

Annual meeting was conducted to **61** (31 Unguja and 30 Pemba) Volunteers and CTC providers. The objective was to discuss performance, challenges and proposes way forward. Among the issues discussed were high viral load among children and poor ART adherence.

Bi annual quality improvement meetings were conducted to **116** (76 Unguja and 40 Pemba) CTC providers. The purpose was to share their best practices, identify gaps and solve problems within the facility. Among the identified gaps were shortage of staff and monitoring tools, cervical cancer screening supplies and equipment.

Five days' workshop to develop Standard Operating Procedures (SOPs) for HIV positive adolescents and young people was conducted. A total of **34** (29 Unguja and5 Pemba) CTC providers attended. The objective was to ensure service provider adhere to SOPs on providing quality of services to adolescents. SOPs were printed and distributed to CTCs.

Four TWG (20 members) and 2 Stakeholders (30 participants each) attended the meetings on the development of f HIV disclosure guidelines in Zanzibar. The aim was to address barriers to disclosure, standardize disclosure processes, and guide measures to be taken to make disclosure process safe and effective, so as to improve adherence to ART. The HIV disclosure guideline was developed and printed. Followed the development of guideline Trainers were oriented on HIV disclosure to children and adolescents, then after TOT, CTC and NGO staff were trained.

One-day meeting with **65** (35 Unguja and 30 Pemba) traditional healers was conducted. The objective was to sensitize them on the importance of ARV adherence to People Living with HIV (PLHIV) based on findings and recommendations of retention study. Traditional healers requested to be capacitated on basic knowledge of ARVs.

3.1.5 HIV care and treatment indicators and trend from 2016 to 2018

SN	Indicator	Year		
		2016	2017	2018
1	AIDS mortality per 100,000 per year	7.6	7.1	6.4
2	Number of new PLHIV started on ART during reporting period	872	955	1,154
3	Number and percent of PLHIV who are currently on ART	4,346	5,269 (92.4%)	5,915 (92.5%)
4	Number of PMTCT sites that are providing comprehensive care and treatment services	1	1	2
5	Percentage of adults and children known to be on treatment 12 months after initiation of ART	71.3	87.5	72.3%
6	Proportion of women living with HIV ages 30–49 who report being screened for cervical cancer using any of the following methods: Visual inspection with acetic acid (VIA), Pap smear or human papillomavirus (HPV) test	-	TBD	TBD
7	Percentage of ART clients with viral load results documented in the medical records and laboratory information system (LIS) within the past 12 months with a suppressed viral load less than 1,000 copies/ml	32% (40/123)	83% (2686/3227)	76.7%
8	Percentage of PLHIV screened for TB	99%	99%	99.6%
9	Percentage of PLHIV who started TB treatment in the reporting period	1.4% 74/5,425	1.5% 91/6,007	1.2% 83/6,825
10	Number of health facilities providing TB/HIV collaborative activities (Under One-Roof)	2	2	2
11	Number of care and treatment clinics (CTCs) providing IPT services	2	6	6

1. AIDS mortality per 100,000 per year

According to the Zanzibar spectrum projection, in 2018 AIDS mortality was 6.4. This was above the 2018 M&E targeting set (reducing AIDS mortality to 6.0 per 100,000 patients per year). However, there was a reduction from 7.1 in 2017 to 6.4 per 100,000 patients in 2018.The highest AIDS mortality was observed among both males and females aged 30 – 59 years. Table 3.1.1 below shows age and sex distribution of AIDS mortality per 100,000 patients.

Table 3.1.1: Age and sex distribution of AIDS mortality per 100,000 patients, Zanzibar 2018

Age category (years)	Sex		Total
	Male	Female	
0-4	47.1	46.5	46.8
5-9	12.2	10.9	11.5
10-14	29.1	26.3	27.7
15-19	26.0	32.6	29.3
20-24	52.3	79.9	66.1
25-29	78.5	84.0	81.2
30-34	113.1	100.2	106.6
35-39	153.3	90.1	121.4
40-44	185.8	118.1	151.6
45-49	208.1	133.3	170.2
50-54	178.1	95.5	135.9
55-59	139.4	58.6	97.6
60-64	90.7	33.4	60.7
65-69	50.9	18.4	33.6
70-74	31.6	9.7	19.6
75-79	21.6	3.9	11.7
80+	9.9	1.5	5.0
Total	**70.2**	**57.2**	**63.7**

2. Number of new PLHIV started on ART during reporting period

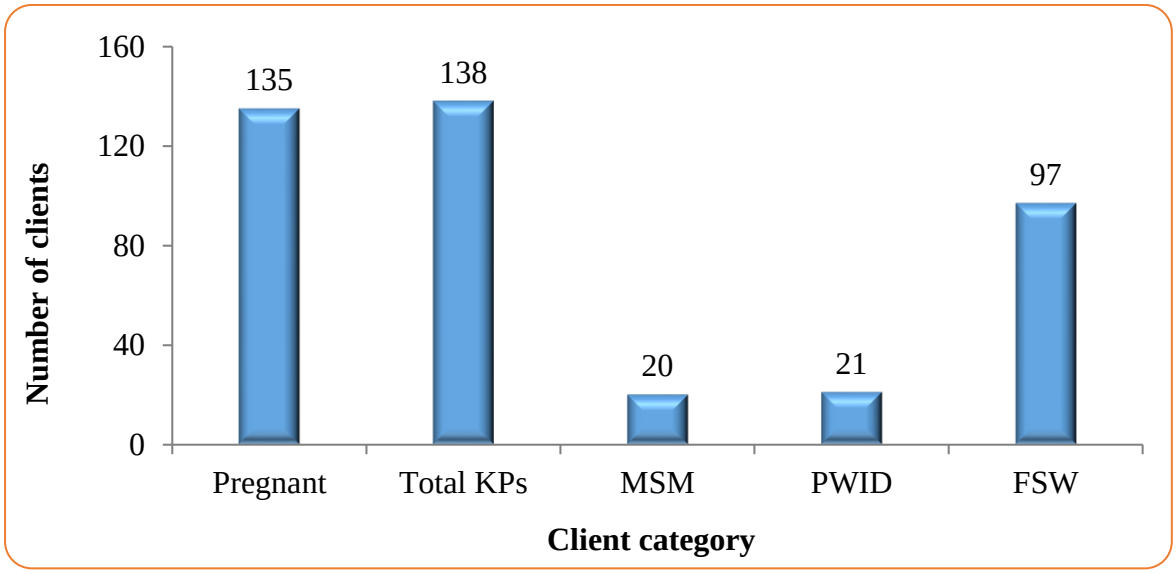
The number of PLHIV started on ART has increased from **955** in 2017 to **1,154** in 2018. The increase was contributed by treat all approach and effective linkage of clients from different HIV testing points by escorting new clients to CTC for initiation of ART. The number of new PLHIV started on ART during the year 2018 was more than double the M&E target i.e. initiating ART to at least 400 clients (Table 3.1.2).

Table 3.1.2: Number of new PLHIV started on ART by age and sex, Zanzibar, 2018.

Age category	Sex		Total
	Male	Female	
0 –11 months	2	4	6
1 – 4 years	5	8	13
5 – 9 years	6	16	22
10 – 14 years	7	10	17
15 – 19 years	5	24	29
20 – 24 years	32	125	157
25 – 49 years	255	538	793
≥ 50 years	49	68	117
Total	**361**	**793**	**1,154**

Among new PLHIV started on ART in 2018, 12%(n=135) were pregnant women, 12%(n=138) were KPs including 20 MSM, 21 PWID and 97 FSW as illustrated in the figure 3.1.2 below

Figure 3.1.1: Number of new PLHIV started on ART by categories, Zanzibar, 2018.



3. Number and percent of PLHIV who are currently on ART

As of December 2018, a total of **6,025** patients received care in all in CTCs of whom **5,915** (92.5%) were receiving ART of patients among the estimated PLHIV in need of treatment according to spectrum file of 2017 in these facilities. The number of patients currently on ART has increased progressively from **5,269 (82.4%)** in 2017 to **5,915 (92.5%)** by December 2018. The proportion of PLHIV currently on ART was slightly higher than the M&E target set (achieving 85% of PLHIV currently on ART). Table 3.1.2 below illustrates the number of PLHIV currently on ART by age, sex and CTC clinics in Zanzibar.

4. Number of PMTCT sites that are providing comprehensive care and treatment services

By the end of 2018, thirteen (13) CTCs were operational in both Unguja and Pemba. Of them, only 2 were providing comprehensive care and treatment services. During this year, we have attained the M&E target of having at least 2 PMTCT sites providing comprehensive care and treatment services. These sites are Fuoni PHCU+ and Mwembeladu hospital.

Table 3.1.3: Number of PLHIV who are currently on ART, Zanzibar, 2018

Name of the clinic	Age group and sex																Total	
	<1		1 - 4		5 - 9		10 - 14		15 - 19		20 - 24		25 - 49		50+			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
UNGUJA																		
Mnazimmoja	0	2	9	12	23	28	52	45	38	58	35	113	471	1,314	242	386	**870**	**1,958**
Mwembeladu	0	0	5	3	7	7	13	6	8	6	4	36	161	575	52	89	**250**	**722**
Bububu	0	0	4	1	5	2	5	4	6	6	4	25	128	346	54	50	**206**	**434**
Kivunge	0	0	0	1	1	5	5	2	3	4	1	7	48	156	26	22	**84**	**197**
Zayedesa	0	0	0	1	0	1	1	0	1	2	8	24	94	127	21	22	**125**	**197**
Makunduchi	0	0	0	0	1	4	0	3	3	1	0	6	18	70	11	13	**33**	**97**
Al rahma	0	0	0	0	1	2	1	0	1	2	3	4	17	103	14	18	**37**	**129**
Fuoni	0	1	0	0	0	1	0	1	0	2	2	4	8	24	1	2	**11**	**35**
Kidongochekundu	0	0	0	0	0	0	0	0	0	0	1	1	22	12	1	0	**24**	**13**
Total - Unguja	**0**	**3**	**18**	**18**	**38**	**50**	**77**	**61**	**60**	**81**	**58**	**220**	**967**	**2,727**	**422**	**602**	**1,640**	**3,782**
PEMBA																		
Chakechake	1	1	2	3	5	0	3	5	3	7	0	10	37	93	20	33	**71**	**152**
Wete	0	0	0	1	4	2	4	1	6	5	1	6	32	67	13	17	**60**	**99**
Micheweni	0	0	1	0	2	1	3	2	0	0	0	1	9	22	1	2	**16**	**28**
Mkoani	0	0	0	0	2	2	1	1	1	4	1	0	9	31	11	4	**25**	**42**
Total - Pemba	**1**	**1**	**3**	**4**	**13**	**5**	**11**	**9**	**10**	**12**	**2**	**7**	**87**	**213**	**45**	**56**	**172**	**321**
Total - Zanzibar	**1**	**4**	**21**	**22**	**51**	**55**	**88**	**70**	**70**	**93**	**60**	**227**	**1054**	**2,940**	**467**	**658**	**1,812**	**4,103**

5. Percentage of adults and children known to be on treatment 12 months after initiation of ART

Overall percentage of patients who are still alive and known to be on treatment 12 months after initiation of ART has decreased from 87.5% in 2017 to 72.3% in 2018. It has been observed that children below fifteen years had low retention rate compared to adults. The observed proportion of PLHIV known to be on treatment 12 months after initiation of ART is lower than the M&E target (achieving 89% retention rate). Figure 3.1.2 below shows the percentage of adults and children known to be on treatment 12 months after initiation of ART.

Figure 3.1.2: Percentage of adults and children known to be on treatment 12 months after initiation of ART by age and sex, Zanzibar, 2018.

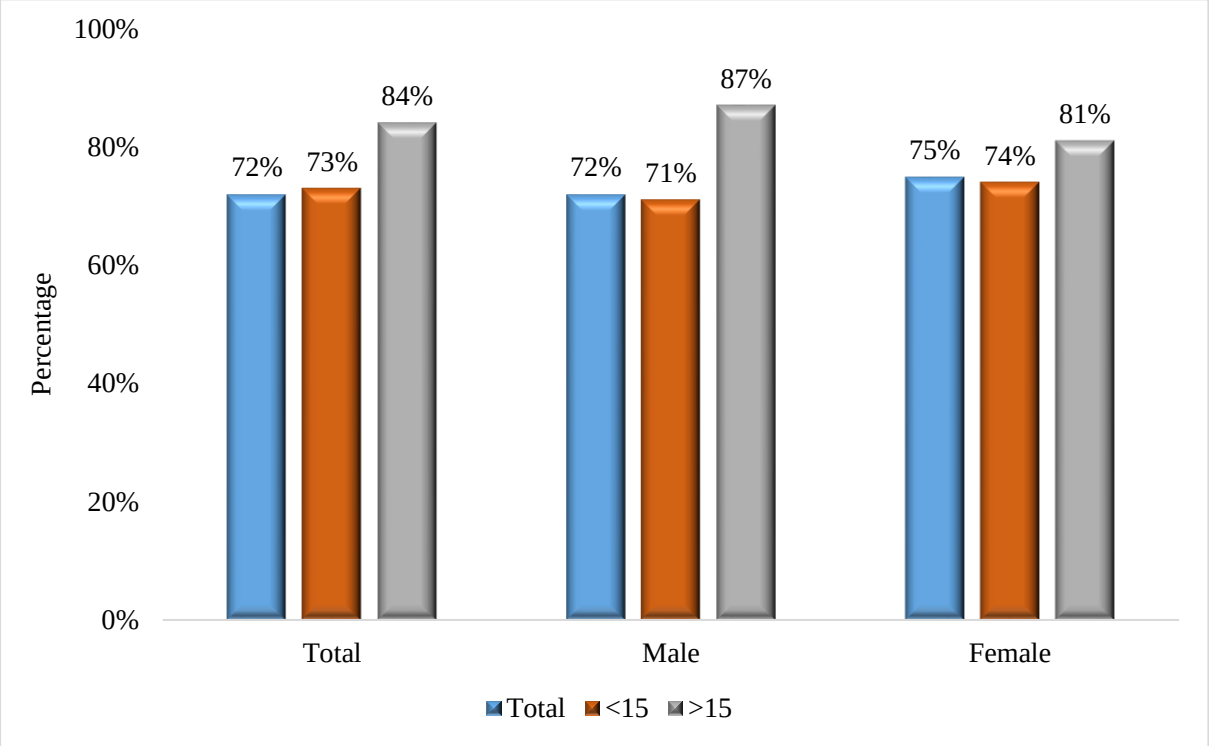
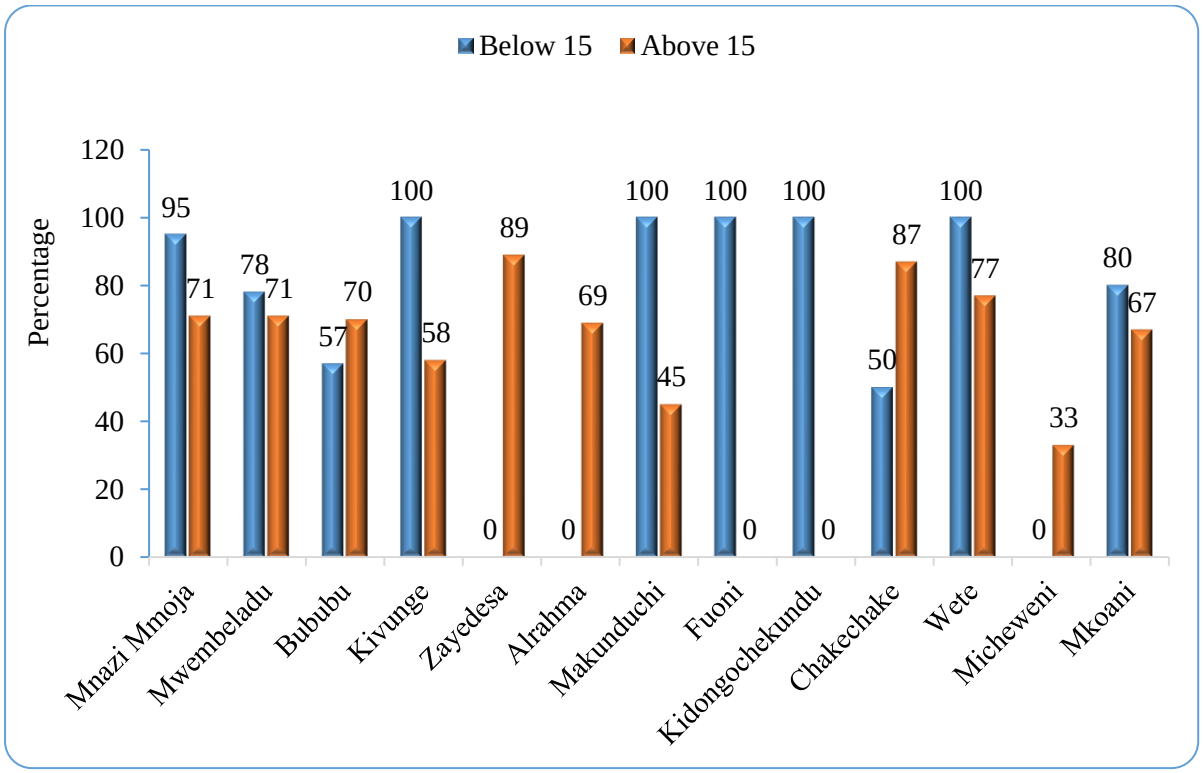


Figure 3.1.3 illustrate percentage of patients who are still alive and known to be on treatment 12 months after initiation of ART by facility, whereby, Micheweni CTC had the lowest retention rate of 12 months after initiation of ART followed by Bububu CTC. Fuoni CTC and Wete CTC had the highest retention rate.

