PACKAGES OF HIV INTERVENTIONS
FOR KEY POPULATIONS IN ZANZIBAR

Zanzibar AIDS Control Program

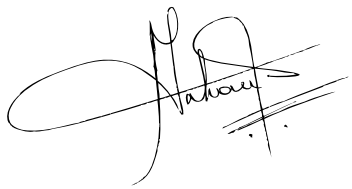
PREFACE

Key populations (KPs) are, by definition, those in which their behaviours put them at higher risk of being infected or affected by HIV, who play a key role in how HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV. Also they are at higher risk of acquiring other infections such as syphilis, viral hepatitis, owing to their high risk behaviours. In the Zanzibar National Strategic Plan II (ZNSP II), four groups have been documented to be at higher risk of HIV infection, namely: Men who have Sex with Men (MSM), Sex Workers (SW), people who inject drugs (PWID) and students in correctional facilities.

While Zanzibar has an HIV prevalence of around 1% in general population (Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS), 2012), the HIV prevalence among KPs has been documented in Unguja among female SW at 19.3%, MSM at 2.6% and PWID at 11% (Integrated Behavioural and Biological Surveillance Survey (IBBS, 2011/12), and in Pemba among female SWs at 18.8%, MSM at 5.0% and PWID at 8.8% (ZIHTLP (RA), 2012). Zanzibar AIDS Control Programme (ZACP), together with the United States Centres for Disease Control (CDC) and University of California, San Francisco (UCSF), carried out a size estimation of KPs, which yielded an estimate of 2,157 MSM, 3,958 female SWs and 3,000 PWID in Unguja (IBBS 2011/12). Given the higher HIV prevalence among KPs, much of the efforts must be made to decrease new HIV infections among these populations, and increase identification and referrals for HIV testing, care and treatment to break the bridge of HIV infection to the general population.

In Zanzibar, services for KPs started in 2003 by involving peer educators on conducting outreach activities at community level to identify other KPs and provide HIV/STIs prevention education and condom distribution. Local and international non-governmental organisations (NGOs) in collaboration with the Ministry of Health, other KP stakeholders currently implement KP interventions in Zanzibar, with support of various development partners.

Based on the above situation, Zanzibar has developed a guide to minimum and comprehensive HIV service delivery for KPs. This guide has been developed to fill the gap in HIV service availability and uptake by KPs in Zanzibar and spells out clear, evidence-based packages of HIV interventions for each category of the KPs as well as what required for minimum and comprehensive HIV service delivery for these groups. This package is intended to be a reference, and hence will be used by all partners providing HIV services targeting KPs in Zanzibar.



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The opinions expressed herein are those of the authors and do not necessarily reflect the views of UNICEF and or partners.

CONTENTS

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
GoZ	Government of Zanzibar
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IBBS	Integrated Bio-Behavioural Surveillance
ICAP	International Centre for AIDS Care and Treatment Programmes
IEC	Information, Education, Communication
KP	Key Population
MAT	Medically Assisted Treatment
MSM	Men who have Sex with Men
NCCDC	National Commission for Coordination and Drug Control - Zanzibar
NSP	Needle Syringe Program
OST	Opioid Substitution Therapy
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PWID	People Who Inject Drugs
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TZS	Tanzanian Shillings
UNAIDS	Joint United Nations Program on AIDS
UNDAP	United Nations Development Assistance Plan
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Programme
ZAIADA	Zanzibar Association of Information Against Drug Abuse and Alcohol
ZAPHA+	Zanzibar Association for People living with HIV and AIDS
ZAYEDESA	Zanzibar Youth Education, Environment and Development Support Association
ZANGOC	Zanzibar NGO Clusters
ZNSP-II	Zanzibar National HIV Strategic Plan – II (2011-2016)
ZYF	Zanzibar Youth Forum

1. INTRODUCTION

HIV in Zanzibar is concentrated among specific key populations (KPs) likely to engage in high risk behaviours for HIV acquisition. As defined by the Zanzibar National HIV Strategic Plan II (2011-2016), KPs for HIV in Zanzibar are defined as *people who inject drugs (PWID)*, *men who have sex with men (MSM)*, *people who sell sex* and *students in the Institute of Education for Offenders (correctional facilities)*. The HIV prevalence among each of these groups is higher than in the general population.

The latest available HIV prevalence figures for KPs in Zanzibar are from the 2011-2012 IBBS implemented by ZACP, Ministry of Health. The study was conducted in both Unguja and Pemba. The study indicates HIV prevalence among people PWID as (Unguja: 11.3%, and Pemba: 8.8%) among MSM (Unguja: 2.6%, and Pemba: 5.0%), and among females who sell sex (Unguja: 19.3%, and Pemba: 18.8%).

While these KPs are characterized by unique risk behaviors, these groups are not mutually exclusive and there is considerable overlap in transmission risks. In the 2011-2012 IBBS, some men who reported injecting drug use also reported engaging in male-male sex. Some females who sell sex also report injection drug use and may face incarceration for sex work or drug use. A significant numbers of students in correctional facilities reported engaging in male-male sex or drug use while incarcerated. In recent years recognition of the needs of KPs pertaining to HIV has brought about a targeted focus of HIV mitigation activities in Zanzibar for KPs as indicated by the most recent strategic plan.

This document outlines the types of interventions recommended for inclusion in a package of services for each KP group in line with global recommendations and evidence. The recommended packages of HIV interventions should address multiple risks and vulnerabilities and build on existing peer education and outreach activities. They should entail programming encompassing a mixture of behavioural, biomedical and structural interventions, and be delivered through both health –facility and community outreach mechanisms. The specific needs of adolescents and young people within KP groups also need to be addressed. The design and delivery of each of the packages' components and interventions should seek to involve members of these KPs to the greatest extent possible.

This document describes the key effective interventions organized in packages for the four groups; PWID, MSM, people who sell sex and students in correctional facilities. The packages operate across the continuum of prevention, care and treatment for HIV. The packages are defined for community and/or health facility levels in Zanzibar and provide guidance on the essential and recommended components needed to ensure mitigation of the HIV epidemic and its impact.

2. GUIDING PRINCIPLES IN DELIVERY OF THE INTERVENTIONS

Twelve principles guide the delivery of the packages outlined in this document, namely;

I. Meaningful participation of people from KP groups in planning and delivery of services and interventions
II. Universal access of the package components to all people within the KPs
III. Recognition that individuals may belong to multiple KP groups with overlapping risks present in their lives
IV. Integration of multiple package components and acknowledgement that people require a range of services delivered in a cost effective and friendly manner
V. For interventions to be effective they need to be delivered with sufficient quality. Quality encompasses scope, completeness, effectiveness, efficiency, safety, accessibility, acceptability and affordability of the interventions/services

VI. Acknowledging the role of various stakeholders in delivering package components; with input from government and civil society
VII. Pursuing social justice and poverty reduction to address health inequalities for KPs
VIII. Upholding the respect, protection and fulfilment of human rights of KPs in Zanzibar
IX. Respecting the values of choice, dignity, diversity and equality for access to public health services
X. Addressing gender and cultural sensitivity
XI. Ensuring that the specific needs of adolescents and young people are met through the delivery of package components
XII. Innovation in content and method of delivery of health promotion for adolescents and young people in KPs is required, as people become bored with repeated messaging and styles of health programming

3. THE STRUCTURE OF PACKAGES OF INTERVENTIONS

The document includes the most relevant and evidence based service components that need to be available and accessible for ensuring quality HIV prevention, care and support services are being delivered to KPs in Zanzibar. The document includes a *Comprehensive Package* of services for each of the four groups (PWID, MSM, people who sell sex and students in correctional facilities). Each package contains a *Minimum Package,* which outlines the minimum required service components for each KP group in Zanzibar.

4. HOW THE PACKAGES OF INTERVENTIONS CAN BE USED AND FOR WHOM ARE THEY INTENDED

The comprehensive packages of services reflect current programming in Zanzibar and global best practice, evidence and recommendations made by various UN development partners (UNICEF, WHO, UNAIDS, UNODC). While some of the interventions are not currently available in Zanzibar, this document intends to inform the ZACP and its partners of the components that their programming should strive to deliver for KPs in Zanzibar. It is expected that the packages of interventions will assist the various partners in the HIV response to implement the evidence based components of HIV prevention, care and support in line with global recommendations. This package should be used as a checklist for Zanzibar to identify gaps in current programming for KPs. Where gaps exist and barriers to implementation include political, cultural or financial barriers to the intervention, strategies should be developed by ZACP and its partners for advocacy to address the barriers. The global guidance reference documents and hyperlinks should be used to garner more detailed information to guide intervention delivery or policy design on the various components of each package.

