THE REVOLUTIONARY GOVERNMENT OF ZANZIBAR
MINISTRY OF HEALTH

Zanzibar Integrated HIV, Hepatitis Tuberculosis and Leprosy Programme

NATIONAL GUIDELINES ON COMPREHENSIVE HIV INTERVENTIONS FOR KEY POPULATIONS (KPS) IN ZANZIBAR

First Edition, June 2017

I. FOREWORD

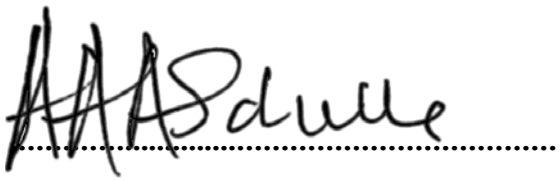
For over the past 3 decades, Zanzibar has been implementing various programs and initiatives to address HIV in the islands including provision of HIV prevention and treatment services. Zanzibar has a concentrated HIV epidemic with HIV prevalence below 1% among general population while, the prevalence of HIV infection among Key Population groups is relatively higher.

Zanzibar started to address HIV in key population groups in 2007 when results of the first studies on key populations showed significantly high prevalence among men having sex with men (MSM), sex workers (SWs) and people who inject drugs (PWID). Efforts to address HIV targeting this group have been undertaken by many implementing partners including CSOs and government.

In 2013 under UNICEF support. a package of interventions for key populations was developed to address minimum package service for MSM, SW, PWID and students in correctional facilities. The package described what kind of services should be rendered to this group. Later in 2015, a key population strategic plan for 2016- 2022 was developed with UNFPA support. However, these documents do not provide details on how each component of the interventions should be operationalized.

In 2014, WHO released important guidelines for KPs services, which were updated in 2016. Zanzibar therefore needs to develop comprehensive guidelines to respond to the current needs and latest evidence in providing care for the KPs. This guideline is intended to be a reference, and hence will be used by all partners providing HIV services targeting KPs in Zanzibar.

It is my hope that, these guidelines will be used to guide our efforts towards improving health of all members of our society. I urge all partners to read, update their knowledge, and use these guidelines to improve their preventive, promotive, and curative efforts in Zanzibar.



Hon. Asha Abdulla

Principal Secretary

Ministry of Health

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II. ACKNOWLEDGEMENT

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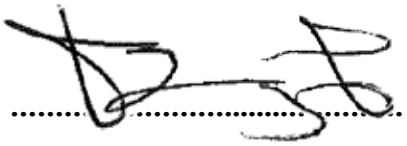
The development of the guidelines was facilitated by Dr. Emmanuel Matechi and Kimwaga Muhiddin Ali under the leadership of Dr. Farhat J. Khalid (Programme Manager ZIHTLP) and Shaaban Haji (Key Population, STI and Youth Coordinator – ZIHTLP) in collaboration with a team of technical working group members and stakeholders based in both Unguja and Pemba. Hence, these guidelines reflect the contribution of numerous civil society organizations, development partners and stakeholders, the UN Team on HIV and government ministries and departments working on issues pertaining to KPs in Zanzibar.

We are grateful to all stakeholders that participated in the review and provided important insights and valuable information regarding the national HIV and Sexual Reproductive Health (SRH) response to KPs in Zanzibar. Without their collective input, the development of these guidelines would not have been possible.

Support from UNICEF was instrumental in terms of guidance in the process, facilitating access to relevant and necessary reports, facilitating stakeholder interviews and consultations, and providing feedback on preliminary versions of this guideline.

We appreciate all your efforts. It is our hope that, your commitment and dedication in supporting the Ministry of Health in responding to HIV in Zanzibar will continue. Thank you!



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III. ABBREVIATIONS

AA	Alcoholic anonymous
AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
ATV	Atanazavir
AZT	Azido thymidine
CBOs	Community-based Organizations
CBHS	Community-based HIV / AIDS Services
CD4	Cluster of Differentiation 4
CSOs	Civil Society Organizations
CRC	Right of the child
DHIS	District Health Information Software
EFV	Efavirenz
FBOs	Faith-based Organizations
FSW	Female Sex Workers
GoZ	Government of Zanzibar
HAART	Highly active antiretroviral therapy
HBcAb	Hepatitis B Core Antibody
HBsAb	Hepatitis B Surface Antibody
HBsAg	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
IBBSS	Integrated Bio-Behavioural Surveillance Survey
ICAP	International Centre for AIDS Care and Treatment Programmes
ID	Identify Document
IEC	Information, Education, Communication
KPs	Key Populations
LPV	Lopinavir
MAT	Medically Assisted Treatment
MDAs	Ministry, Departments and Agents
MDM	Medicos Del Mundo
MSM	Men who have Sex with Men
NCCDC	National Commission for Coordination and Drug Control - Zanzibar
NA	Narcotic anonymous
NGOs	Non-Governmental Organizations

NSP	Needle and Syringe Program
OIs	Opportunistic Infections
OST	Opioid Substitution Therapy
PEP	Post Exposure Prophylaxis
PreP	Pre-Exposure Prophylaxis
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
PWUD	People Who Use Drugs
SBCC	Social Behavioural Change Communication
SDGs	Sustainable Development Goals
SI	Strategic Information Unit
RTIs	Respiratory Tract Infections
SRH	Sexual and Reproductive Health
SWs	Sex Workers
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TC	Lamivudine
TDF	Tenofovir Disoproxyl Fumarate
TWG	Technical Working Group
UN	United Nations
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
UNFPA	United Nations Population Fund
VCT	Voluntary Counseling and Testing
VPs	Vulnerable Persons
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
ZIHTLP	Zanzibar Integrated HIV, TB and Leprosy Programme
ZNSP-III	Zanzibar National HIV Strategic Plan – III (2017-2022)
ZYF	Zanzibar Youth Forum

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V. DEFINITIONS

Adolescents: Individuals between the ages of 10 and 19 years old are generally considered adolescents. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions and their ability to access services

Combination prevention: A combination of prevention, care and treatment interventions is required to respond effectively to HIV among Key Populations. The package has two parts: a) **health interventions**, including comprehensive condom programming; harm reduction interventions; behavioural interventions; HIV testing and counselling; HIV treatment and care; prevention and management of viral hepatitis, TB and mental health conditions; and sexual and reproductive health intervention; and b) **structural interventions**, including supportive legislation, policy and funding; addressing stigma and discrimination; community empowerment; and addressing violence.

Comprehensive Package of Services for KPs: This is the process of rendering services for KP in a full set of interventions recommended for example offering care and treatment services, counselling and testing, PMTCT, community based interventions as well as Information Change Communication at one setting.

Minimum package of Services for KPs: This is a mixed of intervention identified and implemented in a coordinated fashion. The minimum package depends upon the targeted population and includes components of prevention, care and treatment, though the primary emphasis is likely to be prevention. A minimum package of HIV prevention services should include peer-based outreach activities: appropriate messaging (information, education and communication (IEC) materials); condoms and condom-compatible lubrication; voluntary and confidential HIV counselling of Key Populations, and referral for treatment with antiretroviral therapy (ART); sexually transmitted infections (STI) and tuberculosis (TB) screening and referral for HIV, sexually transmitted infections (STI), tuberculosis (TB), Post-Exposure Prophylaxis, Substance abuse and mental health services, and reproductive health services, including family planning and Pap smears.

Gender-based violence Gender-based violence results in physical, sexual and psychological harm to both men and women and includes any form of violence or abuse that targets men or women on the basis of their sex. Unequal power relations between men and women significantly contribute to gender violence.

Harm reduction: 'Harm reduction' refers to policies, programmes and practices that aims to primarily reduce the adverse health, social and economic consequences of the use of drugs without necessarily reducing drug consumption. The first priority is decrease in the negative consequences of drug use.

Key Populations (KPs): KPs are defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. WHO guidelines focus on five key populations: 1) men who have sex with men, 2) people who inject drugs, 3) people in prisons and other closed settings, 4) sex workers and 5) transgender people. The key populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic.

Men who have sex with men refers to all men who engage in sexual and/or romantic relations with other men. The words "men" and "sex" are interpreted differently in diverse cultures and societies and by the individuals involved. Therefore, the term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular community or social group.

Monitoring: Monitoring is a systematic and continuous assessment of the progress of an activity over time. Monitoring is part of the implementation. Monitoring can be done through the process of collecting, coordinating, processing and communicating information to assist management make decisions. Monitoring encompasses follow up of Inputs, Processes and Output.

Evaluation: Evaluation is a systematic and periodic assessment of actions in order to improve planning or implementation of current and future activities. Evaluation involves follow up of inputs, outcomes and impacts to assess whether the set out objectives have been achieved. This can be done internally (by the implementers) or externally (by outsiders).

Outreach: Outreach is an activity of providing services to any populations who might not otherwise have access to those services. A key component of outreach is that the groups providing it are not stationary, but mobile; in other words, they are meeting those in need of outreach services at the locations where those in need are.

People who inject drugs refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, Hypnos-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes – referred to as "therapeutic injection" – are not included in this definition.

People in prisons and other closed settings: There are many different terms used to denote places of detention, which hold people who are awaiting trial, who have been convicted or who are subject to other conditions of security. Similarly, different terms are used for those who are detained. In this guidance document, the term "prisons and other closed settings" refers to all places of detention within a country, and the terms "prisoners" and "detainees" refer to all those detained in criminal justice and prison facilities, including adult and juvenile males and females, during the investigation

of a crime, while awaiting trial, after conviction, before sentencing and after sentencing. In Zanzibar prisons are referred to as **Correctional facilities**.

People who use drugs include people who use psychotropic substances through any route of administration, including injection, oral, inhalation, trans-mucosal (sublingual, rectal, intranasal) or transdermal. Often this definition does not include the use of such widely used substances as alcoholic and caffeine-containing beverages and foods.

Reproductive Tract Infections (RTIs): are Infections of the genital tract. They refer to the site where the infection develops. They may or not be transmitted through sexual contact

Sexually Transmitted Infections (STI): are groups of infections that are predominantly transmitted through unprotected sexual contact with an infected person.

Sex workers: include female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less "formal", or organized. As defined in the Convention on the Rights of the Child (CRC), children and adolescents under the age of 18 who exchange sex for money, goods or favours are "sexually exploited" and not defined as sex workers.

Surveillance is the routine tracking of disease (disease surveillance) or risk behaviour (behavioural surveillance) using the same data collection system over time. Surveillance helps describe the epidemic and its spread, and can contribute to predicting future trends and targeting needed prevention programmes. In the case of HIV, surveillance typically tracks impact in terms of HIV and sometimes STI prevalence, and outcomes in terms of risk behaviour.