Figure 3.1.3: Percentage of adults and children known to be on treatment 12 months after initiation of ART by facility and age, Zanzibar, 2018.



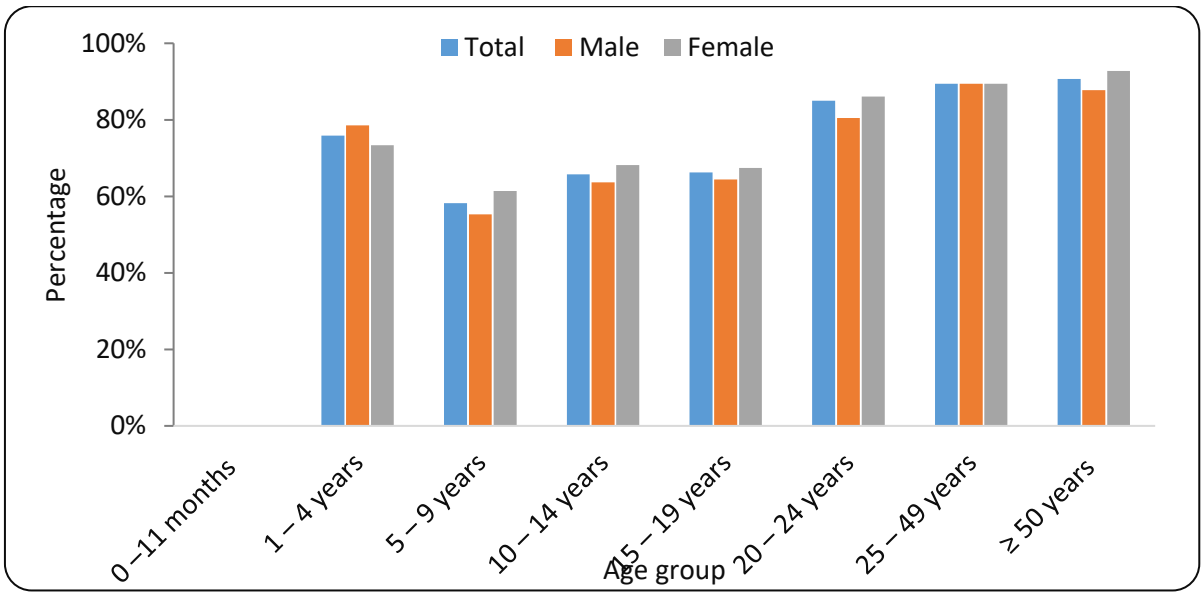
6. Percentage of ART clients with viral load results documented in the medical records and laboratory information system (LIS) within the past 12 months with a suppressed viral load (less than 1,000 copies/ml)

During the year 2018, a total of 4,805 ART clients were tested for viral load and 4,198 **(87%)** were virally suppressed within the past 12 months had a suppressed viral load (less than 1,000 copies/ml). However, this proportion is lower in some age group especially paediatric and adolescent than the 2018 M&E target of achieving 85%. Table 3.1.4 and figure 3.1.4 present this information by age, and sex.

Table 3.1.4: Proportion of ART clients with viral load results documented in the medical records and laboratory information system (LIS) within the past 12 months with a suppressed viral load (less than 1,000 copies/ml) by age, sex and sites, Zanzibar, 2018.

	Viral loads < 1000																Total tested		Viral loads < 1000										
Age	**1<**		**1-4**		**5-9**		**10-14**		**15-19**		**20-24**		**25-49**		**50+**				**1<**		**1-4**		**5-9**		**10-14**		**15-19**		**20**
Sex	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
Mnazimmoja	**0**	**0**	**7**	**8**	**14**	**17**	**28**	**28**	**27**	**37**	**22**	**81**	**350**	**987**	**194**	**296**	**642**	**1454**	0	0	2	2	9	7	18	12	8	19	8
Muembeladu	0	0	0	0	1	1	8	4	2	2	2	16	100	391	29	66	**142**	**480**	0	0	0	0	2	1	2	2	3	1	0
Kivunge	0	0	0	0	0	2	3	0	0	1	0	0	27	96	17	14	**47**	**113**	0	0	0	0	1	2	2	1	1	2	0
Zayedesa	0	0	0	1	0	1	0	0	0	1	3	13	57	92	14	18	**74**	**126**	0	0	0	0	0	0	0	0	0	0	0
Alrahma	0	0	0	0	1	0	0	0	1	3	0	4	19	96	15	16	**36**	**119**	0	0	0	0	1	0	0	0	0	1	0
Bububu	0	0	3	0	2	1	2	2	2	4	2	14	86	261	43	38	**140**	**320**	0	0	1	0	3	1	2	1	2	4	0
Kidongochekundu	0	0	0	0	0	0	0	0	0	0	0	0	10	17	1	1	**11**	**18**	0	0	0	0	0	0	0	0	0	0	0
Makunduchi	0	0	0	0	1	2	0	2	1	1	1	3	6	43	3	11	**12**	**62**	0	0	0	0	0	2	0	1	1	0	0
Fuoni	0	0	0	0	0	0	0	0	0	0	1	2	5	6	0	1	**6**	**9**	0	0	0	0	0	0	0	1	0	0	0
Chakechake	0	0	1	2	5	1	3	6	3	6	0	8	28	72	18	29	**58**	**124**	0	0	0	1	1	0	1	2	2	1	0
Wete	0	0	0	0	1	1	3	1	2	3	1	5	22	63	8	17	**37**	**90**	0	0	0	1	1	2	1	0	3	2	0
Mkoani	0	0	0	0	0	1	0	1	0	4	1	0	8	22	7	4	**16**	**32**	0	0	0	0	2	1	1	0	1	0	0
Micheweni	0	0	0	0	1	0	2	1	0	0	0	2	6	15	1	2	**10**	**20**	0	0	0	0	1	1	1	1	0	0	0
TOTAL	**0**	**0**	**11**	**11**	**26**	**27**	**49**	**45**	**38**	**62**	**33**	**148**	**724**	**2161**	**350**	**513**	**1231**	**2967**	**0**	**0**	**3**	**4**	**21**	**17**	**28**	**21**	**21**	**30**	**8**

Figure 3.14: Percentage of ART clients with viral load results within the past 12 months with a suppressed viral load less than 1,000 copies/ml, 2018, Zanzibar.



7. Percentage of PLHIV who started TB treatment in the reporting period

In this reporting year, **96%** of the PLHIV attending CTC clinics were screened for TB. A total of **83** patients started TB treatment in the reporting period. Of them, **43** were males and **40** females. Among them **10 (12%)** were children before the age of 15 years as shown in the Table 3.1.5.

Table 3.1.5: Percentage of PLHIV who started TB treatment in the reporting period by age, sex and pregnancy status

Age category	Total started treatment	Sex	
		Male	Female
0 –11 months	0	0	0
1 – 4 years	2	0	2
5 – 9 years	5	2	3
10 – 14 years	3	1	2
15 – 19 years	6	3	3
20 – 24 years	2	1	1
25 – 49 years	53	28	25
≥ 50 years	12	8	4
Total	**83**	**43**	**40**

8. Number of health facilities providing TB/HIV collaborative activities (Under One-Roof)

Currently, there are two sites providing comprehensive TB/HIV services (Mnazi Mmoja and Chake Chake hospitals). This number is equivalent to the M&E target i.e. by 2018 having at least 2 health facilities providing TB/HIV collaborative activities (Under One-Roof). In this reporting period, all TB/HIV patients received treatment at these facilities as indicated in the table **3.1.6** below.

Table 3.1.6: distribution of TB/HIV received under one roof services by facility and quarter, 2018, Zanzibar

Quarter	Mnazi Mmoja	Chake Chake	Total
Jan – March	9	1	10
Apr – June	17	3	20
July – Sept	12	2	14
Oct – Dec	13	4	17
Total	**51**	**10**	**61**

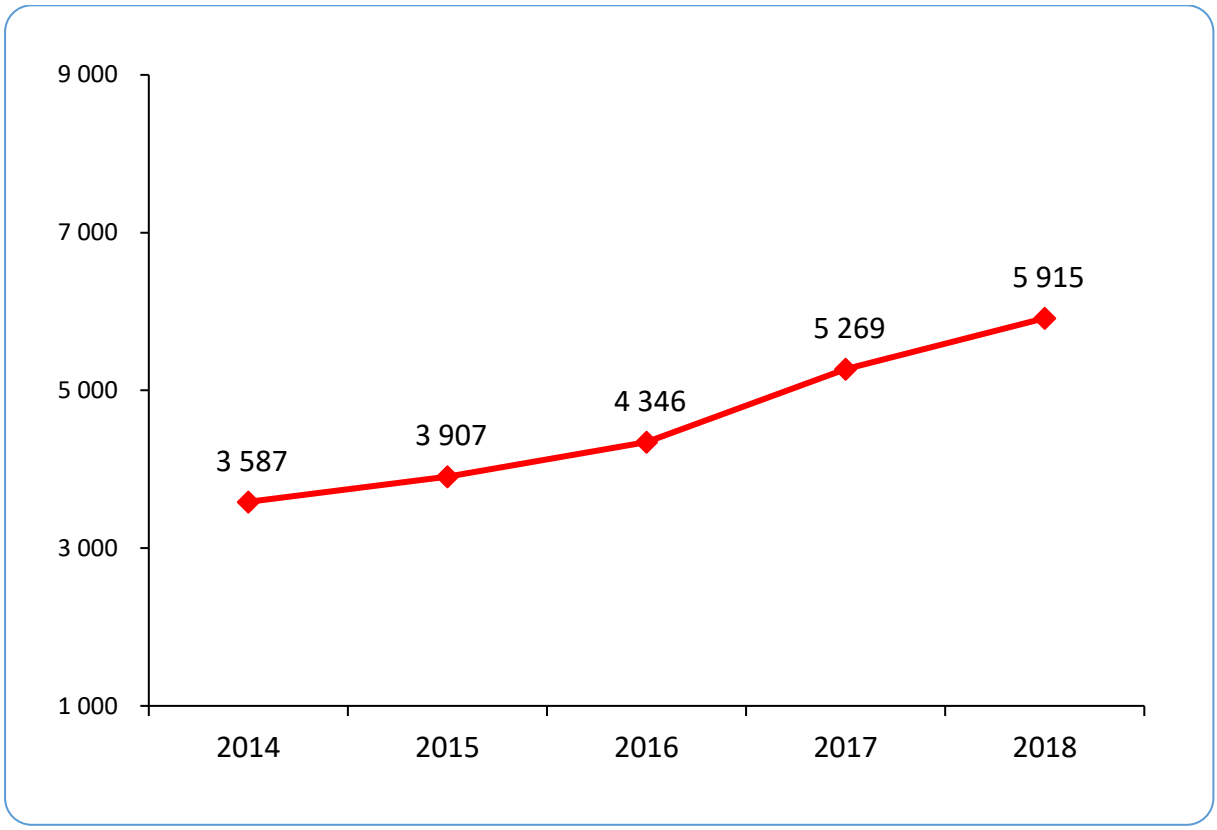
9. Number of care and treatment clinics (CTCs) providing IPT services

The number of care and treatment clinics (CTCs) providing IPT services has remained the same from 2017 to 2018 (n=6). However, this number is below the M&E target (having 7 CTCs facilities providing IPT services by 2018). The target was not reached due to the challenge of IPT in the country, however, 9 facilities were ready to start provision of IPT.

10. Trend of PLHIV currently on ART from 2014 to 2018

The figure below shows patients currently on ART have increased progressively from 3,587 in 2014 to 5,915 by December 2018. The increase in 2018 was contributed by introduction of treat all approach whereby all PLHIV are started on ART and hence efforts are made by different HIV testing approaches to ensure all newly identified HIV positive clients are being escorted to CTC for initiation of ART.

Figure 3.1.1: Number of PLHIV currently receiving ART 2014 - 2018, Zanzibar



3.1.7 Challenges

- Shortage of staff at CTCs especially Nurses and Clinicians
- An increasing number of Lost-to-Follow up patients in CTCs
- Self-stigma among PLHIV as well as the stigma of health care providers

3.2 INTEGRATED COMMUNITY-BASED HEALTHCARE SERVICES

3.2.1 Background

Home Based Care (HBC) services in Zanzibar were established in 1988 in 5 (Mjini, Magharibi and Kati in Unguja and Chake Chake and Wete in Pemba) districts to cater to AIDS patients only. Currently, these services have been scaled up to 144 health facilities in all 11 districts of Zanzibar. The community-based HBC (CHBC) volunteers are pivotal in the provision of these services at the community. The volunteers are working under the supervision of facility-based HBC providers. Each health facility has a contact person (facility supervisor) who is accountable for all HBC services at the facility level.

3.2.2 Goal

The goal is to increase the utilization of quality comprehensive HBC services.

3.2.3 Objectives

1. Increased availability of quality comprehensive CHBC services by PLHIV
2. Strengthened linkage of ICBHC services with health facilities

3.2.4 Program Implementation

3.2.4 .1 Services monitoring

Supportive supervision was conducted to facility-based HBC providers at **121** (46 Unguja and 75 Pemba) health facilities. The objective was to improve the performance of home-based care providers to deliver quality and comprehensive HBC services, including appropriate documentation. The achievement found was the presence of national M&E tools for HBC in place and in use.

In addition, coordination meetings with **270** (150 Unguja and 120 Pemba) CHBC providers were conducted. The objective was to orient the providers on reviewed CHBC tools. Participants shared experience and challenges faced during documentation of HBC services and came up with a resolution of close follow up and mentoring.

Moreover, meetings with **200** CHBC providers (120 Unguja and 80 Pemba) were conducted. The objective was to share experience and challenges faced during the provision of HBC services. Incentive for CHBC volunteers were provided in all districts with the aim to motivate community volunteers to continue providing care to patients.

3.2.5 HBC Services indicator – 2018

SN	Indicator	Year		
		2016	2017	2018
1	Percentage of PLHIV receiving comprehensive HBC services	7.6	7.1	(18.1%)

1. Percentage of PLHIV receiving comprehensive HBC service

The percentage of PLHIV receiving comprehensive HBC services for this year has slowly declined from 22.5%in 2017 to 18.1% in 2018 which is below the 2018 target of 24%. This under achievement might due to less coordination between HBC and CTC services, and the service is depending on the client's consent. More patients have received HBC services in 2018, who were **3,328** compared to **3,158** patients in 2017. This achievement was due to improved documentation of HBC data through proper recording and reporting of HBC into DHIS2 database and provision of the target to all health facilities in Unguja and Pemba.

Table 3.2.1: Number of clients who received HBC services by disease category, sex and age group in Zanzibar, 2018

Age (years)	HIV patients		Other chronic diseases		Total
	M	F	M	F	
0 – 4	7	5	19	21	**52**
5 – 14	**56**	**43**	**102**	**64**	**265**
≥ 15	343	780	843	1045	**3,011**
Total	**406**	**828**	**994**	**1,130**	**3,328**

Home-based care providers offer various services to patients, including basic nursing care, health and hygiene education, psychosocial-spiritual support, assistance with household duties, monitoring adherence of drug compliance as well as referral to health centres, NGOs and CBOs.