5. RESOURCE OPPORTUNITY

Scaling up the delivery of HIV interventions to KPs will require strategic investments to strengthen the performance of community and health systems, in particular regarding commodities, equipment and human resources and management. Resource needs should be informed by size estimation calculations for the various KP groups in Zanzibar (both Unguja and Pemba islands). Effective coordination of HIV interventions is needed to ensure coverage for the KP groups across the geographic scope on the two islands while avoiding duplication. Quality routine surveillance, research and monitoring and evaluation of programming are essential for an effective response to HIV in Zanzibar. Prioritization of intervention types should be made by partners in Zanzibar, in line with their level of effectiveness at mitigating HIV, and financial resource availability. These guidelines should assist ZACP and partners to leverage further financial resources to address HIV among KPs in Zanzibar and should guide strategic planning and funding application development.

PACKAGE 1: PEOPLE WHO INJECT DRUGS

Current Situation in Zanzibar

BACKGROUND

The vast majority of PWID in Zanzibar are male, with only a small number of females injecting drugs. The main drug being injected in Zanzibar is heroin. According to the latest population size estimations, there are an estimated 3,000 people who inject drugs (PWID) in Unguja and between 50-200 in Pemba. The age of initiation into injecting drug use is often in the adolescent years but with a median of about 26 in Unguja. The majority of PWID are males aged in their late teens, 20s or 30s.

According to the 2011-12 IBBS, almost half of PWIDs in Unguja report being introduced to injectable drugs by a friend (47.2%) or another drug user (23.8%). PWIDs often report many years of injecting drug use with 36.9% of Unguja respondents in the 2011-12 survey reporting more than seven years injecting behaviour.

HIV SITUATION AND RISK BEHAVIOURS

According to the 2011-2012 IBBS survey the HIV prevalence among PWID in Zanzibar is 11.3% in Unguja and 8.8% in Pemba. The prevalence of Hepatitis B virus (HBV) is 5.9% in both Unguja and Pemba; Hepatitis C virus (HCV) - 25.4% in Unguja and 20.6% in Pemba; and Syphilis – 0.8% in Unguja (no cases were found in Pemba). Among PWIDs who tested positive for HIV in Unguja, 6.9% also tested positive for HCV infection.

High risk injection related practices are common among PWID in Zanzibar. In the 2011-2012 IBBS, 96.4% of PWIDs reported injecting several times a day and 55.9% reported having ever shared injecting equipment. Only 29.1% reported injecting in the last month with a syringe previously used by someone else. HIV prevalence among PWIDs who reported injecting drugs for three years or fewer was 6.3% compared with 15.9% among PWIDs who injected drugs for seven years or more.

The practice of “flashblood” or injecting the blood of another user who has drugs in their bloodstream has been reported in Zanzibar though only among a minority of people reporting drug use (4.8%). Currently people predominantly access their injecting equipment through sales at pharmacies, and access can be limited.

PWID in Zanzibar are also likely to be engaged in high-risk sexual behaviors. In the 2011-2012 IBBS, 52.7% of PWIDs reported any sex in the past month. Among these, 20.9% reported having two or more partners in that period. Approximately one third (34.9%) of PWIDs reported sex with a non-paid partner in the past month. Among PWID who had sex with a steady partner in the past month, 21.5% reported also paying for sex and 14.3% reported also selling sex in that time period. Less than two-thirds of PWID (60.3%) had ever used a male condom. Among PWID who reported having sex with a non-paid partner in the last month, 71% reported never using a condom.

Transactional sex (sex in exchange for something of value) is common among all recognized KPs in Zanzibar. Transactional sex was reported by 14.3% of PWIDs in the month preceding the 2011-2012 IBBS.

There is high level of stigma directed at PWID. 90.2% of the PWIDs in the 2011-2012 IBBS reported experiencing stigma from family and the community with over half (56.4%) reporting they had been abandoned by their family or partner as a result of their drug use. 59.7% of PWIDs reported being physically abused in the last year and of these, 14.1% reporting being beaten by police in that period. Two thirds of PWIDs (66.1%) had been arrested in the past year, among whom 43.2% reported drug use as the reason for their arrest.

Despite comprehensive HIV knowledge and risk perception being high, only 20.2% of PWIDS reported having an HIV test in the last year.

ORGANIZATIONS WORKING WITH THE GROUP

ZACP, ZAC, NCCDC, Drug Free Zanzibar, ZAYEDESA, ZANGOC, ZAIADA, ZYF, ZAPHA+, Columbia University (ICAP), Mental Health hospital in Unguja, Care and treatment clinics, Sober houses, Tawwabina (sober houses), UMATI, JUKAMKUM - in Pemba, Pharmacies, Government Hospitals and community health centres

SERVICES AVAILABLE IN ZANZIBAR

- HIV Testing and Counselling (HTC) (mobile and fixed site)
- Care and treatment: Access to ART for PLHIV, support groups for PLHIV
- Education programmes on HIV and AIDS
- Sexually Transmittted Infection (STI) diagnosis and treatment
- Tuberculosis (TB) services (diagnosis and treatment)
- Some needle and syringe access, primarily through pharmacies
- Bleach access and education for sterilization of injecting equipment
- Sober house withdrawal and recovery peer support programmes
- Overdose management (Naloxone available in the main hospital in Unguja and Pemba)
- Peer education
- Outreach services
- Condom access (male and limited access to female condoms in Unguja)
- Behaviour change communication, including IEC materials distribution
- Sexual and reproductive health services including family planning
- Prevention of mother to child HIV transmission (PMTCT) services for female drug users
- Viral hepatitis screening, management and, HBV B vaccination programme

GEOGRAPHICAL COVERAGE WITH OUTREACH SERVICES

UNGUJA	PEMBA
Urban: Miembeni, Kwahani, Kikwajuni Chini, Kikwajuni Juu, Kilimani, Mwembeshauri, Kundemba, Malindi. Amani, Mchangani, Shangani, Vuga, Vikokotoni, Mwembetanga, Baghani, , Masumbani, Kwa Agata , Kwaalamsha, Jang'ombe, Nyerere **West:** Bububu, Chukwani, Kiembesamaki, Fuoni, Pangawe, Maili Nne, Tomondo **Central:** Mwera, Koani, Machuwi, Chwaka **North:** Nungwi, Kiwengwa, Pwani Mchangani, Mkokotoni **South:** Paje, Jambiani, Bwejuu, Kizimkazi	**Chake Chake District:** Chake mjini, Pujini, Machomane, Wawi, Vitongoji, Chanjaani **Wete District:** Wete, Kipangani, Limbani, Mzambarau Takao, Bopwe, Gando, Jadida, Selemu, Utaani **Micheweni District:** Micheweni, Finya, Makangale, Kiuyu kwa Manda, Pandani, Wingwi **Mkoani District:** Uweleni, Ng'ombeni, Mkanyageni, Mjimbini, Kisiwa Panza, Kangani, Chokocho

PACKAGE OF HIV INTERVENTIONS FOR PEOPLE WHO INJECT DRUGS

INTRODUCTION

Zanzibar is facing an epidemic of injecting drug use. Consequently Zanzibar should implement a comprehensive set of interventions for HIV prevention, treatment and care for PWIDs. These interventions are also known as harm reduction programmes.

Despite overwhelming public health evidence demonstrating the effectiveness of harm reduction interventions, many decision-makers remain reluctant to implement or scale up these interventions because of their controversial nature and perceived conflict with cultural, religious or political norms. Intense advocacy, citing public health evidence, is often required to initiate and sustain harm reduction programmes.

Where there are barriers to implementing harm reduction interventions, there is a need to create a supportive policy, legal and social environment that facilitates equitable access to prevention and treatment for all, including PWIDs. There is also a need for appropriate models of service delivery, health systems strengthening and strategic information to guide harm reduction programmes. For example, procuring and distributing opioid agonist medicines, such as methadone, may require special measures and procedures.