Vulnerable populations (VPs): are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics (WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations 2016)

Youth: This term refers to individuals between the ages of 15 and 24 years

Young people: This term refers to those between the ages of 10 and 24 years

CHAPTER ONE: INTRODUCTION AND BACKGROUND INFORMATION

1. Introduction

1.1. Epidemiological Overview

For the past 3 decades, Zanzibar has been implementing various programs and initiatives to address HIV in the islands including provision of HIV prevention, care and treatment services. Although the HIV prevalence among general population is 1%[1], while the prevalence of HIV infection among Key Populations is relatively high; 11.3% among People Who Inject Drugs (PWID), 2.6% among Men who have sex with Men (MSM) and 19.3% among Female Sex Workers (FSWs).[2] This shows somewhat downward trends from earlier study where HIV prevalence among these groups was more than 10% i.e. MSM 12%, FSW 11% and PWID 16%[3]. It estimated that there are: 3,200 PWID; 2,200 MSM, and; 4,700 FSW in Zanzibar.[4] Adolescents and young people from key populations are at significant HIV risk, higher than that of their older peers in these populations. UNAIDS 2016 estimates 19% (1223/6269) are adolescent and young people infected with HIV. Similarly, these estimates indicate that HIV new infections is increasing among these populations (39% (99/248)). There is paucity of data for HIV prevalence among adolescents and young people who are KPs. However, according to All In Rapid Assessment (2016) It is estimated that there are 947 adolescent KPs of those 9 are PWID, 677 MSM and 261 sex workers.

1.1.1 HIV Situation and Risk behaviour among PWID

According to the 2011-2012 IBBSS survey the HIV prevalence among PWID in Zanzibar is 11.3%. The prevalence of Hepatitis B virus (HBV) is 5.9% and Hepatitis C virus (HCV) - 25.4%; and Syphilis – 0.8%.

High risk injection related practices are common with 96.4% of PWIDs reporting 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.

PWID in Zanzibar are also likely to be engaged in high-risk sexual behaviours. In the 2011-2012 IBBSS, 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 PWID. There is high level of stigma directed at PWID. 90.2% of the PWIDs in the 2011-2012 IBBSS reported experiencing stigma from family and the community with over half (56.4%) reporting they had been abandoned

[1]Tanzania HIV and Malaria Indicators Survey 2012
[2]Integrated Biological Behavioural Surveillance Survey 2012
[3]Integrated Biological Behavioural Surveillance Survey 2007
[4]Zanzibar HIV SRH KP Implementation Strategy 2016

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.

1.1.2 HIV Situation and Risk behaviour among MSM

According to the 2011-2012 IBBSS survey the HIV prevalence among MSM in Zanzibar is 2.6%. Among the MSM the prevalence of HBV is 2.7%; HCV is 1.3%. There were no cases of syphilis.

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 / IBBSS 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 IBBSS, 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 IBBSS 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

1.1.3 HIV Situation and Risk behaviour among Sex Workers

According to the 2011-2012 IBBSS the HIV prevalence among females who sell sex in Zanzibar is 19.3% while the prevalence of HBV is 2.2%; HCV is 1.6%; and Syphilis – 3.1%. 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 IBBSS 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 IBBSS 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.

1.2 KP services in Zanzibar

In Zanzibar, services for KPs started with support from Medicos del Mundo (MDM) in 2003 by involving peer educators on conducting outreach and moonlight interventions in pubs, ghettos and through multitude of community interventions. Activities included peer-led interventions such as promotion and provision of HIV/STI education and condom distribution. Later on, the need for scaling up of services targeted the three main groups of KP in Zanzibar was noted. This led to the development of minimum comprehensive HIV service delivery package for key populations. This guide was developed to outline evidence-based packages of HIV interventions required for minimum HIV service delivery package for these groups. The package is being used as the reference guidance for KP programmes. As a result, efforts to address HIV targeting these groups have been scaled up by implementing partners including CSOs and government. As of December 2016, about 70 health staff were already oriented on the minimum package for KP programmes. The package has been used to guide implementation of KP programs including introduction of MAT services for PWID in Zanzibar in 2015.

1.3 Rationale for the National Comprehensive KP guidelines

Zanzibar has made substantial progress in the scale up of HIV interventions. Given the disproportionate burden of the HIV epidemic among the specific KP in the Isles, focus is now also very much needed on addressing the HIV prevention, care, treatment and support needs of KP. These KP include people who are both extremely vulnerable to, and at an increased risk of, HIV due to their specific behaviours.

While KPs are characterized by unique risk behaviours, these groups are not mutually exclusive and there is considerable overlap in transmission risks. In the 2011-2012 IBBSS, some men who reported injecting drug use also reported engaging in male-male sex. Some sex workers also report injection drug use and may face incarceration for sex work or drug use. A significant number 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.

The substantial progress reported in Zanzibar includes the existence of this minimum package for KP interventions. Although the minimum package has been used to guide implementation of KP program, it has been noted that, the package is limited in its focus, for example the package does not provide guidance on specific intervention for KP by age groups or sub types.

Furthermore, Zanzibar has developed the HIV Sexual and Reproductive Health Key Populations (2016-2022) Strategy which spells out the need to develop KP Guidelines as part of its operationalization. In 2014, WHO released guidelines for KPs services, which were updated in 2016. Tanzania Mainland also developed a national KP Guidelines in 2014 which was revised in 2016 following WHO recommendations, country context and key lessons that had been gathered in implementing KP programme. Based on this Strategy, and existing in-country experience the Zanzibar Integrated HIV, TB and Leprosy Programme (ZIHTLP) is adopting a number of strategies and interventions in order to continue to scale comprehensive services for KP. It should also be realized that, Zanzibar through the Government of the United Republic of Tanzania has endorsed several global commitments and the respective plans of actions, including Sustainable Development Goals (SDGs), the 2016 UN Political Declaration on HIV and AIDS and 90-90-90[5] targets. Zanzibar national development strategies have declared commitment to improve the quality of life and ending AIDS as a public health threat by 2030.

In line with the above ground, the Government of Zanzibar therefore developed National Comprehensive KP guidelines to guide the operationalization of the packages of services for key populations. These Guidelines outline 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 address multiple risks and vulnerabilities and build on existing peer education and outreach activities. They entail programming encompassing a mixture of behavioral, biomedical and structural interventions, to be delivered through both health –facility and community outreach mechanisms. The Guidelines will ensure an overall effective and sustainable response to HIV, where there is a need for special interventions to reach out to KPs with a comprehensive package of prevention, treatment, care and support services.

Therefore, the goal of this national comprehensive guideline for KPs is to guide implementers of all groups of KPs-related interventions, so as to minimise the HIV transmission as well as to reduce mortality, morbidity, stigma and discrimination caused by HIV and AIDS. The actual implementation of this guideline shall as well contribute to the long-term goal of attainment of zero HIV infections, zero discrimination, Zero AIDS-related deaths and ultimately ending AIDS by 2030.

1.4 Target Audience for this Guideline

The Ministry of Health through the ZIHTLP and in collaboration with Zanzibar AIDS Commission will take responsibility of ensuring that, this national comprehensive guideline for KPs is implemented at all levels of KPs services delivery in Zanzibar. The target audiences for this guideline include all implementers of KPs related interventions including KPs groups and Sober Houses, Commission for National Coordination and Drug Control (CNCDC), Ministries, Departments and Agencies (MDAs), national and international civil society organisations (NGOs, CBOs and FBOs), private sectors, pharmacies, health and community service providers, the general community and development partners.

[5]By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression. (UNAIDS 2014)

1.5 Development of the Comprehensive KPs Guideline

The national comprehensive guideline for KPs was developed through consultations in both Unguja and Pemba, where stakeholders such as ZAC, national and international CSOs – NGOs, FBOs and CBOs; ZIHTLP, MDAs, private sectors and development partners participated in the development of this KPs guideline.

Key Messages:

- Zanzibar has a **concentrated epidemic.** HIV infection among Key Populations is higher compare to general population
- HIV may spread rapidly among KP populations, due to more frequent engaging in **high risk behaviours** such as unprotected vaginal and anal sex and sharing of injection practices
- The risk of HIV infection among these groups is augmented because of **overlaps**. (e.g. sex workers who use drugs, men who have sex with men who sell sex, a female injection drug user engaging in receptive anal sex).
- New HIV infection is increasing in adolescents and young people, there is limited data on HIV situation among adolescents and young people who are key population.

CHAPTER 2: KEY POPULATION FRIENDLY SERVICES

2.1 Health and Social Problems of KPs

KPs usually have a wide range of co-infections, co-morbidities and injection related health and social issues. Some KPs especially PWID have a long history of mental illness without proper diagnosis or treatment. There are some mental conditions that may result from, or be exacerbated by, the use of substances such as alcohol, heroin, cocaine and tranquilizers, sedatives and stimulants. Some of the common health and social problems that are to be considered while delivering care to these group are indicated in the table below: -

Table 1: Health and Social Problems of KPs

Health problems	Social problems
The most common health problems among KPs are: • Other Sexually transmitted infections • infection with other blood borne viruses, including hepatitis B, C and D (delta) leading to liver diseases • tuberculosis • bacterial pneumonia • endocarditis • septicaemia • Drug overdoses • alcohol dependence and alcohol-related liver disease • polysubstance dependence • Psychiatric comorbidity, including depression.	KPs' most prevalent social problems include: • stigmatization, discrimination and social marginalization • poverty • homelessness • unemployment • family and social dysfunction • Criminal behaviour and imprisonment.

2.2 Identification of KPs

The KP definition is linked to risk behaviours and practices rather than clinical presentation. In Zanzibar four groups of KP have been identified. KPs can also identify themselves during provision of friendly services. Peer referral can also support identification of a KP. In Zanzibar, a unique ID system for KPs is being implemented. This will enhance KP identification in all health settings.

2.3 Elements of KP friendly services

It is important to make health services available, accessible and acceptable and friendly to key populations. Involvement of key populations in planning and designing the services including running the services can ensure acceptance. Some of the ways to make the services friendly are:

- Providing services under one roof so that the key populations do not have to go to different places for different services, like providing STI services or ARVs in the drop in centre
- Scheduling services hours to suit the key populations like extended hours during the weekend or clinics being open in the evening. The services should be close to hot spots.

- Building capacity of HCWs to provide friendly services to KPs
- Taking steps to ensure that neighbours and law enforcement activities do not interfere with key populations access to services
- Involvement of key populations in delivery, promotion, and monitoring of services. Peers are the ones who most understand the needs of their fellows. Interaction between them facilitates a sense of belonging to the group and breaks the barriers of misunderstanding, mistrust, and intimidation. In addition, peers can track and refer their fellow peers.
- Encouraging self help and support groups: Belonging to a group where members share similar life conditions and problems provides the assurance that one is not alone. Collective thinking and problem solving in the group empowers individuals through having an insight to how others managed similar or related situations.
- Provision of outreach services. KP may not seek certain services for various reasons. These reasons can be personal (e.g. level of awareness, perceptions, trust, etc.), socio-cultural (taboo, stigma), legal, financial, geographical, etc. Outreaching to KPs can help transcend those barriers.