3.2.6 Challenges

- Shortage of funds to implement HBC services
- Lack of tracking system for Lost follow patients linked back to CTC by CHBC providers

CHAPTER 4: TUBERCULOSIS AND LEPROSY SERVICES

4.1 Background

Tuberculosis and Leprosy services were established in 1987 with the aim of facilitating early diagnosis, treatment and cure of Tuberculosis (TB) and Leprosy patients so as to reduce the incidence and prevalence of the disease. All 169 public health facilities and 30 private facilities are providing TB and Leprosy services.

There are two Gene X pert sites (Mnazi Mmoja and Chake Chake Hospitals) which perform TB molecular test and one Public Health Laboratory performing TB culture. A total of 56 (38 Unguja and 18 Pemba) TB diagnostic centres are performing follow up smear examination and 11 health facilities do X-ray services (6 Unguja and 5 Pemba). Nine (5 Unguja and 4 Pemba) CSOs/NGOs are also involved in TB care and control interventions in Zanzibar.

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

Five days of training on TB and diabetes collaborative activities to **46** (20 Pemba and 26 Unguja) participants was conducted. The objective was to build the capacity of health care providers on the provision of comprehensive quality TB and Diabetes collaborative services in health facilities.

Training on adult and paediatric MDR-TB using short course management were conducted to **25** (20 Unguja and 5 Pemba) health care providers. The objective was to build the capacity of health care providers on appropriate management of MDR TB according to the new guideline.

Moreover, five days training on use of audiometric machine was conducted to **13**(12 Unguja and one Pemba) health care providers. The objective was to capacitate health care providers working at MDR TB clinics on use of audiometric machine and enable them to detect effects caused by drugs during treatment.

A one-day sensitization meeting was conducted to **55** (30 Unguja and 25 Pemba) participants on MDR TB case detection. The aim of the meeting was to orient health care providers on MDR-TB case detection through identification of presumptive cases and proper follow up so as to diagnose those with MDR TB and raise awareness on MDR TB in order to improve suspicious index.

In addition, one-day orientation meeting to drug shop sellers on TB prevention and control was conducted to **50** (30 Unguja and 20 Pemba) participants. The objective was to orient drug shop sellers on TB care and control so as to identify TB presumptive cases at drug shops and refer them for investigation at health facilities.

Five days' workshop to review TB/HIV policy guideline was conducted. A total of **18** (15 Unguja and 3 Pemba) participants were involved. The workshop objective was to review and update previous TB/HIV policy guideline (2007) according to WHO recommendations.

Furthermore, **10** days' mentorship on leprosy management for health care workers was conducted in 47 (28 Unguja and 19 Pemba) health facilities. The objective was to enhance capacity of HCWs on early identification and management of leprosy.

4.4.2 Service Monitoring

Quarterly supportive supervision to **141** (88 Unguja and 53 Pemba) health facilities were conducted at all levels, the objective was to assess performance of HCWs on provision of TB/HIV and Leprosy services at their respective sites. The outstanding supervision finding was inadequate TB screening in health facilities. It was agreed to improve screening for all attendees in all health facilities entry points.

Following supportive supervision, feedback meetings were conducted with health care providers to discuss supervision findings and plan a way forward to overcome the challenges identified. Among the issues discussed was low TB suspicious index and inadequate use of TB presumptive registers.

In addition, bi-annual supportive supervision that followed with feedback meetings to CSOs/NGOs implementing community TB care and control interventions in Unguja and

Pemba was conducted. The major concern was improper filling of referral forms and majority had no feedback copies.

Moreover, quarterly TBHIV quality improvement, program and cohort review meetings which involved key stake holders, coordinators, technical support were conducted. The aim of these meetings were to discuss various TB-HIV, MDR TB and leprosy issues including success as well as reviewing MDRTB patients' treatment progress.

TB contact investigation for **348** (281 Unguja and 67 Pemba) bacteriological confirmed TB patients were conducted, where by 1,581 house hold members were reached, given health education and screened, 248 TB presumptive were investigated for TB, among them 40 (11 from Pemba and 29 from Unguja) were diagnosed with TB and 192 under-fives were provided with INH prophylaxis.

4.5 Tuberculosis service indicators and trend from 2016 to 2018

Indicators		**Year**		
		2016	**2017**	**2018**
1.	Number of notified cases all form of TB Bacteriological confirmed plus clinical diagnosed new and relapse cases	723	948	944
2.	Percent of new bacteriological confirmed TB	50%	52%	37%
3	Treatment success rate bacteriological confirmed TB cases	91%	93%	95%
4	Treatment success rate - all new TB cases	93%	92%	95%
5	Percentage of patient who had HIV test result recorded in the TB register	99%	99%	99%
6	Proportion of registered new and relapse TB patients with documented HIV positive status	15%	13%	13%
7	Percent of HIV positive TB patient initiated on ART	88%	95%	96%
8	Percent of HIV positive TB patient on CPT	90%	99%	96%
9	Number of bacteriological confirmed drug resistant TB cases	3	3	7

10	Number of cases with drug resistant TB that began second-line treatment	1	3	7
11	Percent of notified TB cases, all forms contributed by non-NTP providers – community referral	NA	7%	14%

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

The number of notified cases has slightly decreased from **948** in 2017 to **944** in 2018. Among the notified cases **334** (37%) were pulmonary bacteriological confirmed including 7 MDR patients, 364 (41%) pulmonary clinical diagnosed, **199** (22%) extra pulmonary and **26** (2.7%) retreatment cases as shown in the table below. However, the target set of notifying 1,450 TB cases was not reached. This is due to inadequate TB screening and low suspicious index among health care workers.

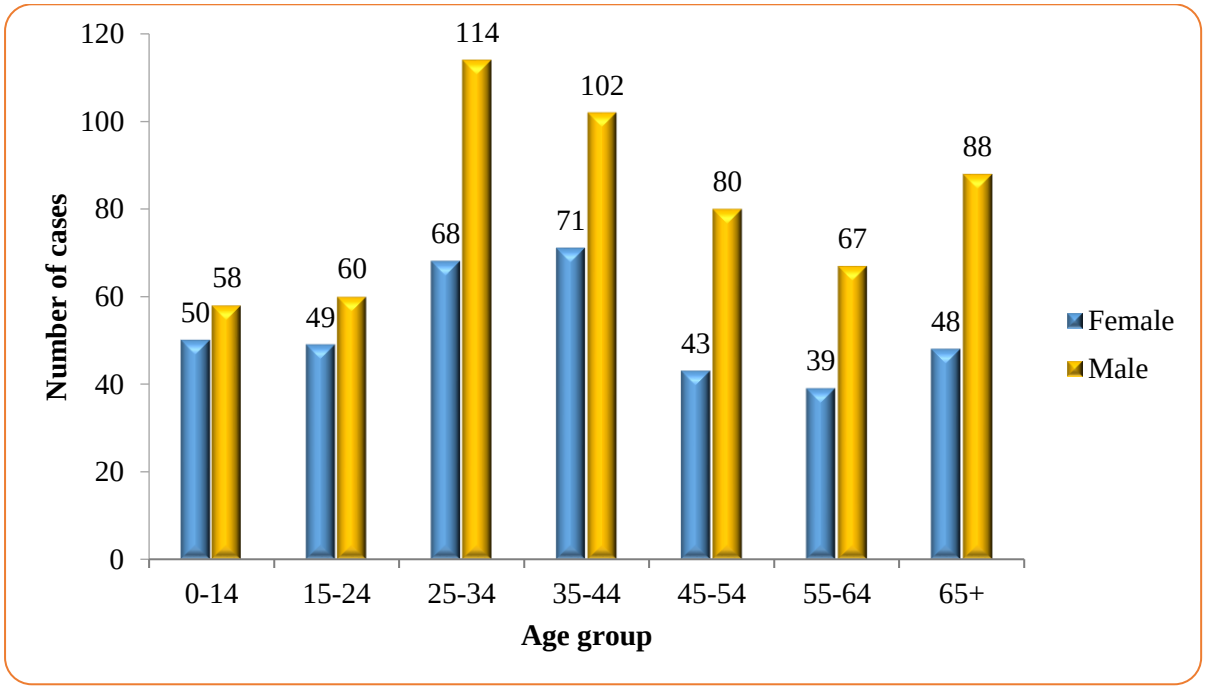
Table 4.1: TB cases notified by type of patient and category, 2018, Zanzibar

Type of patients	Pulmonary Bacteriological Confirmed	Pulmonary Clinically Diagnosed	Extra Pulmonary	Total
New	334	364	199	897
Relapse	15			15
Failure	6			6
Return to control	5			5
Others	0	14	0	14
MDR TB	7	0	0	7
Total	**367**	**378**	**199**	**944**

Of all patients notified in 2018, all sex and age groups were affected, but the most affected age group was 25 – 44 years and the age group of 65yrs and above. The number of children under 15 years of age affected with TB has decreased from **124** (15%) in 2017 to **105** (11%) in 2018.

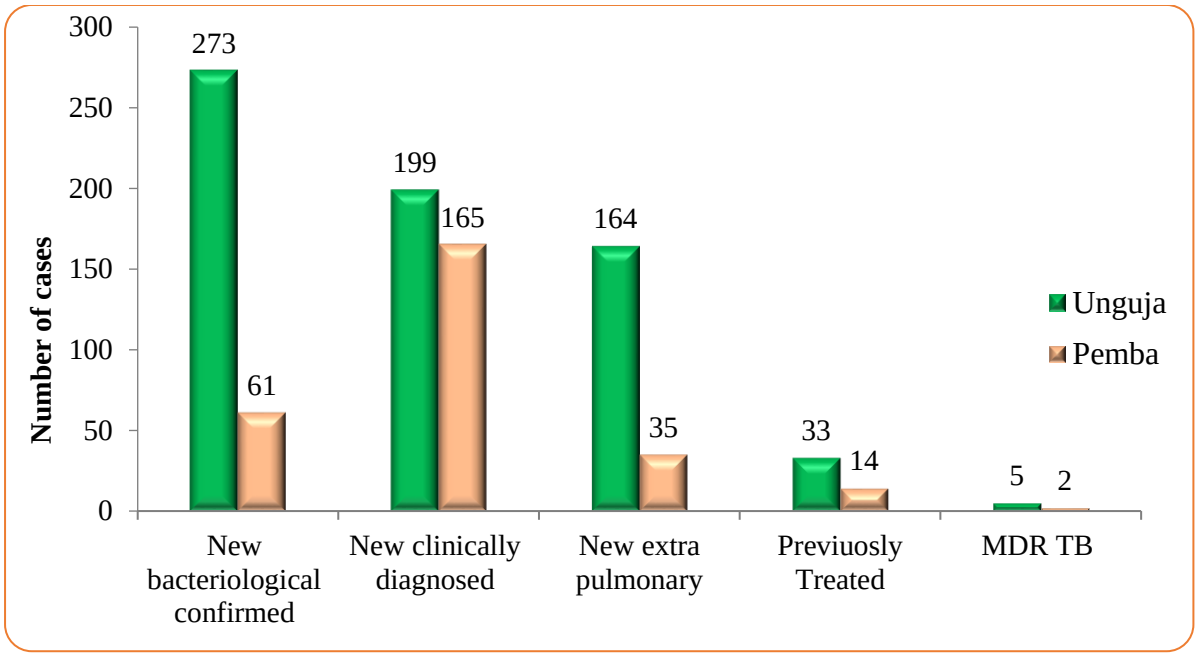
This might be contributed by inadequate capacity of service providers to diagnose paediatric TB. More effort is needed to detect TB in children to reach the WHO target of 15%. Also, it was observed Male is more affected than female.

Figure 4.1.: Age and sex distribution of all TB cases notified Zanzibar, 2018



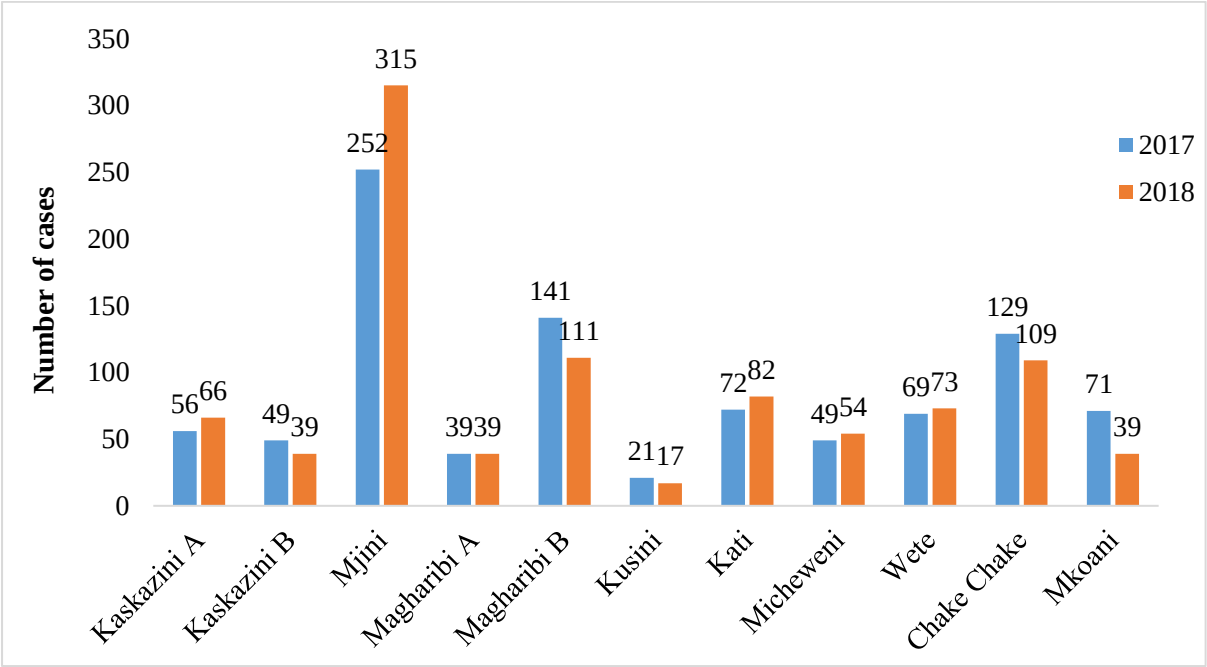
Among **944** patients notified in 2018, **669 (701%)** were in Unguja and **275 (29%)** in Pemba (figure 4.2). The high number of notified patients in Unguja was contributed by effective follow up of engaged private health facilities and CSOs on active case finding and referral of presumptive cases. In addition, a high number of previously treated cases reported in Unguja compared to Pemba. Therefore, the effort is needed to strengthen treatment adherence so as to prevent MDR cases.

Figure 4.2: TB case notification by category and Island, Zanzibar, 2018



There is a remarkable increase in TB case notification in Mjini and Magharibi B in 2018 compared to 2017 while for the other districts the notification has decreased. The increase might be contributed by CSOs and private sectors contribution whereby their intervention is mainly based on two said districts as shown in figure 4.3 below.

Figure 4.3 TB case notifications by Districts, Zanzibar, 2018



2. Percent of new bacteriological confirmed TB

The proportion of new bacteriological confirmed TB has decreased from **52% (493/948)** in 2017 to **35.4% (334/944)** in 2018. The target of 55% was not reached due to delay in sample transportation and inadequate quality of sputum resulting in low yield so as clinician relies on X ray's diagnosis. The most affected age group is adults between 25 to 44 years which was **182 (54.4%)**. Males were more affected **(51.4%)** than Females **(48.4%)** as shown in table 4.2 below:

Table 4.2: Age and sex distribution of new bacteriological confirmed TB case, Zanzibar 2018.

Age Category	Male	Female	Total
0-14	2	3	5 (1.4 %)
15-24	29	25	54 (16.1%)
25-34	63	30	93 (27.8%)
35-44	52	37	89 (26.6%)
45-54	11	32	43 (12.8%)
55-64	6	20	26 (7.7%)
65+	9	15	24 (7.1%)
Total	**172 (51.4%)**	**162 (48.4%)**	**33400%)**

3. Treatment success rate bacteriological confirmed TB cases

A total of **492** bacteriological confirmed TB patients started TB treatment in 2017; among them, **465** were cured, **15** died before treatment completion and **9** transferred out. Therefore, treatment successes rate of bacteriologically confirmed TB cases is 95% which is within the target set. This achievement was contributed by effective patient's sputum sample monitoring and follows up of all bacteriologically confirmed progress.

4. Treatment success rate all new TB cases

The treatment success rate for all new TB cases registered and started treatment in 2017 was **98%** as illustrated in table 4.3 below, which is above the target set of 95%. The success rate has increased compared to 92 % in 2016. The set target of 95% was reached due to the reasons stated above.