KEY GUIDING GLOBAL RECOMMENDATIONS DOCUMENTS

- WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, WHO 2009, http://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf
- Policy and Programming Guide for HIV/AIDS prevention and Care among Injecting Drug Users, WHO, 2005 www.who.int/hiv/pub/idu/iduguide/en/
- The WHO/UNODC Evidence for Action series and policy briefs: http://www.who.int/hiv/pub/idu/idupolicybriefs/en/index.html
- Priority interventions, HIV/AIDS treatment and care in the health sector, WHO, 2010 http://www.who.int/hiv/pub/guidelines/9789241500234_eng.pdf

COMPREHENSIVE PACKAGE

COMPONENTS WITHIN COMPREHENSIVE PACKAGE OF HIV INTERVENTIONS FOR PEOPLE WHO INJECT DRUGS	
HIV PREVENTION	**HIV CARE AND TREATMENT**
• HTC, with the aim of individuals voluntarily accessing HTC every 6-12 months, delivered through health services and community based services • Provider initiated testing and counselling (PITC) should be offered in all health care settings to all PWIDs • Prevention and treatment of STIs • Condom programs for PWIDs and their sexual partners (should include access to both male and female condoms and lubricants) • Targeted information, education and communication (IEC) for PWIDs and their sexual partners delivered through peer based outreach • Needle and Syringe Programs (NSPs), these should include access to injecting equipment through pharmacies in a “pharmacy based needle and syringe access and disposal program approach” • Opioid Substitution Therapy (OST) or Medication Assisted Therapy (MAT) and other drug dependence treatment • Post exposure prophylaxis for HIV • Pre exposure prophylaxis for HIV if the PWID is in a sero-discordant relationship or is a person who has male-male sex • PMTCT services for females who inject drugs who are planning on having children • Interventions to prevent the transition to injecting behaviour among young people who use drugs, whom are not yet injecting	• HTC • Antiretroviral therapy (ART) for all PWIDs living with HIV • Diagnosis and treatment of opportunistic infections • Cotrimoxazole prophylaxis for people living with HIV (PLHIV) • Isoniazid Preventive Therapy for PLHIV, in line with WHO guidelines • Palliative care services • Nutritional support for PLHIV • Peer support groups for PLHIV who are current drug users of have a history of drug use

STRUCTURAL INTERVENTIONS	COMPLEMENTARY HEALTH SERVICES
• Activities to reduce the stigma and discrimination faced by PWIDs • Legal reform to remove laws making possession of injecting paraphernalia illegal • Legal reforms to reduce the level of punishment associated with possession and personal use of small amounts of illicit drugs • Drug diversion programs to keep PWIDs out of the criminal justice system • Services for re-training to enhance employment opportunities for PWIDs • Programs with law enforcement agencies to gain support for health programming for PWIDs • Addition of accurate education on drug use and associated risks into the school curriculum	• Treatment for drug dependence including support during withdrawal, detoxification and rehabilitation services • Psychosocial support services including peer support systems • Prevention, diagnosis and treatment of TB • Treatment of viral hepatitis including vaccination for Hepatitis A and B • Targeted IEC for people living with viral hepatitis on liver care • PITC delivery of testing for asymptomatic syphilis infection – aim for annual testing • Overdose prevention education and community based naloxone provision • Sexual and reproductive health services including family planning, counselling and contraception • Peer support systems for people leaving sober houses and other drug detoxification and rehabilitation services, to reduce recidivism

MINIMUM PACKAGE OF SERVICES FOR PEOPLE WHO INJECT DRUGS IN ZANZIBAR

COMPONENTS IN MINIMUM PACKAGE
• HTC, with the aim of individuals voluntarily accessing HTC every 6-12 months, delivered through health services and community based services. PITC should be offered in all health care settings to PWID • Improved access to clean injecting equipment • OST (OST) or Medication Assisted Therapy (MAT) and other drug dependence treatment • Education on prevention of STIs, including HIV, and referral for diagnosis and treatment of STIs • Condom delivery programmes for PWIDs and their sexual partners (should include access to both male and female condoms and other HIV prevention supplies) • Delivery of targeted, IEC for PWIDs and their sexual partners, delivered through peer based outreach • Access to, and support for adherence to, ART for PLHIV • Activities to reduce the stigma and discrimination faced by PWIDs

BENEFITS OF THE COMPREHENSIVE PACKAGE

- Reduction in HIV transmission among PWIDs and their sexual partners
- Reduction in morbidity and mortality associated with drug use, HIV infection and associated opportunistic infections
- Reduction in deaths associated with overdose
- Reduction in transmission of viral hepatitis (HBV and HCV), and reduction in morbidity and mortality associated with viral hepatitis infections
- Decreased levels of stigma and discrimination faced by PWIDs
- Assistance for PWIDs to reduce or cease drug use and maintain this reduction or cessation
- Reduction in harms associated with criminal classification of drug using behaviour
- Greater integration of people who use drugs with society

SYSTEM REQUIREMENTS NEEDED TO SUPPORT THE DELIVERY OF INTERVENTIONS

POLICY

- Enabling policy to increase access to services like needle and syringes programs or pharmacy based distribution mechanisms and OST
- Health system strengthening including increase in funding allocations for services
- Supportive legislation to support program approaches and remove criminalization of possession of injecting paraphernalia

SERVICE DELIVERY, SURVEILLANCE, MONITORING AND EVALUATION

- Coordination of approaches among multiple partners
- Strengthen links and referral mechanisms between different levels of the health system and community outreach programs
- Ensure active participation of PWIDs in peer education approaches with proper training, supervision and support
- Skilled health professionals and community workers, trained in service delivery components, who are respectful of human rights
- Regular access to, availability and affordability of commodities required to assist behaviour change and promote health seeking behaviour regarding drug use and HIV infection (for injecting equipment: 24 hour services, 7 days a week may be required)
- Essential medicines and medical supplies
- Quality routine surveillance, research and use of data for quality improvement are essential for an effective response to HIV in Zanzibar.
- Adequate recording and reporting mechanisms in the monitoring and evaluation system

FURTHER RESOURCES AND GUIDANCE DOCUMENTS

- WHO, UNAIDS, UNODC. *A guide to starting and managing needle and syringe programmes*. Geneva, WHO, 2007 http://www.unodc.org/documents/hiv-aids/NSP-GUIDE-WHO-UNODC.pdf
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- Adolescent friendly health services: An agenda for change, WHO, 2002 http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf
- Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings, http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf
- Advocacy guide: HIV/AIDS prevention among injecting drug users http://www.who.int/hiv/pub/advocacy/en/advocacyguideen.pdf

- Treatment of opioid dependence (WHO web page) http://www.who.int/substance_abuse/activities/treatment_opioid_dependence/en/index.html
- WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention http://whqlibdoc.who.int/unaids/2004/9241591153_eng.pdf
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PACKAGE 2: MEN WHO HAVE SEX WITH MEN

CURRENT SITUATION IN ZANZIBAR

BACKGROUND

The behaviour of sex between males is present in all societies. In Zanzibar the behaviour of male-male sex is highly stigmatised in line with cultural and religious beliefs. Some men who have sex with men (MSM) do so because it aligns with their sexual preference, some have sex with men for financial reasons although they may be primarily attracted to women. As reported in the 2011-2012 IBBS the median age of sexual debut for MSM in Zanzibar was 16 years and more than half of MSM (58.8%) reported their first sexual partner was a man.

In Zanzibar sex between men is illegal. The law was changed in 2004 to clarify the legality of homosexual acts. While sodomy and "unnatural acts" were already illegal, the new law imposes a penalty of 25 years in prison for sex acts involving two males. A homosexual sex act with a minor carries a penalty of life in prison. Despite having these laws in place, no one has been convicted with such an offence to date according to the Zanzibar Legal Audit Review report, conducted by ZAC in association with the Ministry of Health and Social Welfare - 2009.

Stigma in society is very strong against male-male sex. According to the 2007 Pew Global Attitudes Project, a strong 95% of Tanzania residents said that homosexuality should be rejected by society, making it among the highest rejection of homosexuality in the 44 countries surveyed.