2.4 Principles of KP programming

For a successful programme delivering medical care, including ART, to active KPs the following important principles have been identified:

- Accessibility and right to health services e.g. instituting special KPs clinic on reasonable time for them, preferably evenings
- User-friendly services which are tailored to individual needs
- Continuity of care through integrated services and referral systems among health services, community organizations, KPs networks and families
- All services and programmes are gender and age sensitive and address the special needs of men, women, and disabled people and other vulnerable groups Ensure safety, privacy, informed consent, confidentiality, and the principle of 'do no harm' are respected for KPs engaged in all aspects of HIV programmes – from programme design to delivery.
- Meaningful participation of people from KP groups in planning and delivery of services
- Recognition that individuals may belong to multiple KP groups with overlapping risks
- Provision of comprehensive, quality, scientifically accurate, evidence-based, designed to be responsive to the needs and experiences of KPs, and that reach them in safe and non-judgmental settings. Delivery of quality services should encompass scope, completeness, effectiveness, efficiency, safety, accessibility, acceptability and affordability of the interventions/services
- Acknowledging the role of various stakeholders in delivering package components; with input from government and civil society
- Pursuing social justice and poverty reduction to address health inequalities for KPs
- Respecting the values of choice, dignity, diversity and equality for access to public health services
- Addressing gender and cultural sensitivity
- Ensuring that the specific needs of adolescents and young people are met through

the delivery of package components. 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.

2.5 Comprehensive Package of HIV Interventions for KP groups

In line with global recommendations including achieving universal access and use of public health services among KPs, then each KP group need to be targeted with package of services that should address multiple risks and vulnerabilities and build on existing peer education and outreach activities. The comprehensive services should entail a mixture of behavioural, biomedical and structural interventions, and be delivered through both health – facility and community outreach mechanisms.

a) Comprehensive package for People Who Inject Drugs (PWID)

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 and community awareness, citing public health evidence, is often required to initiate and sustain harm reduction programmes. 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. See PWID comprehensive package table in Annex 1.

b) Comprehensive Package for Men Who have Sex with Men (MSM)

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 STI 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.

Interventions targeting MSM to prevent sexual transmission of HIV and other STI should include the interventions recommended are shown in Annex 2.

c) Comprehensive Package for sex workers

Females and males who sell sex are among the groups that are most vulnerable to and affected by HIV in Zanzibar. Specific behaviours can place sex workers, their clients, regular partners and general community 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 STI 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 sex workers to prevent sexual transmission of HIV and other STI should include the interventions recommended in this package are illustrated in annex 3.

2.6 Minimum Package for KPs Programming

Access and use of public health services are constitutional right of every one in Zanzibar, and it is therefore important for the government and general community to understand that, there is a need to form part of minimum services provision package for KPs, that will improve their access to health services. Therefore, the Government of Zanzibar urges all implementers of KPs-related interventions to develop, implement and evaluate KPs targeted programmes which address the needs of the KPs at all levels.

Table 2. Minimum Package for KPs Interventions

Minimum Package for PWIDs	Minimum Package for MSM	Minimum Package for SWs
Using health and community-based services to do HTS with the aim of individually voluntarily accessing HTS every 6-12 months among PWIDs, and PITC should be offered in all health-care settings	Using health and community-based services to do HTS with the aim of individually voluntarily accessing HTS every 6-12 months among MSM, and PITC should be offered in all health-care settings	Using health and community-based services to do HTS with the aim of individually voluntarily accessing HTS every 6-12 months among SWs, and PITC should be offered in all health-care settings
Harm reduction including improved access to clean injecting equipment, OST / MAT and other drug dependence treatment for PWIDs	Education on prevention and referral for diagnosis and treatment of STIs among MSM	Education on prevention and referral for treatment of STIs including voluntary screening for asymptomatic STIs in line with WHO guidelines
Education on prevention and referral for diagnosis and treatment of STIs among PWIDs	Condoms (male and female) delivery for MSM and their sexual partners	Condoms (male and female) delivery for SWs and their sexual partners
Condoms (male and female) delivery for PWIDs and their sexual partners	Delivery of targeted IEC / SBCC for MSM by using peer-based outreach services	Delivery of targeted IEC / SBCC for SWs by using peer-based outreach services
Delivery of targeted IEC / SBCC for PWIDs by using peer-based outreach services	Access to and support for adherence of ART for MSM who are living with HIV	Access to and support for adherence of ART for SWs who are living with HIV
Access to and support for adherence of ART for PWIDs who are living with HIV	Interventions targeting the reduction in stigma and discrimination faced by MSM	Interventions targeting the reduction in stigma and discrimination faced by SWs
Interventions targeting the reduction in stigma and discrimination faced by PWIDs		Sexual and reproductive health services including family planning, counselling and contraception

2.7 Consideration for Adolescents and young people who are KPs

Adolescents and young people from key populations are at significant HIV risk, higher than that of their older peers in these populations. Adolescents and young people from key populations are even more vulnerable than older cohorts to STIs, HIV, violence, stigma and other sexual and reproductive health problems. Rapid physical, emotional and mental development, complex psychosocial and socio-economic factors and poor access to and uptake of services increase their vulnerability and risk.

Reliable and representative epidemiological and behavioural data on adolescents and young people from key population groups remain limited. This inadequate data on adolescents and young people from key population groups often leads to neglect of their specific needs by policies and programmes designed for youth generally and by services for adults from key populations.[6]
While adolescents under 18 years of age are generally classified as minors and, therefore, must have parental consent for medical care, including HIV related services, such classification can be barriers to or can discourage adolescents from seeking services. These restrictions may create complex dilemmas for providers who endeavour to act in the best interest of their clients but who may have concerns about their own legal liability as well as for the safety of their young clients.

2.7.1 Barriers to accessing health care services

The specific needs of young people from key populations are neglected both by programmes designed for youth generally and by programmes for adults from key populations.

- policy and legal barriers related to age of consent (under 18) often prevent access to a range of health services, including HIV testing and counselling (HTC), harm reduction and other services.
- Adolescents and young people from key populations may face stigma, discrimination and violence even greater than that faced by older people from key populations.
- Fearing discrimination and/or possible legal consequences, many adolescents from key populations are reluctant to attend diagnostic and treatment services.
- Adolescents and young people may also be deterred from accessing health services if:
- they feel the health care provider is likely to act like a parent or guardian and judge them with reference to services that they will demand
- they will be required to obtain permission from their parents or guardians; this can increase the likelihood that they will go to providers of unsafe abortion

2.7.2 Specific consideration and approaches for adolescents and young KPs

The service delivery approaches and considerations discussed in this chapter for all key populations are applicable for adolescents from key populations. However, additional considerations are required.

[6]WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Office on Drugs and Crime (UNODC) and key community networks have developed four technical briefs on young people from key populations. These policy briefs are based on reviews of epidemiological data, the literature on service delivery, a policy analysis, and qualitative research on the values and preferences of young people from key populations. These guidelines include key messages from this work. The technical briefs are available in Web Annex 6.

It is essential that services for adolescents from key populations are designed and delivered in ways that take into account the multiple, overlapping vulnerabilities that confront adolescents from key populations and the diversity of their needs, based on their age, their specific behaviours and the complexities of their social and legal environment.
Specific considerations and approaches for programming adolescents and young people from key populations as shown in table 3 below.

Table 3: Strategies and approaches for adolescents and young people from KP

Improving Access to Care	Providing Psychosocial support
• Make the most of existing services and infrastructure for youth and add components for reaching and providing services to adolescents from key populations, ensuring friendly services. • Provide services in safe spaces that will increase protection from the effects of stigmas and discrimination, where adolescents can freely express their concerns, and where providers demonstrate patience, understanding, acceptance and knowledge about the choices and services available to the adolescent • Adopt a multidisciplinary approach, ensuring that services are as comprehensive as possible so as to address overlapping vulnerabilities. • Provide comprehensive sexual and reproductive health services, including contraceptive information and services, for sexually active adolescents without mandatory parental or guardian authorization/notification • Prioritize their immediate health needs, while being attentive to signs of vulnerability, abuse and exploitation • Appropriate and confidential referral, if and when requested by the adolescent, can provide linkage to other services and sectors for support	• Provide psychosocial support, through counselling, peer support groups and networks, to address self-stigma and discrimination and other mental health issues. • Provide counselling for families, including parents or guardians – where appropriate and requested by the adolescent – may be important to support and facilitate access to services, especially where parental consent is required • Ensure adolescents from key populations know their rights – to confidentiality, health, protection and self-determination – so that they can advocate for themselves and seek the types of support they are entitled to. • Peer support groups and safe spaces can help improve self-esteem and address self-stigma. Additionally, individual and family counselling can address adolescents' mental health co-morbidities. • Involve supportive parents or guardians can be beneficial, especially for those requiring ongoing treatment and care. It is important, however, to have the adolescent's express permission before contacting parents or care-givers.

Social and Behaviour Change Communication	Empowering Young KPs
• Provide developmentally appropriate information and education for adolescents from key populations, focusing on skills-based risk reduction. Information can be disseminated via multiple media, including the Internet, mobile phone technology and participatory approaches • Address social norms and stigma concerning sexuality, gender identities and sexual orientation through comprehensive sexuality education in schools, supportive information for families, • It is recommended that sexuality education programmes for sexually active adolescents and young people from key populations, be scientifically accurate and comprehensive and include information on contraceptives, including how to use them and where to get them	• Acknowledge and build upon the strengths, competencies and capacities of adolescents from key populations, especially their ability to articulate what services they need. • Engage adolescents and young people in decisions about services, recognizing their evolving capacity and their right to have their views taken into account. This is an important consideration when addressing issues of parental consent for services and treatment • Facilitate access to social services and state benefits, including shelter and address food security issues, including nutritional assessments. • Support access to livelihood development and economic strengthening, and encourage adolescents to stay in school or, if out of school, to return to school, where appropriate.

2.8 Building capacity of Health care workers to provide friendly services

Heath care workers may be unfamiliar with providing services to key populations. Therefore, a capacity building process that involve training and mentorship session should be put in place. The goal is to provide acceptable services that address the needs of the population while respecting their health and human rights. Health care workers should have adequate skills and knowledge to:

- Address the HIV/STI behaviours of KP, including anal sex, douching practices, oral sex, and injecting practices.
- Address issues related to KP, including sexual violence, legal issues, stigma, and discrimination.
- Ensure HCW attitudes (i.e., personal views, beliefs, judgments, etc.) do not dismiss the health needs of the key populations.
- Maintain privacy and confidentiality of KPs, unless they give consent for the information to be shared.