Table 4.3: Treatment successes rate for all TB patients registered, Zanzibar, 2018

	Notified	Cured	Treat. comp	Failure	Died	Lost to follow	Not Evaluated	Total
Pulmonary Bacteriologically Confirmed	493	466	0	1	15	2	9	493
Pulmonary Clinically Diagnosed	209		199		7	0	3	209
Extrapulmonary	225		216		5	0	4	225
Relapse	7	4	1	0	1	1	0	7
Failure	3	3	0	0	0	0	0	3
Return	5	4	0	0	0	1	0	5
Others	3		3		0	0	0	3

Treatment outcome for TB patients registered in 2017

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

Among **944** TB patients registered in 2018, among those, **99%** were tested for HIV and result recorded in the TB register. The proportion of TB patient tested for HIV has remained the same as in 2017 which was **99%**. More effort in strengthening counselling on PITC and improving documentation is needed to reach the target of 100%.

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

The proportion of patients who were diagnosed with TB/HIV co-infection in 2018 is 13% (122/944). Among them **78%** were from CTC and **22%** were patients from TB clinics. The proportion remains the same as in 2017. See figure 4.4 below.

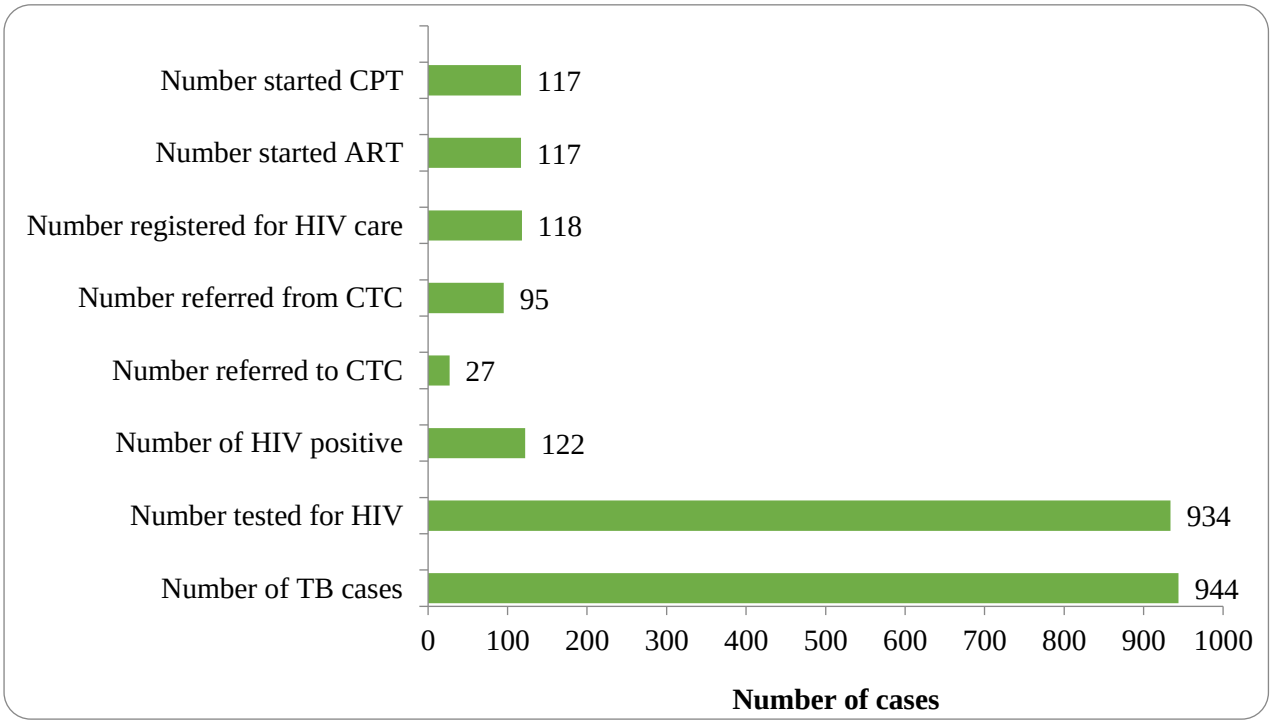
7. Percent of HIV positive TB patient initiated on ART

Among **122** TB/HIV patients diagnosed in 2018, **118** (**97%**) started ART which is above the program target of 96% (figure 4.4). There is an increased proportion of HIV positive started ART compared to 95% in 2017. This increase was due to effective adherence counselling on ART initiation and up to date documentation.

8. Percent of HIV positive TB patient on CPT

The percentage of TB/HIV patients started on CPT is **96%** (117/122), the proportion of TB/HIV patient who started CPT has decreased from 99% in 2017 to 96% in 2018. Five of 122 patients did not start CPT due to sulphur reaction documented.

Figure 4.4: TB/HIV notification, Zanzibar, 2018



9. Number of bacteriological confirmed drug-resistant TB cases

A total of **7** (5 Unguja and 2 Pemba) MDR TB cases were notified in 2018; the number of notified cases has increased from **3** in 2017 to **7** in 2018. This might be contributed by strengthening follow up of MDR TB suspects at the facility level. However, the set target of 10 patients was not reached.

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

All **7** MDR TB cases notified in 2018 started on second-line treatment according to the guideline, the success of beginning second-line treatment for all patients is due to comprehensive counselling.

11. Percent of notified TB cases, all forms contributed by non-NTP providers – community referral

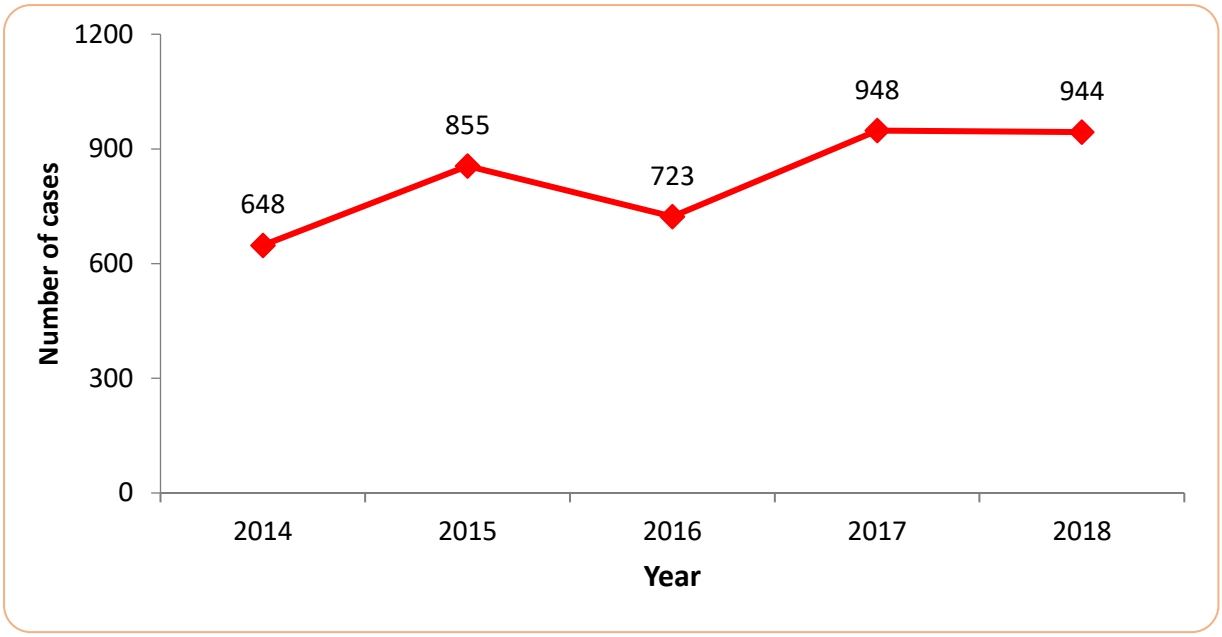
The percentage of notified TB cases all forms contributed by non - national TB program providers (Civil Society organization and private health facilities) is 14% in 2018 compared to

7% of 2017, which is above set target of 13%. This achievement is attributed by engaging private facilities and the involvement of community organizations on active TB case finding.

4.6 Trend of TB case notification from 2014 to 2018

For five years, the number of notified TB cases has generally been increasing. The increase was more remarkable in 2017 as shown in the the figure below.

Figure 4.5: Trend of TB case notification from 2014 to 2018, Zanzibar.



4.3. Leprosy services indicators and trend from 2016 to 2018

Indicators		Years		
		2016	2017	2018
1.	Number of all newly registered Leprosy cases	77	98	82
2.	Percent of MB cases among all new cases	71.8	72.4	70
3.	Percent of children among new cases	19.4	20	18
4.	Percent of WHO disability grade 2 among new cases	9	4	2
5.	Rate of disability grade 2 per 100,000 population	0.4	0.06	0.1
6.	Percent of female patients among new cases	29	39	28
7.	Percent of MB Leprosy patients completing 12 months of MDT amongst those expected to complete their MDT (calculated for 1-year cohort intake)	98	99	98

1. Number of all newly registered Leprosy cases

A total of **82** new leprosy cases were registered in 2018 which is below the set target of 142. This might be contributed by low awareness of the community on leprosy disease and inadequate knowledge of health care workers to diagnose leprosy cases. Of notified cases, **57(70%)** were Multibacillary (MB), and **25 (30%)** were Paucibacillary (PB). The number of leprosy cases diagnosed has decreased from **98** in 2017 to **82** cases in 2018.

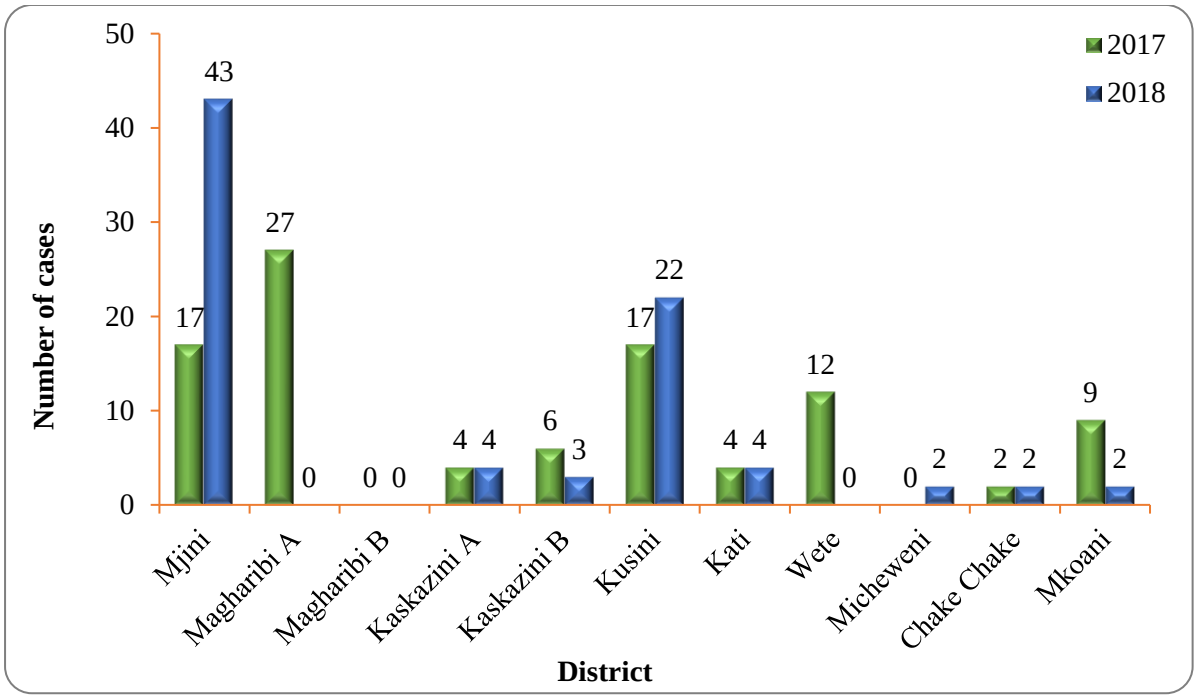
2. Number of notified leprosy cases by Island

Among **82** leprosy cases notified in 2018, **76 (93%)** were diagnosed in Unguja and **6 (7%)** were diagnosed in Pemba. All diagnosed leprosy cases in Pemba were MB. Therefore, special effort is needed to early detection of more leprosy cases in the community, especially in Pemba.

2.1. Leprosy cases by district

The figure below illustrates the number of leprosy cases notified by districts. It has been noted that there is an increase of leprosy case notification in Mjini which contribute **43** (**52%)** of all cases notified in 2018 followed by Kusini districts **22 (27%)** compared to 2017. There is a decrease in the number of notified cases in all districts of Pemba as shown in figure 4.6 below.

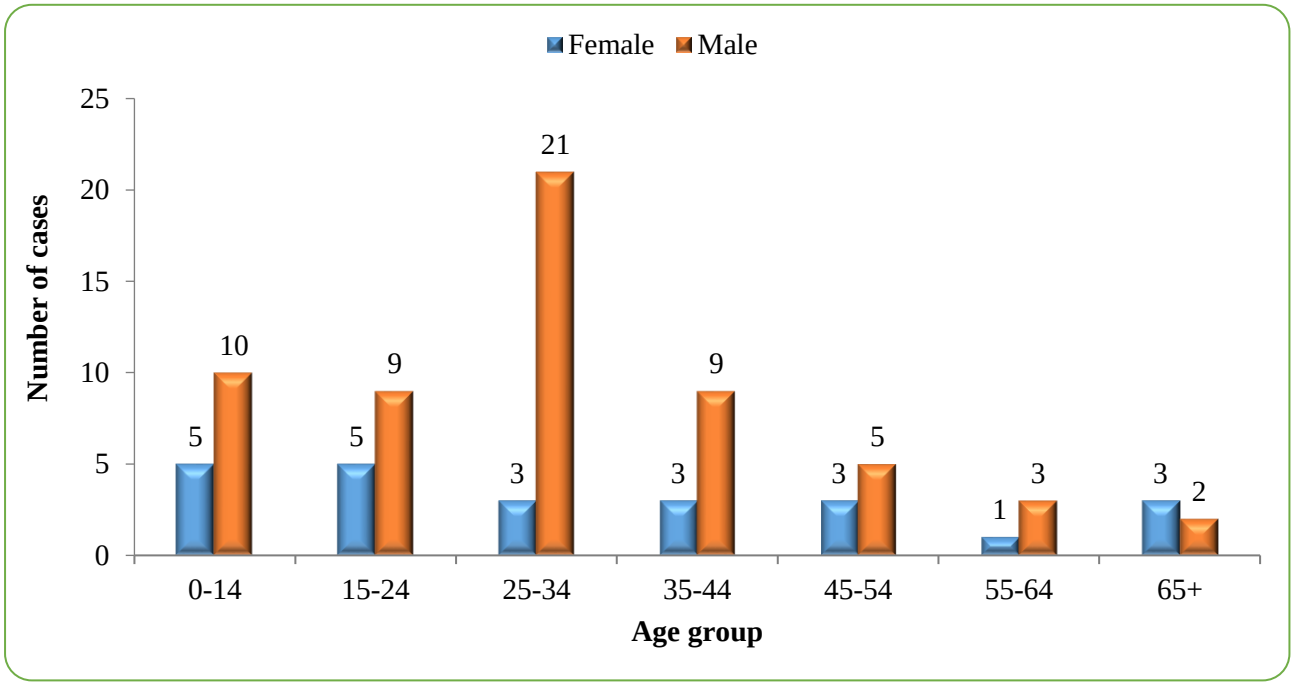
Figure 4.6: Leprosy case notifications by District Zanzibar, 2017 - 2018



2.2. Leprosy notification by age and sex

Among **82** new cases detected, all age groups and sex were affected by leprosy, male with the age group between 25 - 44 male 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 figure 4.7 below.

Figure 4.7: Distribution of age, sex and type of new leprosy cases 2018, Zanzibar.



3. Percent of MB cases among all new cases

The percentage of multibacillary patients, which is infectious and source of Leprosy transmission is **70%** (**57/82**). The percentage has slightly decreased compared to 2017 which was **72.4% (56/77).** This shows that transmission among the community members is still high. Therefore, active case finding interventions are needed to reduce transmission of infection in the community.