HIV SITUATION AND RISK BEHAVIOURS

According to the 2011-2012 IBBS survey the HIV prevalence among MSM in Zanzibar is 2.6% in Unguja and 5.0% in Pemba. In Unguja, the prevalence of HBV is 2.7%; HCV is 1.3%; and Syphilis - 0.0%. No cases of HCV, HBV or syphilis were found among MSM in Pemba.

Many MSM in Zanzibar report having multiple partners in the last month. The median number of male partners reported in the previous month was five. 47.1% of MSM reported two or more non-paying receptive male partners in the past month, and 39.5% reported two or more non-paying insertive partners in the past month. Many of the men report bisexual behaviour with 59.0% of MSM in the 2011-12 / IBBS reported having both male and female sexual partners in the last year. 5.8% reported being married to women. It is evident that transactional sex is prevalent among MSM in Zanzibar. Among MSM who reported paying for sex, 78.7% had paid a man. Similarly, among MSM who reported ever selling sex, 92.1% had sold sex to a man in the month prior to the survey. In total, 86.1% of MSM had either paid for, or sold sex to a man in the last month. Only 12.2% of MSM reported ever selling sex to a woman.

Reported condom use is low among MSM, with 51.5% using a condom the last time they paid a man for sex and 48.3% used a condom the last time they paid a woman for sex. Only 47.4% used a condom the last time they were paid by a man for sex, and 47.1% used a condom the last time they had a sex with a non-paying male partner.

A significant proportion of MSM in Zanzibar also use drugs. Among participants in the 2011-2012 IBBS, 39.8% of MSM reported using any drugs, other than alcohol, in the last three months. Only 1.0% of MSM in the 2011-2012 IBBS reported injecting drugs in the past three months.

There is a significant level of stigma directed at MSM. 41.6% of men reported being a victim of physical abuse in the previous 12 months, among whom 16% were beaten by a family member, and 4.4% reported experiencing physical harassment from the police in the previous 12 months.

ORGANIZATIONS WORKING WITH THE GROUP

- ZACP, ZAC, Kwahani Youth Group, ZAYEDESA, ZANGOC, ZAIADA, ZYF, ZAPHA+, UMATI, Peer groups – through ZACP peer educators, Columbia University (ICAP), Government Hospitals and community health centres

SERVICES AVAILABLE IN ZANZIBAR

- HTC (mobile and fixed site)
- Care and treatment: Access to ART for PLHIV, support groups for PLHIV
- Education programmes on HIV and AIDS
- STI diagnosis and treatment
- TB services (diagnosis and treatment)
- Peer education
- Outreach services
- Condom access
- Behaviour change communication, including IEC materials distribution

GEOGRAPHICAL COVERAGE WITH OUTREACH SERVICES

UNGUJA	PEMBA
Urban: Miembeni, Kwahani, Kikwajuni Chini, Kikwajuni Juu, Kilimani, Mwembeshauri, Kundemba, Malindi. Amani, Mchangani, Shangani, Vuga, Vikokotoni, Mwembetanga, Bwahani, , Masumbani, Kwa Agata **West:** Bububu, Chukwani, Kiembesamaki, Miles 4, Tomondo **Central:** Mwera, Koani, Machuwi, Chwaka **North:** Nungwi, Kiwengwa, Pwani Mchangani, Mkokotoni **South:** Paje, Jambiani, Bwejuu, Kizimkazi	**Chake Chake District:** Chake mjini, Pujini, Machomane, Wawi, Vitongoji, Chanjaani **Wete District:** Wete, Kipangani, Limbani, Mzambarau Takao, Bopwe, Gando, Jadida, Selemu, Utaani **Micheweni District:** Micheweni, Finya, Makangale, Kiuyu kwa Manda, Pandani, Wingwi **Mkoani District:** Uweleni, Ng'ombeni, Mkanyageni, Mjimbini, Kisiwa Panza, Kangani, Chokocho

PACKAGE OF HIV INTERVENTIONS FOR MEN WHO HAVE SEX WITH MEN

INTRODUCTION

Unprotected anal sex between men is increasingly being reported in sub-Saharan Africa including in Zanzibar. Studies conducted in Zanzibar have also shown that many MSM also have female partners or are married. MSM in Zanzibar face stigma or are driven underground through laws or policies criminalizing male-male sexual behaviours. Adopting a rights-based approach will ensure that MSM and their male and female sexual partners have the right to information and commodities, enabling them to protect themselves against HIV and other STIs as well as information on where to seek appropriate care and treatment. Importantly, this approach also ensures their right to access appropriate and effective prevention and care services of the highest possible quality, delivered free from discrimination.

The health and community sectors both have an important role to play by including services for MSM in their program priorities and by advocating for decriminalization of same-sex acts and for legislation against discrimination based on sexual orientation. Program planning needs to include formative assessments to determine the risks and needs of MSM in Zanzibar and these men should be fully engaged in designing and implementing the interventions. Interventions targeting MSM to prevent sexual transmission of HIV and other STIs should include the interventions recommended in this package.

KEY GUIDING GLOBAL RECOMMENDATIONS DOCUMENTS

- Prevention and Treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people, recommendations for a public health approach, WHO, 2011 http://whqlibdoc.who.int/publications/2011/9789241501750_eng.pdf
- Technical Guidance on Combination HIV Prevention. As part of PEPFAR's overall prevention strategy, this guidance document addresses prevention programs for men who have sex with men, May 2011 http://www.pepfar.gov/documents/organization/164010.pdf
- UNAIDS Action Framework: Universal Access for Men Who Have Sex With Men and Transgender People, UNAIDS, 2009 http://data.unaids.org/pub/report/2009/jc1720_action_framework_msm_en.pdf
- Priority interventions, HIV/AIDS treatment and care in the health sector, WHO, 2010 http://www.who.int/hiv/pub/guidelines/9789241500234_eng.pdf

COMPREHENSIVE PACKAGE

<table>
<tr><th colspan="2">COMPONENTS WITHIN COMPREHENSIVE PACKAGE OF HIV INTERVENTIONS FOR MEN WHO HAVE SEX WITH MEN</th></tr>
<tr><th>HIV PREVENTION</th><th>HIV CARE AND TREATMENT</th></tr>
<tr><td>• HTC, with the aim of individuals voluntarily accessing HTC every 6-12 months, delivered through health services and community based services
• PITC should be offered in all health care settings to all MSM
• Prevention and treatment of Sexually Transmitted Infections (STIs), including conducting ano-rectal and pharyngeal examinations for diagnosis of infections
• Condom programs (access and promotion of use) for MSM and their sexual partners. This should include access to both male and female condoms and lubricants, delivered through fixed sites and outreach
• Targeted information, education and communication (IEC) for MSM and their sexual partners delivered through peer based outreach and using social networking and modern technology that is appealing to the target group
• Post exposure prophylaxis for HIV
• Oral pre exposure prophylaxis for HIV
• Treatment as prevention (with ART provision for all MSM living with HIV)
• PMTCT services for female partners of MSM if planning on having children</td><td>• HTC
• ART for all MSM living with HIV
• Diagnosis and treatment of opportunistic infections
• Cotrimoxazole prophylaxis for PLHIV
• Isoniazid Preventive Therapy for PLHIV, in line with WHO guidelines
• Palliative care services
• Nutritional support for PLHIV
• Peer support groups for PLHIV who identify as MSM</td></tr>
<tr><th>STRUCTURAL INTERVENTIONS</th><th>COMPLEMENTARY HEALTH SERVICES</th></tr>
<tr><td>• Activities to reduce the stigma and discrimination faced by MSM
• Programs with law enforcement agencies to gain support for, and acceptance of, health programming for MSM
• Promotion and guarantee of human rights
• Safe internet based and/or physical spaces for MSM to seek information and referrals for care and support
• Empowerment for MSM through development of peer networks</td><td>• Services addressing harmful drug and alcohol use among MSM who use these substances
• Psychosocial support services including peer support systems
• Prevention, diagnosis and treatment of TB
• Treatment of viral hepatitis including vaccination for Hepatitis A and B
• Targeted IEC for people living with viral hepatitis on liver care
• PITC delivery of testing for asymptomatic syphilis infection – aim for annual testing</td></tr>
</table>