Key Messages:

- KPs usually have a wide range of co-infections, co-morbidities and injection related health and social issues
- It is important to make health services available, accessible and acceptable and friendly to key populations.
- Implementers should involve KPs including adolescents and young people KPs in delivery, promotion, and monitoring of services
- The comprehensive services should entail a mixture of behavioural, biomedical and structural interventions, and be delivered through both health – facility and community outreach mechanisms.
- The minimum package depends upon the targeted population and includes components of prevention, care and treatment, though the primary emphasis is likely to be prevention.
- Adolescents and young people from key populations are at significant HIV risk, higher than that of their older peers in these populations and therefore, special consideration should be put in place in order to recognize and address their specific needs.

CHAPTER THREE: EVIDENCE BASED KPs INTERVENTIONS

3.1 HIV Testing Services

HIV Testing Services (HTS) enables individuals to know their HIV status, receive counselling and support in coping with a positive or negative result and obtain HIV prevention, treatment and care services. The goal of HTS among key populations is to increase the number of those who know their HIV status and link them to HIV care and treatment services. HTS is also an important opportunity to put those at risk of HIV in contact with primary prevention programmes and encourage later retesting.

HTS is an integral component of HIV prevention and care strategies worldwide. HTS must always be voluntary and free from coercion. Like all Testing and counselling, HTS for key populations needs to emphasize the WHO **5Cs** of HTS: Consent, Confidentiality, Counselling, Correct results and linkage to Care.[7] It is important that there is clear and robust links between Testing and HIV prevention, treatment and care services even though all the services may not be provided by one service provider. HTS services should be aligned to the current Zanzibar National Guidelines for the Management of HIV and AIDS.

There is evidence that key populations face substantial barriers in obtaining high-quality HTS.

- low risk perception
- fear of a positive test result
- distrust of free HIV Testing
- inconvenient clinic operating hours
- fear that results will not be kept confidential
- fear of insensitivity, stigma, and discrimination from health care providers
- lack of convenient, 'key population-friendly' HTS services

Given the hidden nature of key populations, mobilization by their peers is critical, this is not only to overcome barriers to HTS but also to increase uptake of HIV care and treatment services for key populations found to be HIV-positive, and to develop the risk reduction skills of those found to be HIV-negative so they remain HIV-negative.

3.1: HIV Testing Services (HTS) for Adolescents and Young People

HTS for adolescents and young people as for adults offers many important benefits. Adolescents and young people who lean that they have been diagnosed with HIV are more likely to obtain emotional support and practice preventive behaviours to reduce the risks of transmitting HIV to others.

Adolescents and young people who are sexually active and mature minors should be able to obtain HTS without required parental or guardian consent or presence. Adolescents should be counselled about the potential benefits and risks of disclosure of their HIV status, empowered and supported to determine when, how and to whom to disclose their HIV status. HIV programs should link with schools to ensure identification and linkages for adolescents and young people KP who are in schools

[7] WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, treatment and care for Key Populations. Geneva: WHO. http://apps.who.int/iris/ bit stream/10665/128048/1/9789241507431_eng.pdf? ua=1&ua=1

Refer HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers. Geneva, World Health Organization, 2013.

a) HTS Delivery Approaches to KP

Thoughtful delivery points and approaches shall aim for co-location of services for key populations at higher risk of HIV exposure and reach them in their natural environments and therefore reducing access barriers. HTC shall also prioritize reaching KP at higher risk of HIV exposure together with their sexual partners, which include sexual and injecting drug use partners of PWID, clients and long term partners of SWs, and partners of MSM.

Suggested HTS delivery points for reaching KP include:

- Medically Assisted Therapy (MAT) sites;
- Home-based HTS (Door to door) sites;
- Mobile or outreach HTS at KP hotspots;
- Resource or drop in centres with convenient hours;
- Hotspots e.g. Bars, or other areas or venues frequented by KP at higher risk of HIV exposure
- Other settings such as correctional facilities (prisons), sober houses, fishing camps, orphanage centres, in schools and colleges etc.
- Health facilities, which include hospitals, health centres, dispensaries, be it public, FBO or private etc.

In line with national standards for health care service delivery and human rights principles, HTS shall be conducted with the best interests of clients and patients in mind, and shall respond to the needs and risks of clients and patients.

1. In view of that, all HTS must adhere to the following five core principles of HTC: HTC services are **Confidential**, meaning that anything discussed between the client(s) or patient(s) and the HTC provider may not be shared with another person.
2. HTS must include accurate and sufficient Pre and Post-test **Counselling** that addresses the needs and risks of the clients(s) or patient(s) and the setting in which they are receiving services.
3. Clients and patients must be provided with sufficient information about HIV testing and counselling, so that they may give their explicit and voluntary informed **Consent** to receive services.
4. HTS must adhere to standard operating procedures and quality control measures for testing to ensure the provision of **correct test results** to all clients and patients.
5. It is the responsibility of HTS programmes and providers to ensure that clients and patients are **connected** with appropriate follow-up HTS. This includes prevention, care, treatment, support and other clinical services, as well as non-clinical services within the community.

3.2 Pre-Exposure Prophylaxis

Oral pre-exposure prophylaxis (PreP) of HIV is the daily use of ARV drugs by HIV-uninfected people to block the acquisition of HIV. Studies have demonstrated the effectiveness of PreP in reducing HIV

transmission among sero-discordant heterosexual couples, men who have sex with men, transgender women, high-risk heterosexual couples, and people who inject drugs. WHO encourages countries to undertake demonstration projects to gain experience in implementing PreP safely and effectively.[8] At the moment, ZIHTLP recommends daily oral pre- exposure prophylaxes for sero-discordant couples who wish to conceive.

3.3 Post - exposure prophylaxes

Post-exposure prophylaxis for HIV is a 28-day course of a combination of antiretroviral drugs (ARVs) that must begin within 72 hours after occupational or accidental HIV exposure, such as injury from an infected needle; or rape. While PEP is not appropriate in the context of chronic exposure to HIV, high risk single or episodic exposure (such as rape by a stranger or needle stick injury) may occur against a background of potential chronic exposure, such as regular and ongoing unprotected sex with an intimate partner. In these cases, the high-risk episodic exposure should be treated as such and PEP offered if the person is HIV-negative. The importance of reducing the on-going risk within the intimate relationship should be emphasized as part of the counselling process.

Distinguishing between chronic and episodic exposure can be difficult. Having more than one potential episode of exposure is not inherently linked with evidence of chronic exposure. For example, sex workers who would normally use a condom but have been sexually assaulted would be eligible for PEP. The identification of repeated or chronic exposure to HIV should lead to greater emphasis on prevention. For example, in the case of sexual assault by an intimate partner with whom a person is also having on-going unprotected consensual sex, the likelihood that the ongoing exposure pattern will change needs to be assessed.

In cases where PEP is not indicated because the exposure is chronic, other critical prevention and care services should be provided. Effective interventions in these circumstances include referral to domestic violence organizations, providing Testing and condoms. Patients taking PEP should be forewarned about the side effects (nausea, headaches, tiredness, aches, and pains) and prepared to deal with them. They should, for instance, be informed that they can reduce the intensity by taking the pills with food. Side effects usually diminish with time and do not cause any long-term damage. The purpose of the laboratory monitoring is to pick up the more dangerous side effects, but these are extremely rare in patients taking ARVs for only one month.

a) Post Exposure Prophylaxis for Occupational Exposure

- Inform all staff about PEP and their responsibility towards PEP
- Wash the exposed area with soap and water and flush mucous membrane with water.
- Assess the risk of acquiring HIV infection and document the exposure
- Give an exposed staff a starter pack of ART within 2 hours of exposure and not more than 72 hours

[8] **WHO. 2012. Guidance on Oral Pre-Exposure Prophylaxis (PreP) for Serodiscordant couples, Men and transgender Women Who Have Sex with Men at High risk of HIV: recommendations for Use in the context of Demonstration Projects. Geneva: WHO. http://apps.who.int/iris/ bitstream/10665/75188/1/9789241503884_eng.pdf**

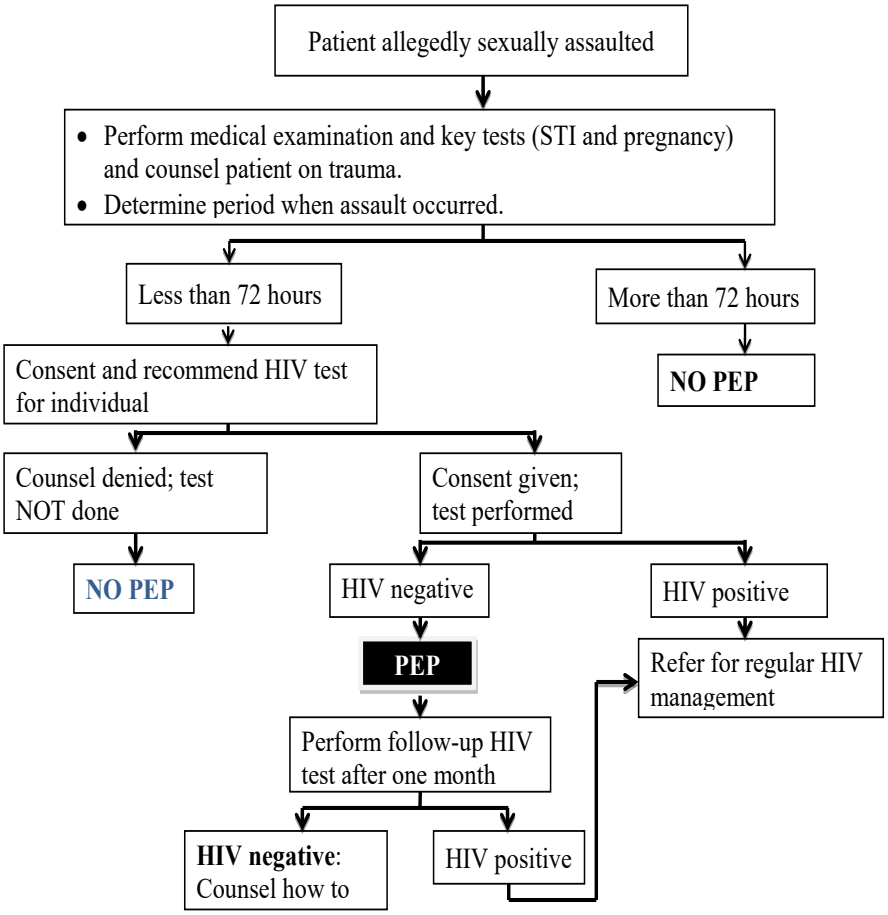
- Offer HIV testing to exposed and source if known (see Figure 1)
- Continue with PEP for 28 days for those who are eligible as per the recommended regimen.
- Counsel on importance of PEP adherence

b) Post Exposure prophylaxis for non-occupational exposure

- Take detailed history of the exposure and document
- Examine the client systematically
- Provide HIV counseling and testing
- Offer PEP for eligible clients if not more than 72 hours of exposure (Figure 1)
- Counsel on importance of PEP adherence
- Provide psychosocial support or refer to social worker
- Assess the risks of pregnancy and offer emergency contraceptives as in Table 2
- Give presumptive treatment for STI.