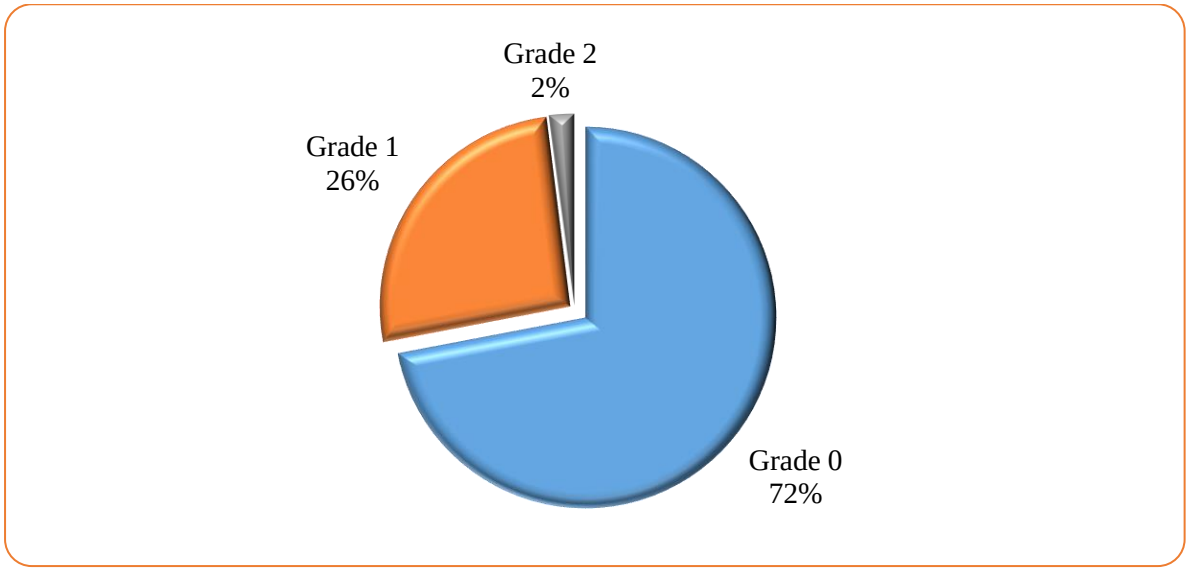
4. Percent of children among new cases

The proportion of children diagnosed with leprosy in 2018 was **18%** (15/82) which is lower than in 2017 which were **20%** (20/98). However, the proportion of children diagnosed with leprosy is still high which is alarming of the infection in the community is ongoing as shown in the figure below:

5. Percent of WHO disability grade 2 among new cases

The percentage of Leprosy cases with disability grade 2 has decreased from **4%** in 2017 to **2%** in 2018. This decrease might be contributed by mentorship conducted to health care workers. See figure 4.8 below:

Figure 4.8: Disability grading for newly diagnosed leprosy patients diagnosed in 2018.



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

The rate for disability grade 2 per 100,000 populations among new cases in 2018 is 0.1, the proportion is tremendously low compared to set a target of 0.35. However, more efforts are needed to detect hidden cases within the community.

7. Percentage of female patients among new cases

Among Leprosy patients identified in this reporting year, the percentage of female patients was 28%. There is a decrease of female patients detected in 2018 as compared to 39% in 2017.

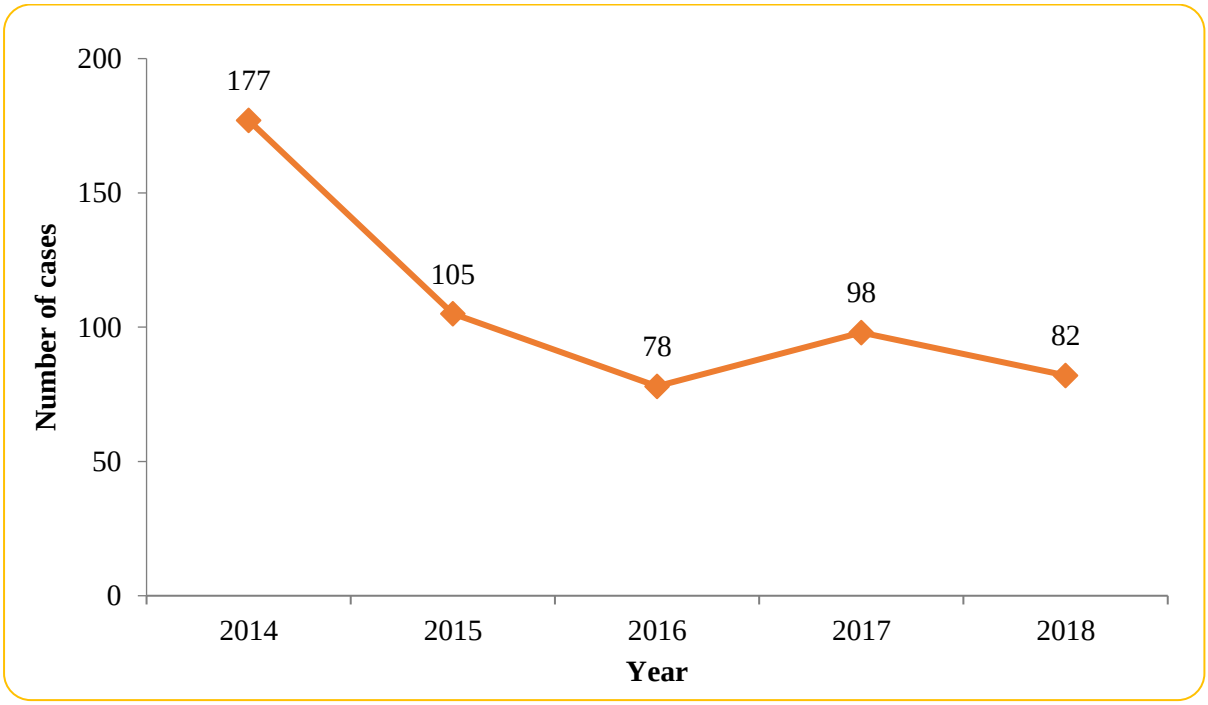
8. Percentage of MB leprosy patients completing 12 months of MDT amongst those expected to complete their MDT.

A total of **57** MB leprosy patients started treatment in the year 2016. Out of them, 56 (98%) completed their treatments and 1 (2%) was out of control. Following treatment, 20 (36%) MB patients improved their disabilities while 36 (64%) had no change.

4.8 Trend of Leprosy case notification from 2014 to 2018

Leprosy case notification has generally decreased from 2014 to 2018; as shown in figure 4.9

Figure 4.9: Trend of Leprosy cases notification from 2014 to 2018, Zanzibar



4.9. Challenges

- Inadequate TB screening in health care facilities including CTC, diabetes clinic and RCH
- Inconsistent documentation of TB screening at health facilities
- Limited access to X-ray facilities for TB presumptive clients
- Inadequate knowledge of health care workers on leprosy cases identification

CHAPTER 5: HIV AND TB LABORATORY SERVICES

5.1 Background

The laboratory services are key components of quality health care services, 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 13 laboratories (9 Unguja and 4 Pemba) which support monitoring of HIV care and treatment services. Furthermore, laboratory supports includes 141(92 Unguja49 Pemba) HTS sites,158 (92 Unguja 66 Pemba) PMTCT sites, 56(38 Unguja 18 Pemba) TB diagnostic sites and Public Health Laboratories (PHL) in Pemba which serves a reference laboratory for TB culture.

5.2 Goal

The goal is to improve laboratory infrastructure at the national and district levels, establish viral load testing and to enable the proper collection of samples.

5.3 Objectives

1. To Increase laboratory capacity to perform quality HIV diagnostic and monitoring tests including diagnosing co-morbidities
2. Increased capacity to perform HIV Viral load
3. To expand proficiency testing to all HIV services delivery points
4. To expand the scope of the Strengthening Laboratory Management Towards Accreditation (SLMTA) to regional and district levels

5.4 Program Implementation

5.4.1 Capacity building

A five days training for laboratory staff on the diagnosis of HIV-DNA (EID) and HIV Viral load using gene Expert machine was conducted for **33**(28 Unguja and 5 Pemba) laboratory technicians from MnaziMmoja and ChakeChake hospitals. The objectives were to impart knowledge and skills on how to run GeneX pert HIV-1 VL, HIV 1 Qual, X pert, identification of appropriate specimen types, laboratory safety precautions and proper transportation to the testing sites.

A one-day refresher training on HIV proficiency testing was conducted to **103** (75 Unguja and 28 Pemba) health care workers from HIV testing sites. The objective was to improve health care worker's skills on performance and reporting of HIV proficiency testing.

In addition, two laboratory technicians from the Public Health Laboratory (PHL) were capacitated for one week on how to perform TB Drug Sensitivity Testing (DST) at Central TB Reference Laboratory (CTRL). Furthermore, a mentor from CTRL was allocated at PHL for two weeks in order to monitor the practical session of the trainees.

5.4.2 Service monitoring

Quarterly supportive supervision was conducted at **56**(38 Unguja 18 Pemba) TB diagnostic sites. The objective of the supervision was to support HCWs to improve diagnostic services and solve problems which were identified and provide support. The major concern was the delay of sputum collection and transportation to the Gene Xpert sites which leads to low TB case detection.

Quarterly Supportive supervision was conducted at all 13(9 Unguja 4 Pemba) HIV CTC laboratories. The objective was to ensure the provision of quality laboratory service delivery. It was found that there was persistence delay of sample transportation for HVL from sites to testing laboratories which leads to delayed management of patients.

5.5 Laboratory services indicators and trend from 2016 to 2018

Indicator	**YEAR**		
	2016	**2017**	**2018**
1. Number of laboratories engaged in continuous quality improvement activities and achieved accreditation	1	1	1
2.Number of laboratories with the capacity to perform HIV Viral load testing	NA	1	2
3.Percentatge of testing sites with satisfactory performance in EQA/PT	90% (28/31) (17 PMTCT &14 HTC sites)	86.3% (145/168) (79 PMTCT & 89 HTS sites)	50.6% (42/83) (52 PMTCT & 31 HTS sites)
4 Percentage of sputum samples transported to gene expert for TB diagnosis	55.6% (2737/4914)	57.7%(3627/6280)	91 % (7,991/8751)

1. Number of laboratories engaged in continuous quality improvement activities and achieved accreditation

Mnazi Mmoja Pathology Laboratory obtained accreditation using ISO15189 standards. Efforts are ongoing to ensure that the accreditation at MnaziMmoja is maintained.

2. Number of laboratories with capacity to perform HIV viral load (HVL) testing

There was an increased number of laboratories which perform HVL from one laboratory (MnaziMmoja) in 2017 to two in 2018 (MnaziMmoja & Chakechake) which have capacity to perform HVL. The set target of two sites for 2018 was attained. This achievement was due to the installation of new Gene Xpert machine and capacity building for respective laboratory technicians. In 2018, a total of **5,995** samples from all 13 CTC were collected and sent to these laboratories for viral load testing. Sample transportation is made by health care workers who are trained in handling of infectious materials. Results are as shown in the table below:

Table 5.1: Number of HIV Viral Load samples tested, Zanzibar, 2018

QUARTERS	Total collected	Sample transported	Results returned	Below 1000 copies	Above 1000 copies	Target not detected (TND)	Failed	Not Returned
Jan - March	1473	1473	1458	368	225	850	31	8
Apr - June	1514	1514	1514	428	289	778	24	18
July- Sept	1495	1495	1495	503	305	687	0	0
Oct - Dec	1513	1513	1513	491	232	788	2	0
TOTAL	**5995**	**5995**	**5980**	**1780**	**1051**	**3103**	**57**	**26**

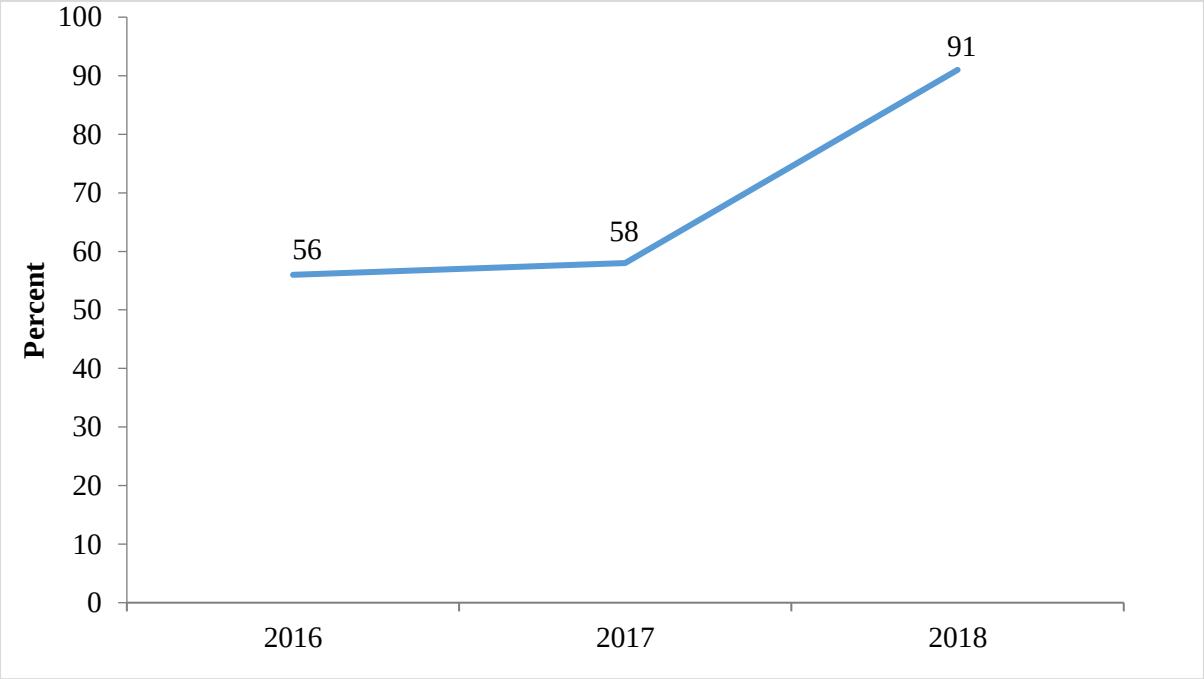
3. Percentage of testing sites with satisfactory performance in EQA/PT

There was a decrease in satisfactory performance of proficiency testing among participating sites in 2018 from **86.3%** 2017 to **50.6%** in 2018 which is below the target set in M&E plan III which is 95%. This was due to the introduction of new electronic SMS system which replaced paper based in which health care workers had a challenge in sending correct codes in the system.

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

There was an increase in percent of sputum samples transported to Gene Xpert testing sites from**57.6 %(3,627/6,280) in 2017 to 91 %**(7,991/8751) in 2018. The target set of 90% in the TB National strategic plan II (2015-2019) was reached. This was the results of an enhanced sample transportation process using local sample transporters (BodaBoda) from the health facilities to Gene expert testing sites. However additional efforts are needed to improve the quality of sputum samples transported.

Figure 5.3: Percent of sputum samples transported to Gene Xpert sites for TB diagnosis Zanzibar, 2016-2018



5.6 Challenges

- Delay of some sputum samples to reach at testing sites which leads to poor quality and rejection of samples which affect patient management.
- The poor performance of health care workers in HIV proficiency testing.

CHAPTER 6: INFORMATION, EDUCATION AND COMMUNICATION (MISSED)

6.1 Background

Information, Education and Communication/Behavioural Change Communication (IEC/BCC) is one of the ZIHHTLP unit responsible for creating awareness and facilitates behavioural change that put individuals at risk of contracting or transmitting HIV, STI, Hepatitis, TB and Leprosy in the community. ZIHHTLP recognizes that information and education for behaviours change to communities are crucial in improving health status of Zanzibar population. The Programme through IEC/BCC unit is expecting to further strengthen its activities on HIV/AIDS, Hepatitis, 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 printing materials on HTS, PMTCT, CTC and STI

A five-days' workshop to develop IEC/BCC materials on HTS, PMTCT, CTC and STI was held at Unguja. with objective to review and design Programme services IEC materials which would help in promoting HIV services. A total of 22 participants (19 from Unguja and 3 from Pemba) participated. The aim of this workshop was to review and develop new IEC materials focusing on HIV services. Following the workshop, the materials were pretested to improve them for further process before printing.