MINIMUM PACKAGE OF SERVICES FOR MEN WHO HAVE SEX WITH MEN IN ZANZIBAR

COMPONENTS IN MINIMUM PACKAGE
• HTC, with the aim of individuals voluntarily accessing HTC every 6 – 12 months • PITC should be offered in all health care settings to MSM • Education on prevention of STIs, including HIV, and diagnosis and treatment of STIs, including conducting ano-rectal and pharyngeal examinations for diagnosis of infections • Condom program (access and promotion of use) for MSM and their sexual partners. This should include access to both male and female condoms and other HIV prevention supplies • Delivery of targeted IEC for MSM and their sexual partners delivered through peer based outreach and using social networking and modern technology that is appealing to the target group • Access to, and support for adherence to, anti-retroviral therapy for PLHIV • Activities to reduce the stigma and discrimination faced by MSM

BENEFITS OF THE COMPREHENSIVE PACKAGE

- Reduction in HIV transmission among MSM and their sexual partners
- Reduction in morbidity and mortality associated with HIV infection and associated opportunistic infections
- Reduction in morbidity and mortality associated with viral hepatitis infections
- Decreased levels of stigma and discrimination faced by MSM
- Reduction in harms associated with criminal classification of male-male sex (i.e. incarceration)
- Greater integration of MSM with society

SYSTEM REQUIREMENTS NEEDED TO SUPPORT THE DELIVERY OF INTERVENTIONS

POLICY

- Enabling policy to increase access to services for MSM
- Health system strengthening including increase in funding allocations for services

SERVICE DELIVERY, SURVEILLANCE, MONITORING AND EVALUATION

- Coordination of approaches among multiple partners
- Strengthen links and referral mechanisms between different levels of the health system and community outreach programs

- Ensure active participation of MSM in peer education approaches with proper training, supervision and support
- Skilled health professionals and community workers, trained in service delivery components, who are respectful of human rights
- Regular access to, availability and affordability of commodities required to assist behaviour change and promote health seeking behaviour with regards HIV infection
- Essential medicines and medical supplies
- Quality routine surveillance, research and use of data for quality improvement are essential for an effective response to HIV in Zanzibar.
- Adequate recording and reporting mechanisms in the monitoring and evaluation system

FURTHER RESOURCES AND GUIDANCE DOCUMENTS

- Peer and Outreach Education for Improving the Sexual Health of Men Who Have Sex With Men: A Reference Manual for Peer & Outreach Workers , October 2010 http://www.c-hubonline.org/sites/default/files/resources/main/Peer%20Education%20for%20MSM.pdf
- Policy Brief: Young Men who have Sex with Men: Health, Access and HIV. The Global forum on MSM and HIV. http://www.hst.org.za/sites/default/files/MSMGF_YMSM_PolicyBrief.pdf
- Consolidated Guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach. WHO, June 2013 http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727_eng.pdf
- The Global HIV Epidemics among Men Who Have Sex with Men, The World Bank, 2011 http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/MSMReport.pdf
- Men who have sex with men, HIV prevention and care. Report of a UNAIDS Stakeholder consultation, November 2005 http://data.unaids.org/pub/Report/2006/jc1233-msm-meetingreport_en.pdf
- Guidance on pre-Exposure Oral Prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV. http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf
- Rapid assessment and response: Adaptation guide on HIV and men who have sex with men (MSM-RAR) http://www.who.int/entity/hiv/pub/prev_care/en/msmrar.pdf
- Policy brief: HIV and sex between men http://data.unaids.org/Publications/IRC-pub07/jc1269-policybrief-msm_en.pdf
- Between men: HIV STI prevention for MSM http://www.aidsalliance.org/includes/Publication/msm0803_between_men_Eng.pdf
- AIDS and men who have sex with menhttp://whqlibdoc.who.int/unaids/2000/a62375_eng.pdf

- WHO and partners. *Guidance on global scale-up of the prevention of mother-to-child transmission of HIV: towards universal access for women, infants and young children and eliminating HIV and AIDS among children*. Geneva, WHO, 2007. http://whqlibdoc.who.int/publications/2007/9789241596015_eng.pdf
- World Health Organization. Guidance on Couples HIV Testing and Counselling, Including Antiretroviral Therapy for Treatment and Prevention in Serodiscordant Couples. April 2012. http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972_eng.pdf
- WHO & UNAIDS. *Guidance on provider-initiated HIV testing and counselling in health facilities*. Geneva,WHO, 2007 http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf
- Programmatic update: Antiretroviral Treatment as Prevention (TASP) of HIV and TB, WHO. June 2012. http://whqlibdoc.who.int/hq/2012/WHO_HIV_2012.12_eng.pdf
- Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries http://whqlibdoc.who.int/trs/WHO_TRS_938_eng.pdf
- Adolescent friendly health services: An agenda for change, WHO, 2002 http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf
- Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf
- Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection. WHO, 2007 http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf
- WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders. Geneva, World Health organization, 2012. http://whqlibdoc.who.int/publications/2012/9789241503006_eng.pdf
- Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings. Geneva, World health Organization, 2011. http://whqlibdoc.who.int/publications/2011/9789241500708_eng.pdf

KEY DOCUMENTS FOR ZANZIBAR

- GoZ 2011, Zanzibar National HIV Strategic Plan II (ZNSP-II) 2011 – 2016. The Zanzibar AIDS Commission
- GoZ 2012, Costed Operational Plan for Zanzibar National Multi-sectoral Strategic Plan (ZNSP-II).
- ZACP 2011-2012, Integrated Behavioural and Biological Surveillance Survey among KPs at risk in Zanzibar
- ZAC 2009, Gap analysis of the Zanzibar HIV and AIDS Response Initiatives.

Dahoma, Mohammed, et al., HIV and Related Risk Behavior Among Men Who Have Sex with Men in Zanzibar, Tanzania: Results of a Behavioral Surveillance Survey, *AIDS and Behaviour,* 15(1), 2011 Jan, pp 186-92.

PACKAGE 3: PEOPLE WHO SELL SEX

CURRENT SITUATION IN ZANZIBAR

BACKGROUND

Sex work is Zanzibar is more common in Unguja than Pemba, and is often associated with the tourism industry areas, though significant trading of sex also occurs in the local population. There are an estimated 4000 people who sell sex in Unguja, according to the latest estimates. According to the 2011-2012 IBBS, females who sell sex typically range in age from 17 – 52 and the median age of women selling sex is 30. The median monthly income among people who sell sex was 150,000 TZS and ranged from 15,000 to 6,000,000 TZS. More than half (52.1%) earned 120,000 TZS per month or less, with the majority of these earning between 50,000 – 120,000 TZS per month. Slightly more than one quarter (27.2%) earned more than 200,000 TZS. Approximately half (50.9%) of people who sell sex report having no other source of income besides sex work.

The majority of females who sell sex (88.7%) reported that they had their sexual debut before 20 years of age, with 29.3% reporting sexual debut at 15 years or younger. The median age of sexual debut was 18 years, with a range from 7 to 35 years. More than half (59.1%) began selling sex before the age of 25. The median age at which people who sell sex reported first selling sex was 23 years and ranged from 11 to 45 years.

The median duration of sex work was five years. At the time of the 2011-2012 IBBS, 39.4% of females who sell sex in Unguja had been engaged in sex work for three years or less while 26.7% reported selling sex for ten years or more.

The majority of respondents (67.4%) reported that they entered sex work because they needed money to support their family or to pay a debt. Another 14.1% of females who sell sex started selling sex after being abandoned by their families and/or husbands, while 10.5% entered sex work because they like the work or have a friend or family member engaged in sex work. Only 1.1% reported entering sex work because of substance dependency, and only 1.0% said they were 'forced' into sex work.

Females who sell sex in Unguja most commonly reported meeting their clients in night-time social settings such as clubs or bars (43.3%), in guesthouses or private rooms (17.8%), at hotels (15.8%) and discos or full moon parties (15.4%). Almost half of females who sell sex (46.6%) have an "agent" or pimp to help manage clients.

HIV SITUATION AND RISK BEHAVIOURS

According to the 2011-2012 IBBS the HIV prevalence among females who sell sex in Zanzibar is 19.3% in Unguja and 18.8% in Pemba. In Unguja, the prevalence of HBV is 2.2%; HCV is 1.6%; and Syphilis – 3.1%. No cases of HCV, HBV or syphilis were found among people who sell sex in Pemba.