Non-occupational exposure refers to Client allegedly sexually assaulted or reported condom spillage or breakage during consensual sex

Figure 2. PEP algorithm for Non-occupational exposure



**Administering PEP on a HIV + individual could lead to resistance development.*

Recommended PEP Regiment

- For Adults: TDF 300mg + 3TC 300mg + EFV 600mg once a day for 4 weeks
- For children (based on body weight):
  - Less than 3 years: AZT + 3TC + LPV/r twice daily for 4 weeks
  - More than 3 years: AZT + 3TC twice daily + EFV once daily for 4 weeks

3.4 Comprehensive programming of condoms and other prevention commodities

Condom and other prevention commodities use is one of the most effective means available of reducing sexual transmission of HIV. Scientific evidence suggests that male latex condoms have an 80 percent or greater protective effect against HIV and other STI. Condom use is therefore a key component of Tanzania's HIV and AIDS prevention strategy to reduce HIV transmission via sexual contact. Consistent and correct use of male or female condoms during sex reduces sexual transmission of HIV and STI. Increasing the availability, accessibility, affordability, and use of male and female condoms among KPs through targeted distribution programmes is an essential component of the HIV response.

The challenges to condom use in Tanzania revolve around four critical factors: 1) Accessibility, including the potentially high cost of condoms, low demand, unavailability, stock outs, and gaps

in integrating condom use into reproductive health programming; 2) Lack of correct knowledge of usage, efficacy, and stigma related to condom usage; 3) Attitudes including persistent risky sexual behaviour and religious beliefs; and 4) Inadequate capacity for women and girls to negotiate condom use due to traditional and cultural factors that perpetuate gender inequality.

To improve KPs condom availability and accessibility, the programme will need to ensure adequate supply of condoms, preferably through public friendly condom outlets that are socially and commercially marketed and distributed by CBOs working with KP groups, KP networks, outreach services, peer educators, contraceptive community distributors, and through social marketing organizations targeting hotspots such as bars, hotels, and markets. For adolescents and young people peer led and outreach approaches should be used to distribute condoms, increase knowledge, develop skills and empower adolescents and young people to use condoms correctly and consistently.

3.4.1 Condom Disposal

The following guidance should be provided to KPs on condom disposal:

- Remove the condom so that fluids do not spill.
- For a male condom, remove with the tip pointed down. Pull from the tip, and gently ease the ring off. Condoms with a reservoir tip are specially designed to help retain fluids at the tip of the condom, and they may help during this process.
- For a female condom, squeeze and twist the outer ring, so that the fluids do no leak out. Pull the condom out gently. The inner ring of the female condom should help to hold any fluids in.http://www.wikihow.com/Dispose-of-a-Condom - _note-2
- Put the condom in a piece of tissue or a paper towel.
- Put the condom in the garbage. Do not flush it down the toilet. Do not throw it outside. Do not reuse or recycle condoms.

3.5 Provision of sterile equipment

Sharing of needles accounts for large number of HIV and Hepatitis B and C infection among PWID. The risk of HIV infection can be reduced by limiting sharing of needles and cleaning them in bleach and water just before and after reuse, or by providing sterile equipment.

3.6 Opioid Substitution therapy

Interventions that effectively treat drug dependence can reduce illicit drug use and, hence improve health and social functioning. For people dependent on opioids, agonist opioid substitution therapy—sometimes referred to as Medically Assisted Therapy (MAT)—is highly effective in reducing injecting behaviours that put opioid dependent people at risk for HIV.[9] OST can reduce

[9]Institute of Medicine of the National Academies. 2007. Preventing HIV Infection among Injecting Drug Users in High Risk Countries: an Assessment of the Evidence. Washington, Dc: National Academy of Sciences, http://www.nap.edu/openbook. php? record_ id=11731

opioid use and improve retention in HIV treatment.[10] Access and adherence to OST can improve health outcomes, reduce overdose and resulting mortality, reduce criminal activity, result in better psychosocial outcomes and decrease risk to pregnant women dependent upon drugs and to their infants. Methadone and buprenorphine, both of which are on the WHO list of essential medicines, are the most commonly used opioid agonists. Zanzibar uses methadone, which is a synthetic opioid used to treat heroin and other opioid dependence.

Methadone is taken orally on a daily basis. It is important to ensure that the dose is sufficient (60–120 mg) and is given for sufficient duration. OST should not be compulsory; patients must give informed consent for treatment. OST should be provided as maintenance treatment for sufficient duration and at adequate doses. MAT services in Tanzania have shown good retention in services[11]. This provides an opportunity to offer additional benefits attaining productive livelihoods through interventions in collaboration with other stakeholders, including occupational therapy, vocational training and economic empowerment initiatives.

3.6.1 Setting up a MAT Clinic

The setting of Methadone services involved a collaborative approach of both community- and health-facility settings.

3.6.1.1 Health facility Settings

This setting provides integrative methadone services, which embrace the concept of "one-stop-shop". The clinic offers assessments at baseline; follow up and during emergencies, as well as management of physical and mental disorders. Other services offered include psychoactive drugs use assessments, screening for HIV and other blood borne infections such as hepatitis B and C, provision of HIV- related comprehensive treatment and care (CTC), provision of medications (such as ART, anti-TB, and antifungal medications) as well as diagnosis of other physical illnesses. The clinics should also offer psychosocial services and reproductive health interventions.

Baseline assessment for MAT should include:

- Client's prescription drug and over-the-counter medication use, history of co-occurring disorders, a mental status assessment, and when possible an initial drug screen
- Provider should use the screening and assessment process as an opportunity to communicate essential information about MAT, including treatment requirements, addiction as a disease, and a discussion of the benefits and drawbacks of MAT,

3.6.1.2 Community-based settings

Under this setting a community based organizations/Non-governmental organizations are used to offer support to PWUDs by providing psychosocial services and referral to methadone and other services as well as follow-ups of case management. Those NGOs also offer other services at the community settings like basic hygiene services, education and information about drug use and its associated complication.

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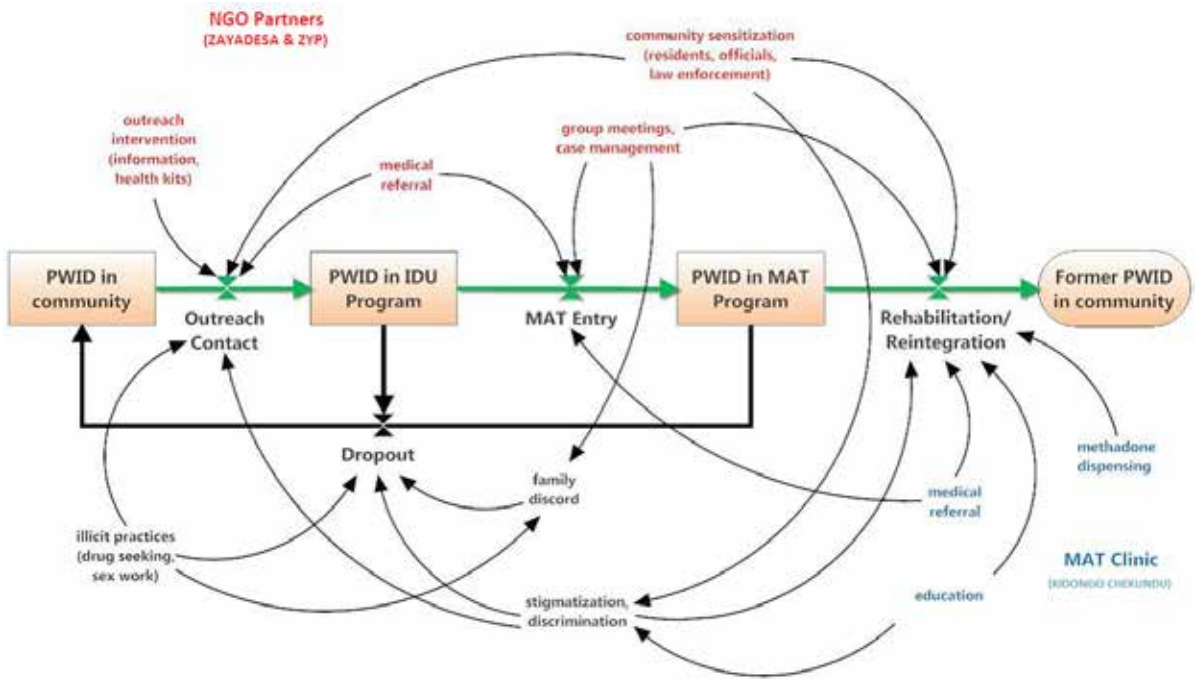
[1] Ward J, Mattick rP, and Hall W, eds. 1998. Methadone Maintenance treatment and Other Opioid replacement therapies. Sydney: Harwood Academic Publishers. http://www.drugsandalcohol.ie/3767

[2] Barrot H. Lambdin, Frank Masao, Olivia Chang, Pamela Kaduri, Jessie Mbwambo, Ayoub Magimba, Norman Sabuni, and R. Douglas Bruce, Methadone Treatment for HIV Prevention—Feasibility, Retention, and Predictors of Attrition in Dar es Salaam, Tanzania: A Retrospective Cohort Study, Clin Infect Dis. (2014) 59 (5): 735-742 doi:10.1093/cid/ciu382

3.6.1.3 Access to Methadone Services and Client Work Flow

Community outreach workers are the first prime individuals to contact the clients from their societies. After contacting them, clients are referred to storefronts or drop-in centres for pre-methadone sessions. The community outreach workers from the two organisations conduct daily field visits to look for PWUDs and establish contact and then refer them to the MAT clinic. Clients have to undergo five sessions within two weeks in order to be eligible for MAT services. The sessions are geared at screening, assessment and motivation of PWUDs for methadone services. Successful clients are then referred to methadone clinic for further assessment prior to enrolment for methadone treatment and other medical and psychosocial services. At the MAT clinic Methadone is dispensed in the form of solution through Daily Observed Therapy.

After enrolment to the MAT site clients are encouraged to keep on attending back to the community-based services at the NGOs for follow-up (case management), psychosocial services and other essential services like self-help groups.



3.6.1.4 Referral and Access to Additional Services

The Methadone clinic offers services for drug use disorder, medical and psychosocial services to MAT clients. Additional services, which are not available at both community and facility-based centres such as legal and specialized medical services, are referred to appropriate services providers. The common referrals included surgical services, emergency medical department (EMD) services, dental, and medical. The most common referrals for female clients were for CTC, gynaecological disorders, antenatal care, and radiological services, mainly pelvic/obstetric ultrasound evaluation and chest X-rays. For male clients, the most common reasons for referral to other departments were for surgical disorders, primarily wound care, emergency services, and dental problems.