Participants were able to develop **four** types of pamphlets, **three** posters, **three** factsheets and **two** stickers. At the end, IEC materials were developed. These are;

A) Care and Treatment

1. Poster 1: “Acha Kujinyanyapaa”
2. Poster 2: Toa huduma rafiki kwa wanaoishi na VVU
3. Brochure 1: Dumu kwenye matibabu ya VVU
4. Brochure 2: "Tumia njia za uzazi wa mpango za muda mrefu”
5. Poster:1 “Tumia njia za uzazi wa mpango za muda mrefu”

B) HIV Testing Services

1. Poster 1: Umuhimu wa huduma za “PITC”
2. Poster 2: Rufaa ya WAVIU kwenda kliniki ya huduma na Tiba
3. Brochure: Rufaa ya WAVIU kwenda kliniki ya huduma na Tiba

C) Sexual Transmitted Infections

1. Poster: Ushiriki wa wanaume kwenye huduma za magonjwa ya kujamiiana
2. Brochure: Ushiriki wa wanaume kwenye huduma za magonjwa ya kujamiiana
3. Brochure: Uelewa kuhusiana na magonjwa ya kujamiiana

D) Prevention from mother to child HIV Transmission

1. Brochure: Ufuasi wa dawa za kupunguza makali ya VVU
2. Poster 1: Ushiriki wa wanaume kwenye kuduma za PMTCT
3. Poster 2: Njia za kumzuia mtoto asipate maambukizi ya VVU
4. Sticker: Ushiriki wa wanaume kwenye kuduma za PMTCT

2. Conduct bi-annual meeting with ACSM group to coordinate involvement of CSO’s and NGO’s in TB and Leprosy control

Two follow up meetings of two sessions (2 in Unguja and 2 Pemba) to ACSM members was conducted. A total of **69** participants **(35** in Unguja and **34** in Pemba**)** participated. The objective of the meeting was to facilitate coordination of ACSM interventions within the community. The participants included members from Health Promotion Unit, Civil Society Organizations, Media personnel’s, District Administrative Secretary, District AIDS committee and Public Health Officers.

3. Commemorations of the World TB Day

Commemoration of World TB day was held on 24th March, 2018. The theme of this year was **"Wanted: Leaders for a TB free world"- "Tunahitaji viongozi wenye ari ya kutokomeza Kifua Kikuu Duniani"**. During commemoration the TB seminar was conducted to councillors, members and staff of House of Representative on the current TB situation in Zanzibar. Preceding the commemoration day, press conference was held whereby the Minister for Health present the theme of the year and planned strategies.

4. Meeting with Key Community Leaders to Discuss About Male Involvement in ANC Services

Four session of one-day meeting on male involvement in ANC services were conducted in each district of Pemba with objective to raise awareness of the community members through sensitization on the importance of male involvement in ANC/PMTCT services. A total of 120 participants, 30 from each district (Mkoani, Wete, Chake chake and Micheweni districts) include community leaders, religious leaders, and influential persons in the community, council's officials including the participants from Council Health Management Team and media personels including journalists.

5. Workshop to develop Radio and Television spots

A three days' workshop to review and develop TB/Diabetic, MDR-TB and Hepatitis Radio and TV spots was conducted in Unguja with the aim to raise awareness on MDR-TB, Hepatitis B and C and relationship between TB and Diabetic in general population. A team of 18 professionals from ZIHHTLP, Health Promotion Unit, Media personnel and artists from Theatre for Social Development (THESODE) participated in the workshop.

6. Airing of Radio and Television spots

Different messages for Radio and Television spots (1 TV and 3 Radio spots) were aired in 1 TV and 3 Radio stations for period of 6 months. The messages (spots) focused on awareness on Hepatitis B and C, MDR-TB and Relationship between TB and Diabetes.

7. Conduct workshop to develop IEC MATERIALS focusing on TB, TB/HIV, MDR-TB, TB/Diabetic and Hepatitis-Unguja

A five-days' workshop to develop IEC/BCC materials on focusing on TB, TB/HIV, MDR-TB, TB/Diabetic and Hepatitis was held at Unguja. A total of **20** participants **(17** from Unguja and

3 from Pemba) participated. The aim of this workshop was to develop new IEC/BCC materials focusing on TB and Hepatitis services. Following the workshop, the materials were pre-tested, printed and distributed to target populations.

Participants were able to develop **four** types of pamphlets, **three** posters, **three** factsheets and **two** stickers as described below;

A) Pamphlets

1) "Fahamu Kuhusu Homa ya Ini B na C "
2) "Tambua kuhusu Kifua Kikuu Sugu"
3) "Tambua uhusiano kati ya Kifua Kikuu na Kisukari-Jamii"
4) "Tambua uhusiano kati ya Kifua Kikuu na Kisukari-Wahudumu wa afya"

B) Posters

1. "Kumkinga mteja asipate maambukizi ya Homa ya Ini B na C"
2. "Ufuasi Mzuri wa Dawa za Kifua Kikuu"
3. "Fahamu Uhusiano kati ya Kifua Kikuu na Kisukari

C) Factsheets

1. "Watunga Sera wawe mstari wa mbele Kutokomeza Homa ya Ini B na C"
2. "Fahamu Ukweli kuhusu Kifua Kikuu sugu"
3. "Fahamu uhusiano kati ya Kifua Kikuu na Kisukari"

D) Stickers

1. **"**Kifua Kikuu Sugu kinatibika, kuwa na ufuasi mzuri wa matibabu**"**
2. "Sambaza taarifa, usisambaze Kifua Kikuu"

8. Workshops to develop TB Advocacy, Communication and Social Mobilization (ACSM) Strategy

ZIHHTLP through IEC/BCC Unit hired Lead and Local consultant to lead the process in the development of TB ACSM Strategy with the aim to increase public awareness on TB and finally increase TB case detection in the community. In the development process, consultants presented Inception report to TWG, later prepared first draft which was presented to stakeholders for further inputs. Following that, final ACSM draft was prepared before finally disseminated to stakeholders.

6.5 CHALLENGES

- Inadequate fund to implement IEC/BCC interventions.

7.0 MONITORING AND EVALUATION OF HIV, HEPATITIS, TB AND LEPROSY SERVICES

7.1 Background

Strategic Information (SI) unit of ZIHHTLP with the collaboration of Health Management Information System (HMIS) unit of Ministry of Health (MoH) is the custodian of health sector HIV, TB, Hepatitis and Leprosy data in Zanzibar. The unit is coordinating, collecting, storing, retrieving, and analysing data from various interventions including Care & Treatment, HIV surveillance, PMTCT, HIV counselling and testing, Home Based Care, Laboratory, STI, KP, Youth, TB and Leprosy services.

7.2 Goal

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

7.3 Objectives

- To strengthen the M&E System in HIV related services
- To execute Surveillance and operational research plans on the field of HIV/AIDS
- To improve the quality of HIV data at all levels
- To provide guidance on collection, processing, use and sharing of TB &Leprosy data for decision-making at all levels.
- To provide a framework for measuring the outcomes and impact of TB &Leprosy interventions in Zanzibar

7.4 Implementation and M&E system performance

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 goal is to establish and maintain a network of institutions responsible for HIV, Hepatitis, TB and Leprosy M&E at the national, district and service-delivery levels. The SI unit has staff responsible to perform M&E functions including SI coordinator, Epidemiologist, Bio-statistician, M&E officer, Data managers, IT officer and Data clerks. This staffs have clearly defined job descriptions coupled with M&E roles and responsibilities. Also, each staff is assigned a service to provide technical assistance on M&E related issues. At district level, the unit works closely with Council Health

Management Teams (CHMTs) especially District Data Managers (DDMs), who are responsible for collection of reports from service delivery sites and data management at district level.

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, complete, and timely). Supportive supervision for different services was conducted quarterly by service coordinators accompanied by other technical and S.I officers within the programme.

Component 3: Human Capacity for M&E

The goal of human resource capacity building for M&E is to establish adequate skilled human resources at all levels of the M&E system.

3.1 Data Management workshop to CTC data clerks& SI officers

Five days' workshop on CTC2 data management to 30 (25 Unguja and 5 Pemba) data clerks and SI officers was conducted. The objectives were to orient these staff on various issues on data management, data quality and data use for program activities

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 of this component 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, ZIHHTLP worked with different local and international partners on the following M&E activities:

- GF provided fund to support the implementation of operational researches and ANC surveillance
- UCSF provided technical assistance and financial support to develop the Integrated Biological Behavioural Surveillance Survey (IBBSS) protocol and actual implementation of the study
- THPS supported HIV/STIs monitoring tools, CTC data management and data review meetings

- MDH provided technical assistance on updating CTC2 database and development of CTC3 macro database
- MEASURE EVALUATION provided technical assistance and financial support on the development of M&E plan
- UNAIDS provided technical assistance in updating 2017 spectrum file for HIV estimates and projections.

Component 5: Monitoring and Evaluation Plan

Five years M&E plan for 2017-2022 that aimed at measuring the level of implementation of Zanzibar Health Sector HIV Strategic Plan III (ZHSHSPIII) was developed. Implementation of the M&E plan will provide strategic information that will be used for planning and decision-making purposes.

Component 6: Survey and surveillance

This entails how frequently relevant national surveys are conducted in the country. National surveys and surveillance needs to be conducted frequently and used to evaluate the progress of related projects.

In 2018, the programme has managed to do the following;

6.1 TB Prevalence study among high-risk groups

6.1.1 Protocol development

Protocol for TB Prevalence study among high-risk groups was developed and submitted to ZAMREC for approval that allowed starting data collection.

6.1.2 Data collection training

Two days' data collection training was conducted to30 (20 Unguja and 10 Pemba, data collectors. The objective of the training was to orient data collectors on the TB Prevalence study among high-risk groups (its objectives, methodology and data collection tools), to pre-test and revise data collection tools before actual data collection.

6.1.3 Data collection

Data collection was conducted for two weeks at selected diabetes clinics and correctional facilities. Data collectors were assigned to collect data based on the set sample size from each selected site.

6.1.4. Data analysis workshop

A five days' data analysis workshop to 20 participants from Unguja on TB Prevalence study was conducted. The objectives of this activity were to do analysis on collected data that aimed at establishing the prevalence of Tuberculosis and associated risk factors among Diabetic patients and Prisoners in correctional facilities in Zanzibar.

6.2 ANC surveillance for pregnant women

6. 2.1 Protocol development

Protocol for ANC surveillance for pregnant women was reviewed and submitted to ZAMREC for approval that allowed starting data collection.

6.2.2 Data collection training

Two days training on ANC surveillance data collection was conducted in 2 sessions, one in Unguja and one in Pemba, which involved 69(42 Unguja and 27 Pemba) HCWs. The objective of the training was to orient data collectors on the ANC surveillance protocol, how to recruit participants, filling of questionnaires, collection and processing of blood samples as well as filling of the lab request forms.

6.2.3 Data collection

Data collection for ANC surveillance was conducted for 12 weeks in 20 sentinel sites (12 in Unguja and 8 in Pemba). The objective of this activity was to collect data on ANC surveillance among pregnant women at identified ANC sentinel sites. Moreover, at each site, two RCH care providers and one lab technician were engaged in data collection. The methodology included link anonymous testing where results are returned to clients and services provided for identified HIV positive clients

6.2.4 ANC surveillance data management

One-day training on ANC surveillance data management to six (6) data entry clerks was conducted. The objectives of the training were to orient them on the ANC surveillance tools (questionnaires and laboratory request forms), how to enter the data into EPI Info (version 3.5.4) database, as well as orient them on the process of cleaning the data. Following the training, the data entry clerks started data entry using double entry approach.

6.2.5. Data analysis workshop

A five days' data analysis workshop to 20 (15 Unguja and 5 Pemba) participants were attended. The objectives of this activity were to do analysis on collected data that aimed to determine HIV,

syphilis, Hepatitis B and Hepatitis C prevalence among pregnant women in selected surveillance sites and to produce data to guide HIV/AIDS/STIs prevention and control efforts in Zanzibar.

6. 3 Rapid Assessment for KPs in Pemba

A rapid assessment was conducted to characterize risk factors among KPs in Pemba and to assess their access to and utilization of HIV and STI services. The study populations were FSW, MSM, PWID and non-KP key informants from three selected districts (ChakeChake, Wete and Mkoani).

The methods were mixed including; qualitative methods (Key informant interviews with KPs and non-KPs, focus group discussions and individual in-depth interviews); quantitative methods (socio-demographic and risk behaviour survey) and rapid testing for HIV, HBV, HCV and syphilis. The findings of the rapid assessment are attached as in Appendix III.

6.4 Integrated Biological Behavioural Surveillance Survey (IBBSS) among KPs in Unguja

6.4.1 Formative Assessment for MSM and FSW

A formative assessment (FA) for MSM and FSW was implemented as part of the third round of IBBS with MSM, FSW, and PWID in Unguja, Zanzibar. The objectives of the FA were to identify potential seeds for the Respondent Driven Sampling (RDS), pre-test the survey instrument and determine the appropriate amount to compensate participants for their time spent participating in the survey and their transport to the IBBS survey site. It included peer educators, gatekeepers, NGO staff, members of civil society organizations and KP advocacy groups.

6.4.2 Unique objects Training & distribution

This activity was done as part of estimating the size of MSM and FSW in the upcoming third round of IBBSS. A total of **15** (7 MSM and 8 FSW) peers from different NGOs implementing KP interventions attended one-day training sessions. Thereafter, unique objects were distributed by peers for five days. A total of **1,245** (430 MSM and 815 FSW) key chains, were distributed in different venues where MSM and FSW are congregated.

Component 7: Routine monitoring

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

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

7.1 Monitoring tools review meeting

Five days' workshop to review HIV/STI and TB monitoring tools was conducted. A total of **19** (18 Unguja and 1Pemba) participants attended the workshop. The objectives were to review the existing monitoring tools including the registers and monthly summary report based on additional new indicators that the program is required to report on. A total of **5** services tools were reviewed, printed and distributed.

Component 8: National M&E databases

The Health Management Information System (HMIS) maintains a DHIS2 database which stores most of the data across all health sector programs including the HIV/STI, TB and Leprosy services data. This database is regularly updated based on the need of the program. ZIHHTLP staff has access to the DHIS2 database through a web-based interface. Despite of being integrated into the HMIS system, the program hosts some database to track aggregated data as needed. These include:

- HTS- This is the case by case HIV Testing services (HTS) surveillance database using EPI Info software. Data for this database is collected directly from facilities to ZIHHTLP for entry. Data entry is done on a daily basis, cleaning on a monthly/quarterly basis while the analysis, presentation and interpretation are done on quarterly, semi-annually and annual basis.
- CTC- In all CTC sites electronic database has been installed whereby data clerks directly enter patient-level data and quarterly reports are generated and sent to ZIHHTLP office. Currently, the CTC database has two different versions (SQL server and MS Access). However, the initial plan has been made to develop CTC3 macro database that will be used to aggregate CTC data from different health facilities. In addition, data generated from the macro database will be integrated into the HMIS system through exporting files for further analysis.

Component 9: M&E advocacy, communication and culture

This refers to the presence of policies and strategies within the organization to promote M&E functions. The goal of this component is to ensure knowledge of and commitment to HIV, TB and Leprosy M&E among policymakers, program managers, program staff and other stakeholders.

Commitment to M&E activities exists within ZIHHTLP whereby it is well reflected in national strategic plans and annual work plans. Furthermore, HIV, TB and Leprosy information is requested by different stakeholders. However, M&E system information products are largely disseminated within the health care system and not to the public e.g. through newsletters and website.

Component 10: Evaluation and Research

This component involves the identification of key questions for research and evaluation; coordinate studies to respond to identified needs and promote the use of evaluation and research findings. However, there were no evaluation or operational research conducted in the year 2018.

Components 11: 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 program planning and improvement. Several dissemination meetings were conducted and reports produced for informing the stakeholders on the status and the level of implementation of various services as follow:

- Two dissemination meetings to **70** (40 in Unguja and 30 Pemba) participants were conducted. The objective was to share findings of the 2018 ANC surveillance survey among pregnant women to key stakeholders. Participants recommended that HIV trend analysis should be included in the ANC surveillance report.
- Two dissemination meetings on TB among diabetes Miletus patients and students in correctional facilities were conducted to **70** (40 Unguja and 30 Pemba) participants to share findings and recommendations for TB service improvements
- Preparation of 2017 annual report whereby **500** copies were printed and distributed to stakeholders.
- Preparation and sharing of quarterly narrative progressive and details indicators performance-based reports for tracking HIV and TB health sectors responses has been

done and submitted to MOH, ZAC and other HIV stakeholders. These reports include BangoKitita, PUDR, PU and dashboard reports.