The highest HIV prevalence was found among 20-24 year olds (25.7%), followed by 30-34 year olds (23.9%), and those 35 years and older (19.2%). The lowest HIV prevalence was among the youngest age group, 15-19 years (3.9%). HIV prevalence was higher among people who sell sex who started selling sex at older ages.

Females who sell sex in Zanzibar report multiple risk behaviours for HIV acquisition / transmission. In the 2011-2012 IBBS the majority of females who sell sex reported having one, two, three or four clients on their last day of sex work (29.3%, 23.9%, 24.6% and 22.2% respectively).The median number of sex clients served on the last day of work was two. The majority of people who sell sex (63.7%) reported having more than 10 sexual partners in the past month, with 21.3% reporting 31 or more.

Four out of five people who sell sex (78.9%) reported using a condom the last time they had sex. The most commonly cited reason for not using a condom at last sex was due to the partner objecting (39.3%), followed by the person selling sex trusting the partner (15.4%), and not having any condoms (9.3%). Condom use varied slightly depending on the type of sexual partner, although overall reported condom use was high. Less than a quarter (24.0%) of people who sell sex reported 'always' using a condom with their steady partner, while 86% reported 'always' using a condom with tourists/foreigners. The majority of people who sell sex also reported 'always; using a condom with one-time clients (79.0%), regular clients (71.8%) and casual, non-paying clients (68.2%).

Reported drug use among females who sell sex is relatively low with only 19.8% of women reporting using drugs, other than alcohol, in the three months prior to the survey. Only 1.5% reported injecting drugs in the three months prior to the survey, although 4.1% had ever injected drugs. Suspicion of drug use and injection drug use by partners differed by partner type, although fewer than 30% of people who sell sex suspected any partner type of using drugs.

There are low reported rates of accessing services, even with high perceptions of HIV risk. Though the majority of females who sell sex perceive themselves at high risk of HIV infection (56.5%), almost one third (27.1%) of respondent believed themselves to have no risk of infection. Only 13.8% of people who sell sex had accessed a clinic or drop-in centre with a 'sex worker' focussed services in the past 12 months.

There is high level of stigma and violence directed at females who sell sex. 43.7% of the females who sell sex in the 2011-2012 IBBS reported physical abuse in the last 12 months. Nearly one in five (18.5%) reported being beaten by a one-time sex partner, a similar percentage (17.2%) were beaten by their steady partner, and 9.4% were beaten by a regular client. More than a quarter (27.3%) of people who sell sex were arrested in the last year.

ORGANIZATIONS WORKING WITH THE GROUP

ZACP, ZAC, ZAYEDESA, ZANGOC, ZAIADA, ZYF, ZAPHA+, UMATI, Peer groups – through ZACP peer educators, Sober house for females, Government Hospitals and community health centres

SERVICES AVAILABLE IN ZANZIBAR
• HTC (mobile and fixed site) • Care and treatment: Access to ART for PLHIV, support groups for PLHIV • Education programmes on HIV and AIDS • STI diagnosis and treatment • TB services (diagnosis and treatment) • Peer education • Outreach services • Condom access (male and limited access to female condoms in Unguja) • Behaviour change communication, including IEC materials distribution • Sexual and reproductive health services including family planning • PMTCT service

GEOGRAPHICAL COVERAGE WITH OUTREACH SERVICES	
UNGUJA	**PEMBA**
Urban: Miembeni, Kwahani, Kikwajuni Chini, Kikwajuni Juu, Kilimani, Mwembeshauri, Kundemba, Malindi. Amani, Mchangani, Shangani, Vuga, Vikokotoni, Mwembetanga, Bwahani, Masumbani, Kwa Agata , Kwaalamsha, Jang'ombe, Nyerere **West:** Bububu, Chukwani, Kiembesamaki, Fuoni, Pangawe, Miles 4, Tomondo, **Central:** Mwera, Koani, Machuwi, Chwaka **North:** Nungwi, Kiwengwa, Pwani Mchangani, Mkokotoni **South:** Paje, Jambiani, Bwejuu, Kizimkazi	**Chake Chake District:** Chake mjini, Pujini, Machomane, Wawi, Vitongoji, Chanjaani **Wete District:** Wete, Kipangani, Limbani, Mzambarau Takao, Bopwe, Gando, Jadida, Selemu, Utaani **Micheweni District:** Micheweni, Finya, Makangale, Kiuyu kwa Manda, Pandani, Wingwi **Mkoani District:** Uweleni, Ng'ombeni, Mkanyageni, Mjimbini, Kisiwa Panza, Kangani, Chokocho

PACKAGE OF HIV INTERVENTIONS FOR PEOPLE WHO SELL SEX

INTRODUCTION

Females and males who sell sex are among the groups most vulnerable to and affected by HIV in Zanzibar. Specific behaviours can place people who sell sex, their clients and regular partners at risk, and contextual factors can further exacerbate their vulnerability to HIV. The evidence base is firmly established to support a range of interventions to prevent transmission of HIV and other STIs in sex work settings, to provide care and support services, and to empower people who sell sex to improve their own health and well-being. Interventions can be tailored for brothel or other entertainment establishments, or for more informal street-based and home-based settings.

A package of interventions is recommended to increase condom use and safe sex, reduce the STI and HIV burden and maximize sex worker involvement in and control over their working and social conditions. Interventions targeting females who sell sex to prevent sexual transmission of HIV and other STIs should include the interventions recommended in this package.

KEY GUIDING GLOBAL RECOMMENDATIONS DOCUMENTS

- Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries. Recommendations for a public health approach. December, 2012. http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf
- Preventing HIV in sex work settings in sub-Saharan Africa, WHO, 2011 http://www.afro.who.int/en/clusters-a-programmes/dpc/acquired-immune-deficiency-syndrome/features/2880-preventing-hiv-in-sex-work-settings-in-sub-saharan-africa.html
- UNAIDS Guidance Note on HIV and Sex Work, UNAIDS , 2009 http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf
- Priority interventions, HIV/AIDS treatment and care in the health sector, WHO, 2010 http://www.who.int/hiv/pub/guidelines/9789241500234_eng.pdf

COMPREHENSIVE PACKAGE

COMPONENTS WITHIN COMPREHENSIVE PACKAGE OF HIV INTERVENTIONS FOR PEOPLE WHO SELL SEX	
HIV PREVENTION	**HIV CARE AND TREATMENT**
• HTC, with the aim of individuals voluntarily accessing HTC every 6-12 months, delivered through health services and community based services • PITC should be offered in all health care settings to all people who sell sex • Prevention and treatment of STIs, including voluntary periodic screening, and presumptive treatment, in line with WHO guidelines • Condom programs (access and promotion of use) for people who sell sex and their sexual partners. This should include access to both male and female condoms and lubricants • Targeted IEC for people who sell sex and their sexual partners delivered through peer based outreach and using social networking and modern technology that is appealing to the target group • Post exposure prophylaxis for HIV • Oral pre exposure prophylaxis for HIV • Treatment as prevention (with ART for people who sell sex living with HIV) • Programs to address risky alcohol consumption among people who sell sex and associated vulnerability to unsafe sex • PMTCT services for females who sell sex if planning on having children	• HTC • ART for all females who sell sex who are living with HIV • Diagnosis and treatment of opportunistic infections • Cotrimoxazole prophylaxis for PLHIV • Isoniazid Preventive Therapy for PLHIV, in line with WHO guidelines • Palliative care services • Nutritional support for PLHIV • Peer support groups for PLHIV who identify as people who sell sex

STRUCTURAL INTERVENTIONS	COMPLEMENTARY HEALTH SERVICES
• Activities to reduce the stigma and discrimination faced by people who sell sex • Programs with law enforcement agencies to gain support for health programming for people who sell sex and their clients/partners • Promotion and guarantee of human rights • Safe internet based and/or physical spaces for people who sell sex to seek information and referrals for care and support • Programmes to reduce demand for adolescent and young girls for sex work • Programmes to protect women and girls from violence and exploitation • Sex worker empowerment through development of peer networks of people who sell sex	• Services addressing harmful drug and alcohol use among people who sell sex who use these substances • Psychosocial support services including peer support systems • Prevention, diagnosis and treatment of TB • Treatment of viral hepatitis including vaccination for Hepatitis A and B • Targeted IEC for people living with viral hepatitis on liver care. • Sexual and reproductive health services including family planning, counseling and contraception • PITC delivery of testing for asymptomatic syphilis infection