3.6.2 MAT Induction

Methadone is a treatment option recommended for patients who are physiologically dependent

on opioids, able to give informed consent, and who have no specific contraindications for agonist treatment. All methadone inductions should be done in a highly monitored fashion. This can be done in an outpatient setting with daily evaluation of the patient and visualize dosing. It is recommended that all induction on methadone be accomplished with specialty level clinician observation.

Maintenance dosing should be agreed upon by the patient, behavioural health staff as well as the clinician treating the patient. As a general rule the lowest dose that accomplishes the abatement of the opioid use disorder behaviours is the most appropriate maintenance dose. Higher doses cause more cognitive impairment as well as chronic adverse events such as constipation, memory deficits as well as tolerance and possible hyperalgesia when using methadone.

3.6.3 MAT Tapering

Tapering is the gradual reduction and elimination of maintenance medication during opioid addiction treatments. If the patient is found to be in remission for greater than one year a "self-tapering" program may be initiated. Allowing the patient to help direct the tapering pathway is of paramount importance, as they are the ones who are most likely to notice risk with the rapid taper versus slow taper. Methadone should be reinstituted immediately if relapse occurs, or when an assessment determines that the risk of relapse is high for patients who previously received methadone in the treatment of opioid use disorder but who are no longer prescribed such treatment.

3.7 Management of Overdose

Opioid overdose causes CNS depression and respiratory depression. Drugs overdose is a medical emergency. Community workers should seek for help from your nearest health facility when you suspect a case of drug overdose. Supportive ventilation is usually sufficient to prevent death but may be avoided by cautious antidote administration. Ventilatory support is the most important intervention and may be life-saving on its own. Patient who presents with signs of opioid overdose, or when this is suspected, should be treated with the opioid antagonist drug naloxone. The endpoint of naloxone therapy should be the restoration of adequate spontaneous ventilation but not necessarily complete arousal. Naloxone can be given subcutaneously or intravenously every 2 to 3 minutes. Most patients respond with the return of spontaneous respirations and minimal withdrawal symptoms. Opioid-naive patients may be given starting doses of up to 2 mg without concern of precipitating withdrawal symptoms. For adolescents, the WHO guidelines do not specify age restriction for opioid substitution therapy. In such circumstances, management will be provided at discretion of service provider.

3.8 Management of STI

KP has higher prevalence of STIs. STI screening and management is therefore recommended for all KP as part of comprehensive care. STI screening consists of medical examination by a doctor, which includes close inspection of the patient's genitals for signs of discharge, redness, lumps, or ulcers; and either etiological testing (lab tests) to identify the specific STI and/ or syndromic diagnosis based on presence of STI symptoms. Routine screening for anal, oral, and genital STIs is recommended for all key populations. It is recommended that vaginal STI screening be conducted with a speculum and anal STI screening be conducted with a proctoscope. STI treatment is based on laboratory results or syndromic diagnosis. Syndromic management is commonly used in Zanzibar to diagnose and treat symptomatic STIs. See more on STI screening and management in Chapter 5.

3.9 Targeted Social Behaviour Change Communication for KPs

Information, Education and Communication (IEC) is an important component of HIV prevention package and when combined with other interventions, such as condom promotion can successfully assist and sustain positive change in the reduction of HIV risk behaviours. [12] Information and skills should be shared and disseminated to KP's with the intention of influencing adoption of HIV prevention healthy practices and creating demand for HIV and SRH services.

Throughout the HIV cascade of care IEC is an important element in supporting prevention of new HIV infections, ensuring KPs are tested for HIV and those tested HIV positives are enrolled in HIV Care and retained. IEC should be developed to suit the local context and match the needs of KPs for example raising awareness about HIV, STI, and other key health issues.
For SBCC/IEC to be effective it should be non-judgemental based on known facts, researched information within the KPs being targeted. Paying respect to social and cultural norms within the limits of existing policy environment or demanding for policy changes is of paramount importance.

SBCC targeting Key population should aim at reducing risky behaviours and create demand for HIV and SRH services. However, experience has shown that providing people with information and telling them how they should behave ('teaching' them) through information, education, and communication (IEC) materials is not enough to bring about behaviour change. While providing information to help people to make a personal decision is a necessary part of behaviour change, behaviour change communication recognizes that behaviour change also requires a supportive environment.
Implementers should recognize that behaviour change is a process; individuals need to move through several stages and steps before they change their behaviour. The following should be considered when planning or implementing a behaviour change programme:

- Not all individuals go through the same steps of the process in the same order, speed or time.
- Individuals at different steps require different messages and sometimes different approaches.
- It is important to know what stage the individual is in before beginning a communication process.
- As knowledge and approval reach high levels, the emphasis of SBCC must shift to advanced measures such as; identifying cues for action, maximizing access and quality of services, identifying and removing barriers to change and creating opportunities for increased peer advocacy

Behaviour change communication should therefore use science-based approach to communication that involves behavioural sciences, social learning and persuasion theory to achieve realistic targets The objectives of SBCC are to reduce high-risk behaviours and promote health-seeking behaviours among key populations. SBCC also seeks to influence healthcare providers to deliver quality, non-discriminatory services to key populations and those living with HIV. Key SBCC messages are shown in Table 6 below.

[1]Aggleton P et al. HIV/AIDS and injecting drug use: Information, education and communication. International Journal on Drug Policy, 2005, 16(1): S21-S30

Table 6: Aim of different types of BCC messages

KP Group	General Message	Specific Messages	Media/Chanel/ Approach
SW	• Correct and consistent condom use • Condom negotiation skills • STI/ RTI prevention and control • HIV prevention (HTC and ART) • GBV (HIV Related) • Stigma and discrimination • Multiple/ concurrent partnerships • SRH promotion • Demand creation for HTC • Referral and linkage to other services (MAT, ART, Gender desk, legal, Faith) • Promotion of Health seeking behaviour	• FP • PMTCT • Economic empowerment • Cervical cancer prevention services • Child care and protection • Psychosocial support	• peer education • Small/large group IPC sessions • Interpersonal communication materials • Mobile phone technologies (SMS, Hotline, IVR) • Closed groups social media • Resource or Drop in Centre
PWID/PWUD		• Needle sharing challenges • Family/Community reintegration • Demand creation for MAT services • Psychosocial support	• peer Education • Family
MSM		• Psychosocial support	• peer Education • Interpersonal communication materials • Mobile phone technologies (SMS, Hotline, IVR) • Resource or Drop in Centre
Adolescents and young KPs		• delay sexual debut • ASRH education • Psychosocial support • Address VAC • FP • Transactional sex • Cross generational sex SRH educational sessions	• peer education • Peer clubs • Small/large group IPC sessions • Interpersonal communication materials • Mobile phone technologies (SMS, Hotline, IVR) • Resource Centre

3.10 Addiction Rehabilitation

3.10.1 Types of Rehabilitation Facilities

Rehab treatment programs may offer:

1. Inpatient services: Programs remove those struggling with addiction from their old ways of

life and place them into a treatment facility. This inpatient care helps to eliminate stress by removing the individual from temptation and the ability to relapse — both during detox and during rehab.

2. Outpatient services: Programs are very similar to inpatient programs, with the exception that you are permitted to return home after your treatment. If the client has significant work or familial obligations — such as caring for children or elderly parents — outpatient care allows them to maintain some of those responsibilities.
3. Some combination of both service types.

3.10.2 Steps of the Addiction Rehab Process

The specific steps of a person's addiction rehabilitation process will vary according to the type of addiction, the treatment plan used, and the individual seeking rehab. However, all recovery processes share the following key elements:

1. **Enrolment:** Usually conducted to determine psychological and clinical assessment in order to optimize the treatment plan.
2. **Detoxification (detox):** designed to remove traces of drugs and alcohol from the body. In some cases, a maintenance medication may be given to ease the withdrawal symptoms.
3. **Rehabilitation (rehab).** This is where patients get to the core reasons behind their addictions, addressing those issues so they can effectively move on with their lives without going back to drugs, alcohol, or their addictive behaviour.
4. **Ongoing Recovery**. Recovery is a continuous process, requiring their ongoing work and attention. For some, the path to lifelong recovery may feel easy, while for others it will be difficult for individuals to withstand the temptation to relapse.

3.10.3 Withdrawal

When a person takes a drug or consumes alcohol regularly, the body becomes accustomed to having certain levels of the substance in it. Once the substance is removed, the body may begin to experience withdrawal symptoms. Depending on the substance used, withdrawal symptoms can even start to appear within a couple hours, though they usually tend to appear within the first 24 hours after the last drug dose.

Withdrawal symptoms may vary, depending on the drug used. Some typical withdrawal symptoms, however, may include problems with extreme depression, concentration, decreased appetite, severe fatigue, agitation, runny nose, inability to sleep, sweating, nausea, cramping, diarrhoea, trembling or shaking, rapid heart rate, troubled breathing, headaches, muscle tension and pain, seizures, stroke, hallucinations and heart attack.

3.11 Addressing alcohol and other substance abuse

Key populations often experience multiple and cross-cutting levels of risk (e.g., drug and alcohol abuse) over and above their primary vulnerabilities. Alcohol and drug use interfere with adherence to ARVs, and some illicit drugs are known to result in adverse reactions when combined with ARVs. Therefore, service providers should screen key-population clients for alcohol and drug abuse to understand the pattern and frequency of use and propose minimization strategies.

From an HIV-prevention standpoint, alcohol and substance use/dependence increase HIV-risk by diminishing inhibitions. Selling sex to maintain drug supply also increases the risk for HIV infection. KP programming should therefore ensure:

- All KP with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice

- Programmes support Key populations members to form and organize self-help groups, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)
- An alcohol intake assessment is recommended for all persons with HCV infection, followed by the offer of a behavioural alcohol reduction intervention for persons with moderate-to-high alcohol intake

Key Messages:

- HTS for KP should be provided without stigma and discrimination in both facility and community based settings to improve access of testing to KPs
- KP should be encouraged to retest 4 weeks after previous HIV negative test then every 6 months.
- Implementers should continue to advocate for wide accessibility, availability, and affordability of male and female condoms and promote consistent and correct use of condoms for KP and their sexual partners or clients.
- Community-based HIV service (CBHS) providers and peer educators including adolescent and young people should conduct condom demonstrations, promote and distribute condoms and report on progress and challenges.
- Medically Assisted Therapy (MAT)—is highly effective in reducing injecting behaviours that put opioid dependent people at risk for HIV. OST can reduce opioid use and improve retention in HIV
- MAT should not be compulsory; patients must give informed consent for treatment. MAT should be provided as maintenance treatment for sufficient duration and at adequate doses.
- Allowing the patient to help direct the tapering pathway is of paramount importance, as they are the ones who are most likely to notice risk with the rapid taper versus slow taper
- Drugs overdose is a medical emergency. Community workers should seek for help from your nearest health facility when you suspect a case of drug overdose.
- SBCC targeting KP should aim at reducing risky behaviours and create demand for HIV and SRH services.
- Implementers should recognize that behaviour change is a process; individuals need to move through several stages and steps before they change their behaviour.
- Drug addiction recovery process usually follows the following steps: enrolment, detoxification, rehabilitation, ongoing recovery

4.1 Antiretroviral Therapy (ART)

Key populations should have access to a core package of HIV care and treatment services that include assessments for WHO stage, CD4 count and VL, management of opportunistic infections, Positive Health, Dignity, and Prevention (PHDP) interventions, community-based survives and provision of ART.