- Two days' data review meeting with program staffs and other stakeholders was conducted. The meeting involved **80** (50 Unguja and 30 Pemba) participants from ZIHHTLP, DHMTs, HTS, PMTCT, CTC, KP and TB providers and ZAPHA+. Data from different units were presented and discussed

11.1 Data use

HIV/TB and leprosy data were used for planning purposes e.g. designing interventions, prioritization, and resource allocation and setting targets. In the year 2018, the programme has used data for various activities including the following:

- Tracking patients on HIV care and treatment that are lost to follow up and return them to care.
- Tracing HIV positive pregnant women and their exposed infants who are lost to follow up
- TB and Leprosy contact tracing
- Preparing a spectrum file that is used for HIV projection.

However, the use of data for service improvement at councils and health facilities levels was still inadequate and needs further strengthening.

7.5. Strategic Information Indicators, 2016-2018

Indicator	YEAR		
	2016	**2017**	**2018**
1. Percentage of health facilities submitting HIV/AIDS report in a timely way into DHIS 2	47%	54.3%	TBD
2. Percentage of health facilities which submitted HIV report into DHIS 2	75%	82.7%	TBD
3. Number of HIV and TB surveillances conducted	NA	NA	4
4. Number of HIV operational researches conducted based on national HIV health sector research agenda	0	1	0
5. Number of HIV data review meetings conducted at district and facility levels	0	2	2
6. Number of HIV information dissemination products produced and disseminated by ZIHHTLP	NA	2	2
7. Proportion of health facilities with DQA conducted at least every 6 months	N/A	N/A	0

TBD**: ***Data are not available due to unavoidable circumstances of DHIS2 to be offline

1. Number of HIV and TB surveillances conducted

A total of four surveillances were conducted during the reporting time (ANC surveillance, IBBSS for KPs, TB prevalence studies among diabetes and correctional facilities). This reflected an achievement of the 2018 M&E target which required at least one HIV surveillance to be conducted.

2. Number of HIV operational researches conducted based on national HIV health sector research agenda

No operational research was conducted during this period. Hence, we didn't achieve the target set of conducting at least one HIV operational researches.

3. **Number of HIV data review meetings conducted at district and facility levels**

Two data review meetings were conducted at the district and facility level. However, we didn't achieve the target set of conducting 4 data review meetings due to inadequate fund.

4. **Number of HIV information dissemination products produced and disseminated by ZIHHTLP**

Two information dissemination products were produced and disseminated by ZIHHTLP. This aligns with the M&E target set for 2018 of producing two information dissemination products. These products include the 2017 annual report and ANC surveillance.

5. **Proportion of health facilities with DQA conducted at least every 6 months**

DQA was not conducted in any health facility in 2018due to inadequate funds.

7.5 Challenges

- Lack of programme website for knowledge management and information sharing
- Inadequate use of data for service improvement at councils and facility level
- Shortage of funds to support data verification and supporting supervision at health facilities and district levels
- Shortage of fund to support HIV/TB/STI data review meetings

CHAPTER 8: PROGRAMME MANAGEMENT AND FINANCE

8.1 Background

The principal role of the Programme Management Unit (PMU) is to coordinate and support other programme units to implement technical roles by ensuring the availability of necessary requirements to execute their duties effectively. In addition, it oversees all administrative, programmatic 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, compiling technical reports and submission to the Ministry and stakeholders. It is also responsible to ensure proper implementation of programme work plan towards meeting programme objectives.

8.2 Goal

The goal of the programme management unit is to strengthen programme management and coordination for effective implementation of HIV, Hepatitis, TB and leprosy strategic plan

8.2 Objectives:

i. Developing human resource capacity at all levels

ii. Ensure alignment of partners in implementing HIV, Hepatitis, TB and leprosy interventions

iii. Improve office infrastructure to accommodate all staff and other needs

iv. Maintain higher performance of ZIHHTLP central office

v. Increase efficiency, resource mobilization capacity and accountability of ZIHHTLP

vi. Existence of a well-functioning Procurement Management Unit with sufficient capacity to perform procurement functions

vii. Improved safe storage and efficient distribution of quality health commodities that will guarantee last mile accessibility and availability

viii. Existence of well-coordinated and functional logistics management systems at all levels of the supply chain

ix. Improved information sharing and knowledge amongst supply chain

x. Community access to safe and quality medicines and medical supplies ensured

8.3 Planning and administration

Programme Management Unit is responsible for: Policy guidance; Planning and budget; Human resource management; Capacity building; Inter and Intra Coordination; Procurement and provision of logistics; Financial management; and 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, Hepatitis, 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 prepared and developed the TB/HIV guideline and developed SOP on HIV positives adolescent services.

8.3.2 Planning and budget

In this financial year of 2018, the programme prepared a comprehensive work plan and budget that includes Government and various HIV, Hepatitis, 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 was then submitted to the Ministry of Health for submission to the Ministry of Finance and presentation to the House of Representatives for approval. In addition, reprogramming of the planned activities was done from the saving of the budget allocated in accordance with programme priorities.

8.3.3 Human resource management

Majority of ZIHHTLP 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 a contractual basis. By December 2018, a total of 8**2** staff (73 Government and 9 on contractual basis) with different specialities were working in the programme.

8.3.4 Capacity building

During the reporting period, technical staff from the programme participated in long and short term National, Regional and International Conferences/Meetings/Exchange visits/Training funded through HIV, Hepatitis, TB and Leprosy partners. These include the following:

- International Meetings and Conferences

- 5th TB Conference in South Africa (1 Participant)
- 22th International AIDS Conference Amsterdam Netherland (1 Participant)
- 49th Union World Conference on TB and Lung Health at The Hague Netherlands (2 Participants)
- East Africa Community HIV, TB and STI related meetings (3 Participants)

- Training
  - MSc Project Management, Monitoring and Evaluation in Health (1participant)
  - MSc in Procurement and Supply Chain Management (1 Participant)

8.3.5 Inter and Intra Coordination

ZIHHTLP has continued to collaborate with development partners to support the implementation of HIV, Hepatitis, TB and Leprosy activities at all levels. Outlined in Table 8.1 below are the partners which provided technical support to ZIHHTLP during the year 2018.

Table 8.1: ZIHHTLP Technical Support by Partners, Zanzibar, 2018

NAME OF PARTNERS	TECHNICAL SUPPORT PROVIDED
1. KNCV	• Support in strengthening TB and TB/HIV data quality
2. UCSF	• Provide technical assistance on IBBS study
3. Measure & Evaluation	• Provide technical support on development of M&E plan
4. Management Development for Health	• Provide technical support on updating CTC2 database and development of CTC3 macro database

8.3.6 Procurement and provision of logistics

Procurement unit supports another technical unit in the areas of quantification, procurement and monitoring of supply chain plan for the program commodities. It also has a responsibility for all procurement to be done by the Programme based on the Zanzibar Procurement Act.

ZIHHTLP's commodities are divided into two categories; core and non-core products. Core product are ARVs, HIV test kits and Condoms and these are procured by Global Fund through Procurement Pool Mechanism (PPM) whereby the programme do quantification and making order. Non-core products are Reagents, Opportunistic infection (OI) drugs and other related commodities.Some non-core products are procured locally and other are procured through PPM. All products except Ant-TB drugs are procured through support from Global Fund, stored and distributed by Central Medical Store (CMS) to facility level.

During the year 2018, the programme has ordered and received commodities as summarized in table below.

Table 8.3.1; commodities procured through GF PPM, Zanzibar, 2018

	Item	Pack	Quantity	Cost of product (USD)
1.	ARVs*			18,069.55
2.	SD Bioline	25 test	1326	56,539.79
3.	Unigold	20 test	468	14,976
4.	Viral Load test	10 test	339	50,511
5.	EID	10 test	21	3,129
6.	Condom	144 pcs	17,000	62,526.87

*ARVs (Items procured are only 8, these are TLE, TDF/FTC, NVP - suspension, 3TC/AZT, TDF/3TC/EFV, Lopinavir/Ritonavir, Effavirence 600, 3TC/AZT/NVP (Adult),

In the year 2018, only 8 out of 17 items of ARVs needed in Zanzibar were procured. The remaining 9 items were at maximum stock level (15Month of Stock) and hence were not procured. The quantity of HIV test kits ordered was less due to the available stock in the country.

8.3 Procurement performance indicator in 2018

S.N	Indicator	2018
1	Percentage of tracer HIV/AIDS commodities received	100%
2	Percentage of facilities reporting stock out of tracer HIV commodities in the last 3 months of their ordering	7%
3	Percentage of tracer commodities orders delivered on time by the Central Medical Stores (CMS)	91%
4	Percentage of facilities reporting and requesting HIV/AIDS commodities in a timely way	92%

1. Percentage of tracer HIV/AIDS commodities received

In the year 2018, all tracer HIV/AIDS commodities were procured as planned, 11/11 (100%). These are ARV, HIV Test Kits, and Condoms. All items were procured through PPM and received in the country in April 2018. This achievement is the result of procurement through Wambo system whereby procurement is done through electronic system, compared to paper based system used in previous years.

2. Percentage of facilities reporting stock out of tracer HIV commodities in the last 3 months of their ordering

During this reporting period, a total of 11 out of 161 Health facilities (7%) reported a stock out of HIV tracer commodities within the last 3 months. This was due to poor communication between CMS and the CHMT through District Material Manager (DMM), improper filling of Report &Request (R&R) forms from the health facility to CMS and failure of some districts to request an emergency order when need arises. The proposed solution to overcome that problem is an establishment of electronic health commodities facility edition system.

Moreover, during the last quarter of this reporting period, the program experienced a shortage of second line ARVs in some of health facilities. This was contributed by increase in number of clients on second line ARVs, following introduction of HVL monitoring test. The shortage was overcome by receiving additional ARV from Tanzania Mainland.

3. Percentage of tracer commodities orders delivered on time by the Central Medical Stores (CMS)

During this reporting period, a total 10/11 (91%) were delivered by Central Medical Store (CMS). One item SD Bioline in the last three months of the reporting period was redistributed among facilities because there was imbalance of stock of SD Bioline at the facility level were other facilities have over stock and other have minimum stock. To mitigate the risk of expired, the decision of redistribute those test kit was taken which lead to CMS not deliver 10 items instead of 11 items of tracer commodities.

4. Percentage of facilities reporting and requested HIV/AIDS commodities in a timely way

During this reporting period, a total of 148 out of 161 Health facilities (92%) reporting and requested HIV/AIDS commodities in time. Out of 13 facilities which fail to report on time 7 facilities were in Central District while no other District which have more than one facility which fail to report on time. More supervision is needed in Central District in order to reduce the number of facilities which fail to order on time.

Challenges

- Unexpected increase in consumption of second line ARV Drugs.
- Non-visibility of logistics data at the facility level.

8.4 Financial Management

Finance unit supports other technical units in financial management 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 stakeholders periodically.

The following is the overview of the financial position for ZIHHTLP in 2018:

a. Budget

Program received funds from different sources for the implementation of HIV, STI, Hepatitis, TB and Leprosy interventions. The major planned support was from the Revolutionary Government of Zanzibar and development partners as illustrated in the table below.

Table 8.2: Source of funds from the Government and development partners and area supported, 2018

	Name of Partners	Area Support
	Government of Zanzibar	• HIV, Hepatitis, TB and leprosy programme activities.
	Global Fund fighting against AIDS, Tuberculosis and Malaria	• HIV and TB programme activities
	Tanzania Health Promotion Support	• HIV programme activities
	United National Development Program – Tanzania (UNICEF)	• HIV programme activities
	MDH	• HIV programme activities
	AMREF (AfyaKamilifu)	• HIV and TB programme activities
	UCSF	• HIV programme activities

Every partner has got its own accounting period. Table 8.3shows financial year and budget allocated for mentioned partners.

Table 8.3: ZIHHTLP budget from different sources per fiscal year 2016- 2018

FUND SOURCE	FINANCIAL YEAR	BUDGET 2016 USD	BUDGET 2017 USD	BUDGET 2018 USD
Government	June to July	50,403.23	42,666.67	114,907.80
Global Fund	Jan to Dec.	3,694,042.00	2,419,820.00	1,534,388.45
UNICEF	June to July	26,196.35	50,677.77	22,468.59
THPS	Oct to Sept	19,845.00	131,236.35	298,390.05
AMREF	Oct to Sept	-	-	162,840.20
UCSF	Oct to Sept	-	-	5,829.60

b. Inflow and outflow of financial resource

Cash Inflow /Income

During the year 2018, ZIHHTLP received funds as a cash inflow from various sources as mentioned above, the total amount received was USD 1,467,646.81. The following is a summary of cash inflow received (Table 8.4).

Table 8.4: Summary of ZIHHTLP funds received from various sources 2016-2018

SOURCE OF FUND	2016	2017	2018
Government	23,234.20	7,111.11	39,267.02
GF	3,750,042.80	-	1,273,208.26
UNICEF	17,142.49	50,677.77	22,468.59
THPS	14,483.36	208,377.53	94,308.03
AMREF	-	-	32,565.31
UCSF	-	-	5,829.60
TOTAL	**3,804,902.85**	**266,166.41**	**1,467,646.81**

Cash outflow/expenditures

During the year 2018, the programme absorption rate was 98% for the entire fund. However, ZIHHTLP have financial commitments amounting to USD $364,437.

Table 8.5: Summary of expenditure of ZIHTLP funds from various sources, 2016-2018

SOURCE OF FUND	2016	2017	2018
Government	0	30,345.31	27,486.91
GF	773,864.61	2,952,189.44	1,257,345.99
UNICEF	17,142.49	50,677.77	22,468.59
THPS	19,596.40	153,787.09	94,308.03
AMREF	0.00	0.00	32,565.31
UCSF			5,829.60
TOTAL	**810,603.50**	**3,186,999.61**	**1,440,004.43**

The Programme utilizes the entire fund received from UNICEF, THPS, UCSF and AMREF while the absorption rate was 98% and 70% for the Fund received from Global Fund and Government Fund respectively. The remaining 30% from Government Fund were reprogramming for development of strategic planning of Hepatitis.

I. Projection of budget for the year 2018/2019

The support of the program for the coming year is as indicated in the Table 8.6 below. However, THPS support has phased out in this year.

Table 8.6: Budget Projections from different sources for 2018/2019

SOURCE OF FUND	FISCAL YEAR	AMOUNT USD
GLOBAL FUND	January - December	2,042,090.85
GOVERNMENT	July – June	130,947.18
AMREF	October-September	108,249.67

8.5 Programme Management Indicators:

S/n	Indicator	2018
1.	Number of health training institutions integrating HIV knowledge and skills in their training curricula	**1**
2.	Number of partners coordination meetings conducted by ZIHHTLP per year	**0**
3	Proportion of required funds mobilised	**40%**

1. Number of health training institutions integrating HIV knowledge and skills in their training curricula

In the year 2017 the programme supported State University of Zanzibar through School of Health and Medical Science to develop HIV, TB and Malaria training guidelines. Following this development, in 2018 support was provided to School of Health and Medical Science to orient Tutors/Facilitators on the developed guidelines. This will ensure Graduating health staffs have adequate knowledge and skills pertaining to HIV, TB and Malaria service delivery.

2. Number of partner's coordination meetings conducted by ZIHHTLP per year

There were no annual partners coordinating meeting conducted due to limited fund.

3. Proportion of required funds mobilised

The percentage of required fund mobilised were 40% in 2018 which is below set target of 60% in Monitoring and evaluation Plan III, 2017-2022. Proportion of required funds mobilised were not achieved due to inconsistence of the fund received from Government Fund against the budget.

8.6 Challenges

- Delayed disbursement of fund from funders.
- Inadequate fund for HIV, TB, Hepatitis and Leprosy interventions.

CHAPTER 9

VIRAL HEPATITIS SERVICES

9.0 VIRAL HEPATTITIS

Viral Hepatitis epidemic affects a wide range of population and its elimination as a public health threat requires high impact and coordinated interventions across various health and non-health sectors. Hence national response to viral hepatitis entails multi-sectoral approach and partnerships among various local and international stakeholders at national, district, health facility and community levels.

9.1.1 Background

Viral Hepatitis remains a public health challenge worldwide, with devastating impact on health, lives, country's health system and economy. Hepatitis B and C infections are of great concern to due to associated morbidity with life threatening complications such as liver cirrhosis, cancer and liver failure as well as high mortality rates. Zanzibar has recognized the epidemic as a major and growing public health threat that requires an urgent and robust national response. Hence the government concurs with global target to eliminate viral hepatitis as a public health threat by 2030. In April 2017, Ministry of Health established Viral Hepatitis Unit under Zanzibar HIV, Hepatitis, Tuberculosis and Leprosy Programme (ZIHHTLP) to spearhead national response to viral hepatitis. The unit is responsible for planning, coordinating and overseeing implementation of viral hepatitis interventions that include prevention, diagnosis, treatment, care and support services at all levels of service provision. The services are provided at a wide range of platforms such as Integrated Reproductive and Child Health Program (IRCHP), Key Population, STIs and Adolescent Unit, HIV Care and Treatment Unit, Zanzibar National Blood Transfusion Services (ZNBTS), public, private and parastatal health facilities as well as diverse service delivery entities such as Occupational Health unit (OHU), Ports Health Unit etc.