MINIMUM PACKAGE OF SERVICES FOR PEOPLE WHO SELL SEX IN ZANZIBAR

COMPONENTS IN MINIMUM PACKAGE
• HTC, with the aim of individuals voluntarily accessing HTC every 6-12 months, delivered through health care services and community based services. PITC should be offered in all health care settings to people who sell sex • Prevention and referral for treatment of STIs, including voluntary periodic screening for asymptomatic STIs, in line with WHO guidelines • Condom programmes (access and promotion of use)for people who sell sex and their sexual partners (should include access to both male and female condoms and other HIV prevention supplies) • Delivery of targeted IEC for people who sell sex and their sexual partners delivered through peer based outreach and using social networking and modern technology that is appealing to the target group • Access to, and support for adherence to, ART for PLHIV • Activities to reduce the stigma and discrimination faced by people who sell sex • Sexual and reproductive health services including family planning, counselling and contraception

BENEFITS OF THE COMPREHENSIVE PACKAGE

- Reduction in HIV transmission among people who sell sex and their sexual partners
- Reduction in morbidity and mortality associated with HIV infection and associated opportunistic infections
- Reduction in morbidity and mortality associated with viral hepatitis infections
- Decreased levels of stigma and discrimination faced by people who sell sex
- Reduction in harms associated with criminal classification of sex work (i.e. incarceration)
- Greater integration of people who sell sex with society

SYSTEM REQUIREMENTS NEEDED TO SUPPORT THE DELIVERY OF INTERVENTIONS

POLICY

- Enabling policy to increase access to services for people who sell sex
- Health system strengthening including increase in funding allocations for services

SERVICE DELIVERY, SURVEILLANCE, MONITORING AND EVALUATION

- Coordination of approaches among multiple partners
- Strengthen links and referral mechanisms between different levels of the health system and community outreach programs
- Ensure active participation of people who sell sex in peer education approaches with proper training, supervision and support
- Skilled health professionals and community workers, trained in service delivery components, who are respectful of human rights
- Regular access to, availability and affordability of commodities required to assist behaviour change and promote health seeking behaviour with regards HIV infection
- Essential medicines and medical supplies
- Quality routine surveillance, research and use of data for quality improvement are essential for an effective response to HIV in Zanzibar.
- Adequate recording and reporting mechanisms in the monitoring and evaluation system

FURTHER RESOURCES AND GUIDANCE DOCUMENTS

- Work-safe in sex work, training toolkit – A European manual on good practices for work in and for sex workers, TAMPED, 2009 http://tampep.eu/documents/wssw_2009_final.pdf
- Training course for the 100% Condom Use programme, WHO-WPRO, 2002 http://www.who.int/hiv/topics/vct/sw_toolkit/training_course_100_condom_use_programme-.pdf
- HIV/AIDS Sex Work Toolkit, targeted HIV/AIDS prevention in sex work settings, WHO, 2004 http://www.who.int/hiv/topics/vct/sw_toolkit/en/
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- Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries http://whqlibdoc.who.int/trs/WHO_TRS_938_eng.pdf
- Adolescent friendly health services: An agenda for change, WHO, 2002 http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf
- Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf
- Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection. WHO, 2007 http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf

- WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders. Geneva, World Health organization, 2012. http://whqlibdoc.who.int/publications/2012/9789241503006_eng.pdf
- Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings. Geneva, World health Organization, 2011. http://whqlibdoc.who.int/publications/2011/9789241500708_eng.pdf

KEY DOCUMENTS FOR ZANZIBAR

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- GoZ 2012, Costed Operational Plan for Zanzibar National Multi-sectoral Strategic Plan (ZNSP-II).
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- ZAC 2009, Gap analysis of the Zanzibar HIV and AIDS Response Initiatives.

PACKAGE 4: STUDENTS IN CORRECTIONAL FACILITIES

CURRENT SITUATION IN ZANZIBAR

BACKGROUND

The Correctional Facilities system in Zanzibar is composed of nine serving units and the department is placed under the Ministry of the President's Office and chairman on the revolutionary council regional administration and local government. Two of the serving units serve as administrative centre (headquarters) in each island. Zanzibar has one officers training centre for correctional facilities officers. It is estimated that the correctional facilities system has the capacity of accommodating around a 1,000 students and around 2,000 officers and prison officers.

Nearly half (47.6%) of all students at the Institute of Education for Offenders in Zanzibar are aged between 25 to 34 years, and a large proportion of them are single (40.8%). Most of these students have primary education (51.9%) and about a quarter of them have been sentenced more than once (2-4 times).

The vast majority of inmates in prison settings in Zanzibar are male. At the time of this review it was reported by authorities that only two females are incarcerated in the prison system in Zanzibar.

HIV SITUATION AND RISK BEHAVIOURS

According to the Zanzibar Correctional Facilities HIV/AIDS Strategic Plan 2011 – 2014, the HIV prevalence among students in correctional facilities is 2.8%. The HIV infection pattern among correctional facility students disaggregated by age group is:

15 - 24 years – 3.3%

25 – 34 years – 2.8%

35 – 44 years – 2%

45 years and above – 0% (ref: ZNSP-II)

The prevalence of HBV is 7.1%; HCV - 4.8%; and Syphilis - 3.8%. A prison study also outlined potential transmission potential to include:

HIV infection appeared higher among prisoners who practised male-male anal sex compared to those who were not practicing anal sex (3.3% and 2.6% respectively).

Correctional facility students with recent history of an STI were more likely to be HIV positive compared to those with past history of STIs (14.3% and 8.3%, respectively). HIV prevalence among correctional facility students who had a history of injecting drug use was recorded at 4%.

HIV risk behaviour is prevalent among students at these Institute of Education for Offenders including anal sex. About 23% have reported to have had sex with their male counterparts. The practice of male-male sex is common among the younger inmates compared to the older ones. The inmates serving longer sentences have a greater risk of engaging in same sex relationships compared to those serving shorter sentences. Incidences of sexual assault among students at the Institute of Education for Offenders have also been reported by 1.3% of

students. Sex with prison officers has been documented by 1% of students, while 1.6% of students have indicated that they have been engaged in transactional sex. The high drug risk behaviour among students in the Institute includes syringe sharing (40%) as well as flashblood practices (22%) among those identifying themselves as PWIDs.

As at September 2012, four inmates were on ART. It was reported that there were no cases of other STIs among inmates, though the studies conducted in the prisons indicate in the past that STIs have been present (reported through personal communication from correctional facility health staff – September 2012).

ORGANIZATIONS WORKING WITH THE GROUP

ZAC, ZACP, Prison officials, UNODC, ZYF, Drug Free Zanzibar, ICAP and Tawwabina

SERVICES AVAILABLE IN ZANZIBAR

- HTC
- Access to ART for PLHIV
- Education programmes on HIV and AIDS
- STI diagnosis and treatment
- TB services (diagnosis and treatment)
- Hepatitis screening, vaccination and management
- Recovering drug user programmes

PACKAGE OF HIV INTERVENTIONS FOR STUDENTS IN CORRECTIONAL FACILITIES

INTRODUCTION

Many people in prisons are living with or at high risk of HIV infection. It is in the interest of public health that all people in these settings have access to HIV prevention, treatment and care. They are entitled to the same standard of health as all other members of society.

A wide range of services is required for people in prisons and similar settings, including condom distribution, clean needle and syringe provision, OST, HTC, provision of ART and treatment for STIs.

Prison authorities should work with people in other branches of the criminal justice system and with health authorities and nongovernmental organizations to ensure continuity of care from community to prison and back to community, and also between prisons.

Prisons should offer a full range of HIV prevention, treatment and care services and commodities, including HTC and ART. Interventions students in correctional facilities to prevent transmission of HIV and other STIs should include the interventions recommended in this package. Staff working in prison settings and their family members should also be offered the same services as available to the students.