The use of ART for HIV in key populations should follow the same general principles and recommendations as for all adults.[13] Key populations may experience discrimination and marginalization that can impede their access to health services, including treatment for HIV. It is important to ensure that key populations have equitable access to HIV treatment and care. A tailored follow-up mechanism should be instituted to ensure that the drop-out rate is minimized while maintaining principles of confidentiality.

All HIV positive clients including KP should be given ART regardless of CD4 counts and or clinical stage criteria (Test and Treat) as per the national guidelines.

For adolescents and young people KP, ART delivery through NGO should be considered as it improves treatment adherence and retention of adolescents living with HIV.

4.1.1 Clinical Evaluation of KP prior to initiation of ART

i) Initiation assessment

Initial evaluation of KPs' HIV/AIDS status is not different from that of the general population. Offering HIV testing, counselling and information should be routine procedure in health care settings dealing with KPs. Health care providers should explain the reasons for offering the test and its importance for correct clinical management. However, a patient has the right to refuse the test. Initial assessment of HIV status should include the following:

- Pre-test HIV counselling and information;
- A serological test for HIV antibodies (typically rapid tests), according to the national algorithm
- Post-test counselling, including information on reducing risk behaviours, whether the results are positive or negative.

ii) Risk Assessment

Risk assessment is a process of identifying behaviours of KPs, which are currently risky, or has had a history of such behaviours/habits that contributes towards a risk of acquiring STI/HIV or transmitting such an infection. This is done with the objective of helping KPs increase his/her perception of risk and making appropriate changes.

Risk assessment also includes how consistently a condom is used, alcohol use while at work, involvement in group sex, violence at the hands of goons, police and others, sharing of needles for injecting drugs etc., Risk assessment also involves identifying STI symptoms.

[1] Consolidated Guidelines on the Use of Antiretroviral Drugs for treating and Preventing HIV Infection: recommendations for a Public Health Approach. Geneva: WHO. http://apps.who.int/iris/ bitstream/10665/85321/1/9789241505727_eng.pdf

iii) Evaluation of substance use and dependence

Standardized assessment tools should be used for screening and initially evaluating substance use and dependence. Typically, a substance uses and dependence assessment includes a complete history of substance use and treatment and a physical examination. A substance use and treatment history will include:

• Substances used, including alcohol and combinations of drugs, and age at first use • Modes of drug administration • Lifetime, recent and current use • Changes in drug effects over time • History of tolerance, overdose and withdrawal	• Periods of abstinence and attempts to quit • Complications of substance use (hepatitis, abscesses, etc.) • Current problems, including severity of dependence • Types and outcomes of previous treatment for drug dependence.

A physical examination may indicate complications associated with substance use.

Further evaluation of drug dependence severity and appropriate treatment strategy should be done by, or in close collaboration with, substance dependency treatment experts or other trained staff.

iv) Further Clinical Evaluation

Further evaluation is required for developing a strategy of clinical management of HIV-infected KPs, including:

• presenting symptoms • physical examination • mental health and social assessment • preparedness for treatment • routine laboratory assessments • CD4 lymphocyte count to determine the severity of immunodeficiency • Viral load testing, if available	• History of contraception use and pregnancy test if indicated • Screening for hepatitis B and C, TB, STI • Assessment for psychiatric disorders • Weight • Other tests based on the patient's condition • Cervical cancer screening for female drug users, female sex workers

Since many KPs present for care at an advanced stage of HIV infection, it is important to thoroughly evaluate new patients for active opportunistic infections. The initial history and physical examination will usually identify common complications, including:

- oral candidiasis and difficulty swallowing, suggesting oesophageal candidiasis
- non-healing genital or anal ulcers, indicating herpes simplex
- Fever with cough and/or shortness of breath, suggesting bacterial pneumonia, TB or PCP.
- Initial evaluation should be followed by treatment of opportunistic infections and other conditions as indicated.

v) Psychosocial Assessment

Mental health co morbidities are common among PWIDs with HIV. A thorough psychosocial

assessment should be undertaken at initial evaluation, focusing on:

- any source of instability that might undermine adherence to treatment
- depression and other mood disorders
- Other psychiatric problems.
- Social factors to be assessed include:
- social stability, family and community support
- homelessness
- major life events and crises
- financial security
- nutrition
- frequently in prison/jail due to crime

vi) Pregnant and lactating women

Female KP who are pregnant or breast feeding should be tested for HIV. Those who are HIV positive should have access to ART as for other women in the general population. This should be the case even among pregnant and lactating women in correctional facilities. All pregnant women from key populations should have the same access to eMTCT services and should follow the same national recommendations as women in other populations.

4.2 Adherence to ART

Adherence to ART is key to HIV suppression, reduced risk of drug resistance, improved overall health, and decreased risk HIV transmission. This underscores the importance of monitoring adherence among key populations. Adherence counselling and support groups need to be provided to address the challenges in adherence. Peer educators and outreach workers may need to follow-up on individuals who skip doses or stop ART altogether.

Special considerations for Adolescents KP.

Training of health-care workers can contribute to treatment adherence and retention in care of adolescents living with HIV. Health-care providers can support adherence among adolescents by:

- **Assisting them in exploring factors influencing their adherence**
- **Improving their understanding of HIV, ART and adherence**
- **Recognizing developmental needs while supporting their emerging independence**
- **Assisting them in integrating ART into daily life**
- **Offering simplified ART regimes**
- **Encouraging participation in peer support groups and community-based interventions**

4.3 ART Drug Interactions

Providers should be aware of all drugs that people with HIV are taking when ART is initiated and new drugs that are added during continuing treatment. For KP, this may include recreational drugs, drugs for co-infections and co-morbidities. Possible drug interactions add complexities when prescribing ARV drugs and monitoring treatment. Counselling on the possible consequences

of drug interactions and an environment that promotes and enables reporting of concomitant medications are critical components of high-quality care for all people with HIV.

a. Tuberculosis

TBHIV patients who are to be initiated into Rifampicin and were on Nevirapine based regimen ART should either be switched to Efavirenz based ART due to increased liver toxicity as a result of interaction of Rifampicin and Nevirapine or Rifabutin should be used instead of Rifampicin. Those on boosted LPV/r, the dose of LPV/r should be doubled when using Rifampicin for TB treatment

b. Hormones used for contraception

ARV drugs have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives. Limited data suggest potential drug interactions between contraceptive hormones and many ARV drugs (especially some non-nucleoside reverse transcriptase inhibitors (NNRTIs) and ritonavir (RTV)-boosted PIs). These interactions may alter the safety and effectiveness of both the hormonal contraceptive and the ARV drug. If women receiving ART decide to initiate or continue using hormonal contraceptives, consistent use of condoms is recommended both to prevent HIV transmission and to compensate for any possible reduction in the effectiveness of the hormonal contraception.

c. Opioids

WHO recommends methadone and buprenorphine to treat opioid dependence. Co-administering Efavirenz (EFV) decreases methadone concentrations. This could subsequently cause withdrawal symptoms and increase the risk of relapse to opioid use. People receiving methadone and EFV should be monitored closely, and those experiencing opioid withdrawal may need to adjust their methadone dose.

Table 9. Key ARV drug interactions and suggested substitutions

ARV drug	Key interactions	Suggested management
Boosted PI (ATV/r, LPV/r, DRV/r)	Rifampicin Estrogen-based hormonal contraception Methadone and buprenorphine	Substitute EDPHS RCH or double the dose of boosted LPV/r Advise additional use of male or female condoms Adjust methadone and buprenorphine doses as appropriate
EFV	Methadone Estrogen-based hormonal contraception	Adjust the methadone dose as appropriate Advise additional use of male or female condoms
Nevirapine (NVP)	Rifampicin Estrogen-based hormonal contraception	Substitute NVP with EFV Advise additional use of male or female condoms

4.4 Management of Common Co-infections and Co-morbidities

4.4.1 TB -HIV Co-infection

Tuberculosis (TB) is a bacterial disease caused mainly by Mycobacterium tuberculosis.[14] TB is transmitted from person to person via moisture droplets from the throat and lungs of people with active respiratory disease (smear-positive sputum).

People susceptible to TB are those with a weakened immune system, such as people living with HIV and AIDS and drug and alcohol abusers. Despite being preventable and curable, TB is the leading cause of HIV-associated mortality, accounting for one of every five HIV-related deaths. The risk of developing TB is 30-times higher among people living with HIV than among people who do not have HIV. Key populations, who are more likely to be HIV-positive and/or abuse alcohol and drugs, have increased susceptibility to TB. Therefore, service providers should screen both HIV-positive and negative key population for TB, using the WHO-recommended four-TB-symptom screening algorithm—that is, current cough, fever, night sweats, or weight loss—at each contact with a health care worker. Early detection and treatment of TB will decrease the risk of further TB transmission.

Completing TB treatment is critical to reducing mortality and avoiding the development and spread of drug resistant TB. It is important to provide a supportive, non-judgemental and non-discriminatory environment that enables people from key populations to complete treatment, provides additional adherence support measures to improve treatment outcomes, and reduces risk of continued TB transmission. Timely initiation of ART significantly reduces the risk of mortality from HIV associated TB. As TB is one of the most common AIDS-defining illnesses, all those with presumptive or diagnosed TB should be offered HIV Testing Services as a priority so that those Testing positive can start ART as soon as possible, in any case no later than eight weeks after initiation of TB treatment, regardless of CD4 count.[15]

Tuberculosis (TB) remains a leading killer of people with HIV. People living with HIV and infected with TB are 20 to 40 times more likely to develop active TB compared to people not infected with HIV living in the same country. [16] PWUD/PWID and prisoners are highly vulnerable to TB. Tuberculosis (TB) is reported to be up to 30-100 times more common in prison than in the wider community. Of increasing concern is that the prevalence of multidrug-resistant TB can be up to 10 times higher inside prisons. A combination of late diagnosis and treatment of infectious cases as well as overcrowding and poor ventilation has resulted in TB as a major cause of sickness and death in prisons. [17] [18]

4.4.2 Viral Hepatitis

Both HBV and HCV can cause acute inflammatory hepatitis, which can result in fulminant liver failure. chronic infection can result in liver fibrosis and ultimately cirrhosis and hepatocellular carcinoma—conditions resulting in increased mortality. Additionally, they can complicate HIV treatment, and HCV can accelerate the progression of HIV disease.