9.1.2 Goal

The main goal is to eliminate viral hepatitis epidemic as a public health threat in Zanzibar and improve care for infected individuals.

9.1.3 Objectives

1. To eliminate transmission of hepatitis-related viruses.
2. To ensure universal and equitable access to comprehensive prevention, diagnosis, care and treatment services.

3. To improve care, treatment and support for people living with viral hepatitis.
4. To reduce morbidity and mortality due to viral hepatitis and its complications.
5. To reduce socio-economic impact of viral hepatitis at individual, community and population levels.

9.1.4 Program Implementation

9.1.4.1 Service monitoring

Viral Hepatitis Unit, in collaboration with IEC/BCC Unit conducted sensitization meeting with 60 health authorities and healthcare workers (30 Unguja and 30 Pemba). The main objectives were to raise awareness on viral hepatitis among participants and to engage them in combating and controlling the epidemic at their levels of service provision. Meeting agenda included current situation, public health significance, modes of transmission, clinical presentation, ccomplications and management of viral hepatitis B and C as well as national Response to viral hepatitis epidemic. It ewas emphasized that hepatitis B and C are prevalent worldwide, including in Zanzibar and the epidemic is rapidly growing. Hence the epidemic is a public health threat that requires urgent national response due to its devastating impact on health, lives as well as country's health system and economy. Joint efforts among various health sectors are crucial for effective control of the epidemic at various levels of service provision and every stakeholder should play an active role in in combating the epidemic. Participants were given handouts and IEC/BCC materials (leaflets) on viral hepatitis as reference materials for conducting regular health talks at community level. Following the presentation and discussion session, participants recommended the following action items:

- Establishment of universally accessible screening, immunization and treatment services for hepatitis B and C at all levels of healthcare service provision
- Training for healthcare workers and supervisors to conduct health education at community level as well as to identify and manage viral hepatitis B and C infections
- Support for community-based organizations including training on viral hepatitis, conducting awareness creation activities and distribution of IEC/BCC materials.

Furthermore, Viral Hepatitis Unit identified various community structures that provide health education at community level and in collaboration with IEC/BCC Unit conducted sensitization meeting with 60 representatives (30 Unguja and 30 Pemba) from various Community-based Organizations and Non-Governmental Organizations (NGOs) including ZAPHA+, JUKAMKUM, Zanzibar Youth Forum, ZAYEDESA, MKUPE and Pemba Press

Club as well as Health Officers. The main purpose was to enlighten participants on viral hepatitis epidemic and to engage them in disseminating appropriate information, promoting prevention and encouraging infected individuals to utilize existing care and treatment services in the country.

In addition, Viral Hepatitis developed draft Viral Hepatitis Action Plan to guide national response to viral hepatitis as well as Concept Note on Viral Hepatitis which was distributed to various international organizations including WHO, UNFPA, UNICEF and CDC, with an intention to engage them in planning and mobilizing resources for executing urgent response to viral hepatitis in Zanzibar, before it becomes a national disaster.

In collaboration with IEC/BCC Unit, Viral Hepatitis Unit distributed newly developed Information, Education and Communication (IEC) materials (fact sheets and brochures) on viral hepatitis to various health facilities, community organizations and institutions. The aim was to raise awareness, to promote health seeking behaviour at community level and to engage policy makers, healthcare providers and community in combating viral hepatitis epidemic.

Besides, Viral Hepatitis Unit participated in sensitization meetings which were organized by IEC/BCC Unit on tuberculosis for healthcare workers, district authorities and media representatives (40 Unguja and 40 Pemba). The main purpose was to provide basic information on viral hepatitis epidemic worldwide and in the country that will enable participants to cascade appropriate information to community while providing health education on tuberculosis.

Moreover, representatives fromViral Hepatitis and IEC/BCC Units, Zanzibar AIDS Commission (ZAC) and Hepatitis B clinic were invited to conduct health education sessions on viral hepatitis to management teams and various cadres of employees from Tanzania Civil Aviation Authority (65 participants), Ministry of Finance (80 participants) and Zanzibar Electric Company (45 participants). The sessions taught included basic knowledge, current situation on viral hepatitis epidemic and related services available in the country. It was emphasized that health education and right information are crucial components of prevention and early detection of viral hepatitis, aimed at minimizing transmission as well as associated morbidity and mortality in the community. Participants were provided handouts and IEC materials for reference.

Viral hepatitis Unit also had dialogues with various representatives from mass media (radio and television) including ZBC, ITV, Star TV, Swahiba FM radio, Radio JamiiMicheweni and Deutsche Well. The main intentions were to raise awareness among media representatives on viral hepatitis epidemic worldwide and in the country as well as available related services to facilitate dissemination of appropriate information to community through radio and television programs.

Viral hepatitis Unit visited various service areas that offer hepatitis B and C testing services, including main laboratory and Occupational Health Unit at MnaziMmoja Hospital, parastatal health facilities (Bububu and JKU), private health facilities (Al-Rahma and TASAKHTAA Global Hospitals), Zanzibar National Blood Transfusion services (ZNBTS) as well as Various potential public and private entry points, including health facilities, institutions as well as standalone laboratories. Main objectives were to improve documentation and linkage of Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) infected individuals to care, treatment and support services. A total of 14 sites were visited, out of which 10 (FarhamMartenity Home, J&M Hospital, Smart, Mehtas, Mina, Lancet laboratory, Machui Mission, Ziwani Police, Mafunzona KMKM) offer test for viral hepatitis B, while 4 (Rahaleo, MAT Clinic, Marie Stopes and Kitope Mission) used to provide the services but have ceased due to stock out of test kits. Testing for Hepatitis C is offered at 4 sites (ZNBTS, Main laboratory at MnaziMmoja Hospital, Bububu and JM Hospitals) only. Viral Hepatitis Unit developed local electronic dataset to routinely keep records of HBV and HCV infected individuals identified at all entry points and to track linkage to appropriate care, treatment and support services.

Besides, ZIHHTLP Program Management and Viral Hepatitis Unit had a meeting with two representatives from WHO Dar-es–salaam Office, with an objective to execute joint groundwork in preparations for developing Viral Hepatitis Strategic Plan. It was jointly agreed that ZIHHTLP will conduct rapid assessment to attain a snapshot of implementation status of viral hepatitis interventions in Zanzibar. Findings will serve as a basis to formulate strategic plan for national response to viral hepatitis, towards elimination target. Components of the rapid assessment will include interviews with various relevant key informants, review of related national documents, guidelines and reports as well as data collection from various public and private viral hepatitis entry points. Participants reviewed WHO recommended Rapid Assessment tools on viral hepatitis and adapted them to suit local context for conducting

structured interviews with key informants. The draft tools will be shared with Viral Hepatitis Technical Working Group (VHTWG) for further inputs and finalization

- Prepared a proposed list of key informants which will be reviewed and finalized by VHTWG
- Proposed formation of four teams of experts from various relevant health sectors to conduct the rapid assessment in Unguja and Pemba
- Discussed three resumes of potential consultants who were proposed to lead development of Viral Hepatitis Strategic Plan and it was jointly agreed that WHO and ZIHHTLP will seek more candidates to expand options and widen choice of suitable consultant.

Also, first Viral Hepatitis Technical Working Group (VHTWG) meeting was conducted to review Terms of Reference (TOR) for the VHTWG and WHO adapted tools for conducting rapid assessment on national response to viral hepatitis. The assessment will involve structured interviews with key informants, desk review of related national documents, guidelines and reports as well as data collection from various sites that provide testing services for hepatitis B and C. Findings from the rapid assessment will be used to formulate Viral Hepatitis Strategic Plan that will guide focused and high impact interventions to eliminate viral hepatitis as a public health threat in Zanzibar.

9.2 Performance of services

During this year, a total of 247 (144 male and 103 female) hepatitis B infected clients were enrolled, out of whom 17 (15 male and 2 female) were initiated antiretroviral therapy.

9.3 Hepatitis services indicators and trend from 2017 to 2018

Indicator	**Year**	
	2017	**2018**
1. Number of patients newly enrolled into the Hepatitis Clinic	**157** out of **150** **(105%)**	**247 out of 150** **(165%)**
2. Number of patients newly initiated Hepatitis B treatment	**10** out of **40** **(25%)**	**17/40 (43%)**

Enrolment of hepatitis B infected clients at care and treatment clinic is progressively exceeding the set annual targets due to ongoing health education and sensitization conducted by Viral Hepatitis Unit at national, health facility and community levels. This has increased community demand for care, treatment and support services. In addition, the Unit has established linkage of identified hepatitis B infected individuals between entry points and Hepatitis B clinic. Although proportion of hepatitis B infected individuals who were initiated antiretroviral therapy has increased from 25% in 2017 to 43% in 2018, the accomplishment is still far below the set study target due to the fact that majority of clients do not meet eligibility criteria for treatment, according to WHO guidelines. Besides, the clinic is under 5-year CDC funded pilot study which caters for hepatitis B mono infection only and the study requirements excludes those clients with Hepatitis B and C co-infection. Another contributing factor could be restricted accessibility of treatment services as the clinic is situated in Unguja only, limiting access to Pemba clients whose number of eligible clients for treatment is not known and cannot be currently determined.

9.3 Challenges

Although Zanzibar government has committed itself to eliminate viral hepatitis epidemic as a public health threat by 2030, the following fundamental and systemic challenges impede national response to achieve the global and national elimination targets:

1. Limited awareness and knowledge on viral hepatitis among policy makers, health authorities, healthcare workers and community.
2. Lack of local or international funding specifically allocated for implementation of viral hepatitis interventions.
3. Lack of universal acess to prevention, diagnosis, treatment and support services, even for most at risk population such as pregnant women, Key population and healthcare workers, including unavailability of the following key program components:
    - Test kits for viral hepatitis B and C diagnosis
    - Access to treatment for HBV-infected individuals who do not meet specific study eligibility crieria at viral hepatitis clinic, Mnazi Mmoja hospital
    - Medicines for treatment of hepatitis C infection which can be effectively cured within 3 months

- Hepatitis B vaccine for eligible clients who are at high risk of acquiring and transmitting the infection

4. Lack of national:
    - Prevalence data on viral hepatitis to facilitate evidence-based planning for interventions to combat and control the epidemic
    - Strategic plan to guide and sustain effective national response to viral hepatitis
    - Monitoring tool (register) and database for monitoring viral hepatitis services
    - Cancer Register to determine prevalence of viral hepatitis-related liver cancers. .
5. The currently existing clinic which is located at Mnazi Mmoja hospital is under five-year research project which caters for hepatitis B monoinfection only and treatment access for Pemba residents is limited.
6. The newly-established Viral Hepatitis Unit lacks basic but essential working tools and office equipment such as furniture, air conditioner, desktop and laptop computer as well as internet connection.

CHAPTER 10

RECOMMENDATION

- To strengthen escort referral system by peer counsellors in the high yield HTC sites
- To mobilize fund for refresher training and mentorship for counsellors
- To sensitize community on the importance of utilising HIV services
- To establish the unique identification system for HIV services
- To liaise with district council to monitor and promote PITC services
- To revive engagement with private hospital board about the private facilities providing HTC services without official authorization

- Establishment of electronic system of mother-infants follow up
- Liaise with CHMTs to include procurement of syphilis test kits in their work plan
- Improve documentation on PMTCT monitoring tools through supportive supervision and follow up on updated EID register
- Advocate for resource mobilization to implement viral hepatitis interventions
- Conduct training to service providers (NGOs and Health facilities) on the provision of quality HIV related services using training manual on HIV services for KPs in Zanzibar.
- Strengthening linkage mechanisms for all infected KPs at all levels in Unguja and Pemba
- Strengthening pre – MAT sessions conducted by NGOs to PWIDS in Unguja
- Conduct meetings with leaders from CHMT, Central Medical store and some service providers on the importance of adequate supply of STI drugs to health facilities in Unguja and Pemba
- Mobilization of funds to support conducting STI quarterly supportive supervision at all health facilities in Unguja and Pemba.
- Lobbying to hospital management and CHMT to allocate nurses and clinician at CTCs
- Strengthen tracking system
- Enhance counselling to PLHIV
- Mobilize resources to support HBC services

- Revise CHBC monitoring tools to accommodate newly established tracking system for lost to follow up patients
- To conduct mentorship and coaching to health care providers in health facilities and clinics regarding effective TB screening and documentation
- Resources mobilization for procurement of Digital X ray
- To conduct training for health care providers on leprosy management
- Capacity building for proper collection and transportation of sputum samples should be enhanced.
- Mentorship should be conducted to health facilities which did not perform well in proficiency testing.
- To speed up the process on development of program website.
- To develop data demand and information use plan that will guide on how to persuade data use at all levels
- To lobby with other partners to support data verification, supportive supervision and data review meeting activities
- CTCs should test HVL all eligible ART client to enable accurate quantification of second line ARVs.
- To scale up electronic Facility Edition system to all CTCs.
- Liaise with partners to ensure timely Disbursement of funds.
- Fund mobilization to implement IEC/BCC interventions

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

UNGUJA

Mjini 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	BANDARINI	PUBLIC					
10	KIDUTANI	PUBLIC	√	√			
11	ZIWANI POLICE PHCU	PARASTATAL	√	√	√	√	√
12	MWEMBELADU RCH	PUBLIC		√	√	√	√
13	MPENDAE PHCU	PUBLIC	√	√	√	√	
14	KWAMTIPURA PHCU	PUBLIC		√	√	√	√
15	SEBLENI PHCU	PUBLIC		√	√	√	√
16	MATARUMBETA PHCU	PUBLIC		√	√	√	√
17	UTAPOA DISPENSARY	PRIVATE	√				
18	SEVENTH DAY ADVENTIST DISPENSARY	FBO			√	√	√
19	SHAURIMOYO PHCU	PUBLIC		√	√	√	√
20	OTTU RCH	PUBLIC			√	√	√
21	MENTAL HOSPITAL	PUBLIC		√		√	√
22	GLOBAL HOSPITAL	PRIVATE	√			√	√
23	ASAA KHEIR	PRIVATE	√			√	√

Magharibi A 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	CHUINI PHCU	PUBLIC		√	√	√	√
5	KINUNI/MTUFAANI PHCU	PUBLIC		√			
7	BUMBWISUDI PHCU	PUBLIC		√			
8	KIZIMBANI PHCU	PUBLIC	√	√	√	√	√
9	SELEM PHCU	PUBLIC	√	√	√	√	√
10	WELEZO CAMP PHCU	PUBLIC		√	√	√	√
11	BEITRAS PHCU	PUBLIC	√		√	√	√

Magharibi B District

S/NO	Facility	Ownership	VCT	PITC	PMTCT	TB	HBC
1	ZANGOC MWANAKWEREKWE	NGO	√				
2	SOS MEDICAL CENTRE	PRIVATE	√		√	√	√
3	FUONI PHCU	PUBLIC	√	√	√	√	√
4	KIEMBE SAMAKI PHCU	PUBLIC	√	√	√	√	√
5	CHUKWANI PHCU	PUBLIC	√	√	√	√	√
7	ST CAMILAS DISPENSARY	FBO	√	√	√		√
8	BWEFUMU PHCU	PUBLIC		√	√	√	√
9	FUONI KIBONDENI PHCU	PUBLIC		√	√	√	√
10	KOMBENI PHCU	PUBLIC			√	√	√
11	MAGOGONI PHCU	PUBLIC		√	√	√	√
12	SHAKANI PHCU	PUBLIC		√	√	√	√
13	SANASA DISPENSARY	PRIVATE			√	√	
14	MWANAKWEREKWE KKT DISPENSARY	FBO				√	
15	KISAUNI PHCU	PUBLIC		√	√	√	√

Kati 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				√	√

Kusini District

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

KASKAZINI 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			√	√	√

KASKAZINI 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	KIONGWE PHCU	PUBLIC			√	√	√
14	ZINGWE ZINGWE PHCU	PUBLIC			√	√	√

PEMBA

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		√	√	√	

n 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	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	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			√	√	√

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			√	√	√