KEY GUIDING GLOBAL RECOMMENDATIONS DOCUMENTS

- HIV and AIDS in places of detention. A Toolkit for policymakers, programme managers, prison officers and health care providers in prison settings, UNODC, 2008 https://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf
- Effectiveness of interventions to address HIV in prisons, WHO, UNODC and UNAIDS, 2007 http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf
- Southern and Eastern Africa Declaration of Commitment for HIV and AIDS Prevention Care, Treatment and Support in Prisons in Africa (Adopted: Johannesburg, South Africa, 18 November 2009) http://www.unodc.org/documents/hiv-aids/publications/AHPPN_-_Declaration_Africaine_dengagement_-_Francais_REV_2._05.07.2010.pdf

COMPREHENSIVE PACKAGE

COMPONENTS WITHIN COMPREHENSIVE PACKAGE OF HIV INTERVENTIONS FOR STUDENTS IN CORRECTIONAL FACILITIES	
HIV PREVENTION	**HIV CARE AND TREATMENT**
• HTC, with the aim of individuals voluntarily accessing HTC every 6-12 months, delivered through health services and community based services • PITC should be offered in all health care settings to all people who sell sex • Education on prevention of STIs, including HIV, and diagnosis and treatment of STIs • Condom programs (access and promotion of use) for people in correctional facilities. This should include access to both male and female condoms and lubricants • Delivery of targeted IEC for people in correctional facilities delivered through peer based outreach • Post exposure prophylaxis for HIV • Treatment as prevention (with ART for PLHIV) • Needle and syringe Programmes NSPs, these should include access to injecting equipment and mechanisms for safe disposal • OST or MAT and other drug dependence treatment • Pre exposure prophylaxis for HIV if the person has male-male sex • Measures that reduce the demand for, and supply of, drugs in prisons • PMTCT services for female prisoners	• HTC • Access to, and support for adherence to, ART for all PLHIV • Diagnosis and treatment of opportunistic infections • Cotrimoxazole prophylaxis for PLHIV • Palliative care services • Nutritional support for PLHIV • Peer support groups for PLHIV • PLHIV Preventive Therapy for PLHIV, in line with WHO guidelines

STRUCTURAL INTERVENTIONS	COMPLEMENTARY HEALTH SERVICES
• Activities to reduce the stigma and discrimination faced by PLHIV • Promotion and guarantee of human rights • Safe virtual and/or physical spaces for prisoners to seek information and referrals for care and support • Activities to reduce overcrowding in prison settings • A proper system of classification needs to be in place which keeps children or youth separately from adults, women separate from men, and pre-trial prisoners separate from sentenced prisoners—such a system will decrease the likelihood of sexual abuse and violence in prisons. • Improved prison conditions, with reasonable space, decent sanitation and daylight and regular access to the open air will improve general health of prisoners, reduce the spread of tuberculosis, and likely decrease use of drugs. • Reducing violence, including sexual violence and rape, through a variety of activities, including hiring additional staff • Providing prisoners with work and other purposeful activities has many benefits, but it will also reduce high-risk behaviours that are often the result of boredom • Regular contact with family and friends through visits, telephone and post is also important in supporting safe behaviours among students	• Treatment for drug dependence including support during withdrawal, detoxification and rehabilitation services • Psychosocial support services including peer support systems • Prevention, diagnosis and treatment of TB • Treatment of viral hepatitis including vaccination for Hepatitis A and B • Targeted IEC for people living with viral hepatitis on liver care. • Overdose prevention education and naloxone availability • Periodic testing for asymptomatic syphilis infection • Sexual and reproductive health services including family planning, counselling and contraception • Peer support systems for people leaving prisons to reduce recidivism to drug use behaviours • Pre-release overdose prevention education for people who have a history of using drugs who are released from prisons

MINIMUM PACKAGE OF SERVICES FOR STUDENTS IN CORRECTIONAL FACILITIES IN ZANZIBAR

COMPONENTS IN MINIMUM PACKAGE
• HTC, with the aim of individuals voluntarily accessing HTC every 6 – 12 months
• PITC should be offered in all health care settings for all students in correctional facilities
• Education on prevention of STIs, including HIV, and diagnosis and treatment of STIs
• Targeted IEC for people in correctional facilities delivered through peer based outreach
• OST or MAT and other drug dependence treatment
• Access to, and support for adherence to, ART for PLHIV
• Activities to reduce the stigma and discrimination faced by PLHIV
• Prevention, diagnosis and treatment of Tuberculosis (TB) including provision of Isoniazid Preventive Therapy for PLHIV

BENEFITS OF THE COMPREHENSIVE PACKAGE

- Reduction in HIV transmission among students in correctional facilities and staff of correctional facilities
- Reduction in morbidity and mortality associated with HIV infection and associated opportunistic infections
- Reduction in morbidity and mortality associated with viral hepatitis infections
- Reduction in overdose mortality associated with release from prisons
- Decreased levels of stigma and discrimination faced by PLHIV
- Greater integration of prisoners back into society of release

SYSTEM REQUIREMENTS NEEDED TO SUPPORT THE DELIVERY OF INTERVENTIONS

POLICY

- Enabling policy to increase access to services for staff and students in prison settings
- Health system strengthening including increase in funding allocations for services

SERVICE DELIVERY, SURVEILLANCE, MONITORING AND EVALUATION

- Coordination of approaches among multiple partners
- Strengthen links and referral mechanisms between different levels of the health system and prisons authorities

- Ensure active participation of students in correctional facilities in peer education approaches with proper training, supervision and support
- Skilled health professionals and correctional facilities staff, trained in service delivery components, who are respectful of human rights
- Regular access to, availability and affordability of commodities required to assist behaviour change and promote health seeking behaviour with regards HIV infection
- Essential medicines and medical supplies
- Quality routine surveillance, research and use of data for quality improvement are essential for an effective response to HIV in Zanzibar.
- Adequate recording and reporting mechanisms in the monitoring and evaluation system

FURTHER RESOURCES AND GUIDANCE DOCUMENTS

- Policy Brief: HIV testing and counselling in prisons and other closed settings, UNODC & WHO, 2009 http://www.unodc.org/documents/balticstates/Library/PrisonSettings/UNODC_WHO_2009_Policy_Brief_TC_in_Closed_Settings-EN.pdf
- Effectiveness of interventions to address HIV in prisons (Drug dependence treatment), WHO, UNODC and UNAIDS, 2007 http://whqlibdoc.who.int/publications/2007/9789241595803_eng.pdf
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- Women and HIV in prisons settings, UNODC and UNAIDS, 2008 http://www.unodc.org/documents/hiv-aids/Women%20and%20HIV%20in%20prison%20settings.pdf
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- Programmatic update: Antiretroviral Treatment as Prevention (TASP) of HIV and TB, WHO. June 2012. http://whqlibdoc.who.int/hq/2012/WHO_HIV_2012.12_eng.pdf
- Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries http://whqlibdoc.who.int/trs/WHO_TRS_938_eng.pdf
- Adolescent friendly health services: An agenda for change, WHO, 2002 http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf
- Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf
- Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection. WHO, 2007 http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf
- WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders. Geneva, World Health organization, 2012. http://whqlibdoc.who.int/publications/2012/9789241503006_eng.pdf
- Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings. Geneva, World health Organization, 2011. http://whqlibdoc.who.int/publications/2011/9789241500708_eng.pdf

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- GoZ 2012, Costed Operational Plan for Zanzibar National Multi-sectoral Strategic Plan (ZNSP-II).
- ZAC 2009, Gap analysis of the Zanzibar HIV and AIDS Response Initiatives.
- Dahoma et al, 2008, Light behind Bars:- Addressing the HIV and AIDS challenges in all settings in Zanzibar
- GoZ 2011, the Zanzibar Correctional Facilities HIV/AIDS Strategic Plan (ZCFSP), 2011 – 2014. Zanzibar AIDS Commission.

SPECIAL CHAPTER: PRACTICAL APPLICATIONS FOR USING THESE GUIDELINES TO WORK WITH KEY POPULATIONS

1) For the specific KP group under consideration, go to the relevant 'package' in this guideline document.

2) Look at the recommended components in the minimum package, and assess which services are available and which are not yet available.

3) Look at the recommended components in the comprehensive package, and assess which services are available and which are not yet available.

4) Agree among stakeholders on which priority services need to be developed on enhanced in quality

5) Refer to the specific reference document for clinical/policy or practical advice on how to implement this component

6) Agree on who will be involved in the delivery of the component (preferably through partnership between government health system and civil society agencies)

7) Seek technical guidance for capacity building where needed through requests to external development partners

8) Build planning and funding for start-up of these activities into future grant applications (work-plans and budgets)