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[1]WHO. Health topics. Tuberculosis. http://www.who.int/topics/tuberculosis/en/

[2]WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, treatment and care for Key Populations. Geneva: WHO. http://apps.who.int/iris/ bitstream/10665/128048/1/9789241507431_eng.pdf? ua=1&ua=1

[3]WHO. Update Tuberculosis Facts 2009. World Health Organization, Geneva, 2009

[4]WHO and International Committee of the Red Cross. Tuberculosis control in prisons: a manual for programme managers. WHO 2000.

[5]WHO. Status paper on prisons and tuberculosis. Copenhagen, WHO Regional Office for Europe, 2007

Hepatitis B

4.4.3 Hepatitis B coinfection

Hepatitis B is endemic in Africa. HBV is also more common in PWIDs in both developing and developed countries. Hepatitis B is transmitted from mother to child in about 5% of pregnancies among hepatitis B carriers, and through unprotected sex, sharing of injecting equipment and importantly through close contact particularly between infected and uninfected children via open cuts and scratches and contact with HBV contaminated environmental surfaces. It is also transmitted through unsterile medical injections and unscreened blood products.

Coinfection with hepatitis B virus (HBV) and HIV is common. Factors affecting the prevalence of chronic HBV include age at time of infection and mode of acquisition, which vary geographically. Although spontaneous clearance of HBV acquired in adulthood occurs in >90% of immunocompetent individuals, HIV-infected persons are half as likely as HIV-uninfected persons to spontaneously clear HBV. Therefore, chronic HBV infection occurs in 5-10% of HIV-infected individuals who are exposed to HBV, a rate 10 times higher than that for the general population. HIV/HBV coinfection rates are highest among men who have sex with men (MSM) and people who inject drugs.

HBV Screening: All patients should be screened for HBV with HBsAg testing.

Treatment of HBV in HIV coinfection: All Hepatitis B co infected patients with HIV should be offered tenofovir based ART regimen if no contraindication is found. Patients with HIV/ HBV coinfected should be started on TDF/3TC/EFV or TDF/FTC/EFV. Treatment with 3TC or FTC as the only HBV-active agent in ART (ie, HBV monotherapy) is not recommended owing to a high risk of developing HBV drug resistance over time.

HBV Vaccination: HBV vaccination reduces the risk of new HBV infection in HIV positive persons; and also reduces the risk of new infections becoming chronic. Therefore, all HIV positive clients without evidence of hepatitis B infection (HBsAg negative) should be vaccinated against hepatitis B using the standard vaccination regimen. All at-risk individuals who are HBsAg negative immune-protected (no HBsAb nor HBcAb) should be vaccinated. The vaccination regimen in coinfection should be 0, 1, 6 months.

4.4.4 Hepatitis C co-infection

Hepatitis C is a contagious liver disease that results from infection with the Hepatitis C virus. The infection is often asymptomatic, but chronic infection can lead to scarring of the liver and ultimately to cirrhosis, which is generally apparent after many years. Injecting drug use is a very common way of acquiring HCV. Screening of blood and blood products for HCV is an effective way to reduce transmission.

While the primary focus is on HIV, it is important to include other major blood borne viruses such as Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) in comprehensive prevention HIV care and treatment. It is estimated that more than 185 million people around the word are infected with

HCV, 67% being PWID, of whom 350,000 dies each year. [19] HCV co-infection is common among PWID who are also infected with HIV. [20] A study done in Dar es Salaam among PWID show that HCV antibody positive (indicating past exposure but not confirmed current infection) at 28% prevalence, and that co-infection (HIV and HCV) was 17% overall. [21] Co infection of HIV and HCV is of concern due the fact that HIV accelerates HCV-related disease progression and mortality. There is no vaccine for HCV and while there is treatment it is mostly prohibitively expensive for most people to afford in low and middle income countries.

HCV Screening: HCV screening is done through the following blood tests:

- HCVab,
- Liver Function Tests: ALT, AST, FIB-4

All HIV infected individuals should be tested for HCV antibody at time of enrolment into HIV care. A positive HCV antibody test should be followed by nucleic acid test for the detection of HCV RNA to establish diagnosis of chronic HCV infection.

Treatment of HCV in HIV coinfection: HCV is treated using direct acting antivirals (DAA) such as Daclatasvir (60 mg) + Sofosbuvir (400 mg) for genotypes 1, 2 and 3 for duration of 12 weeks. However, they are currently unavailable in our setting.

- Effective HIV treatment (ART) reduces the progression of liver disease in HIV/HCV coinfected individuals.
- NVP should possibly be avoided in moderate to severe liver dysfunction. Liver function should be monitored at treatment initiation and throughout treatment.
- Despite this, there are a number of precautions that need to be taken.
- Hepatotoxicity
- Abnormal liver function tests are common in HIV/HCV co-infected individuals on ART. Severe dysfunction can lead to hepatotoxicity (markedly abnormal liver function, alanine aminotransferase [ALT] >5x upper limit of normal [ULN]). The mechanism is unclear but may be a combination of the direct effect of medication on the liver cells or a hypersensitivity reaction.
- PI-based regimens

Protease inhibitors (PIs) affect the liver either directly or by affecting the metabolism of other drugs to hepatotoxic ranges. Ritonavir (RTV), particularly at higher doses, has been associated with increased liver function abnormalities and hepatotoxicity. The risk of hepatotoxicity is more than doubled in HIV/HCV coinfection compared with HIV monoinfection.

4.4.5 Antiretroviral drugs for people who inject drugs (PWID) on medical assisted therapy

Drug use and addiction do not preclude successful ARV treatment. HAART is as effective for HIV positive PWID as it is for other people with HIV and AIDS. Given appropriate support, former and

[1]Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D, et al. Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. Lancet. 2011; 378(9791):571–83.
[2]Alter MJ. Epidemiology of viral hepatitis and HIV co-infection. Journal of Hepatology, 2006, 44, Supplement 1(0): S6-S9.
[3]Bowring A Et al. Assessment of risk practices and infectious disease among drug users in Temeke District, Dar es Salaam, Tanzania: Prepared for Médecins du Monde France. Melbourne: Centre for Population Health, Burnet Institute. 2011

active PWID can adhere just as well as others and should have equal access to ART. Special attention should be paid to the particular needs of former and active PWID when administering ART, including those related to substance dependence, co-morbidities and co-infections. ART services should be integrated into Medical Assisted Therapy (MAT) Clinics. For the ART naïve patient ART should be initiated when the patient has been stabilised and his /her methadone dosage has been determined. This usually takes between 2-3 months after starting MAT. The currently used NNRTIs, NVP and EFV and to a less extent Lopinavir and Ritonavir induce metabolism of methadone through cytochrome CYP 450 3A with a net effect of reducing serum concentration of Methadone. EFV for example, decreases methadone plasma concentration up to 50% overtime. Use of combined TDF back borne with preferably DTG or alternatively use of ATV/r is recommended. These are not associated with significant decreases of methadone plasma concentration.

4.4.6 Mental Health

In addition to being disproportionately burdened by HIV, key populations experience higher rates of depression, anxiety, smoking, harmful alcohol use and alcohol dependence, other substance use and suicide as a result of chronic stress, social isolation, violence and disconnection from a range of health and support services[22].Stigma and discrimination against key populations have been described as key drivers of poor physical and mental health outcomes across diverse settings. In addition to being disproportionately burdened by STI and HIV, key populations, especially MSM and transgender persons, experience higher rates of depression, anxiety, smoking, alcohol and substance abuse, and suicide as a result of chronic stress, social isolation, and disconnection from a range of health and support services. From an HIV-prevention standpoint, alcohol and substance use/dependence increase HIV-risk by diminishing inhibitions. Selling sex to maintain drug supply also increases the risk for HIV infection.

Routine screening and management for mental health disorders (particularly depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and improve adherence to ART. Management can range from co-counselling for HIV and depression to appropriate medical therapies.

Mental considerations for Adolescents KP

Mental health co-morbidities among adolescents are a particular concern. Suicide is one of the leading causes of death of adolescents **(163)**. Adolescents from key populations may face social isolation, harassment and discrimination, which may add to their vulnerability to mental health co-morbidities, emotional distress and self-stigma. Peer support groups should be used to improve self-esteem and address self-stigma. Additionally, individual and family counselling should address adolescents' mental health co-morbidities. The involvement of supportive parents or guardians should be encouraged, especially for those requiring ongoing treatment and care. It is important, however, to have the adolescent's express permission before contacting parents or care-givers

[1] Effectiveness of interventions to address HIV in prisons. Geneva, World Health Organization, 2007 (Evidence for Action Technical Papers) (http://whqlibdoc.who.int/publications/2007/9789241596190_ eng.pdf? ua=1, accessed 23 May 2014).

163: Global health estimates 2013 summary tables: DALYs, YLLs and YLDs by cause, age and sex by WHO regional group and World Bank income classification, 2000-2012 (provisional estimates). Geneva, World Health Organization, 2014

Key Messages:

- ART Care for HIV-positive KPs must address substance use and substance dependence, psychological and social issues, and medical complications associated with injecting drug use and HIV/AIDS.
- Before initiation of ART a thorough risk assessment, clinical examination and evaluating substance use and dependence should be conducted.
- Peer educators and outreach workers should be involved to follow-up individuals who skip doses or missed their appointment
- Counselling on the possible consequences of drug interactions and an environment that promotes and enables reporting of concomitant medications are critical components of high-quality care for all people with HIV.
- KP have increased susceptibility to TB. therefore, service providers should screen both HIV-positive and negative key population for TB, using the WHO-recommended screening tool
- KP with active HBV or HCV infection should receive treatment according to available and affordable treatment regimens. When available, HBV vaccination shall be offered to KP at risk of HBV infection.
- Mental health co-morbidities among adolescent KP are common and need particular attention.

CHAPTER FIVE: SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR KP

5.1 Introduction

STIs are caused by more than 30 bacteria, viruses, and parasites, and are spread predominantly by sexual contact, including vaginal, anal, and oral sex.[23] STIs include gonorrhoea, chlamydial infection, syphilis, trichomoniasis, cancroid, genital herpes, genital warts, HIV infection, and hepatitis B infection. Many STIs are curable, and others can be mitigated or modulated through treatment. Key populations are at higher risk for STIs due to unprotected sex, sex with multiple partners, and increased frequency of partner change. Several STIs may facilitate the sexual transmission of HIV infection.[24]

Key populations, also regarded as most at risk populations, comprise a group of individuals who are important in the fight against STI/RTIs including HIV. In the context of Zanzibar, they include people who inject drugs, female sex workers, and men who have sex with other men. In these individuals, throughout the world including the sub-Saharan Africa, HIV prevalence is substantially high. This is even evidenced in the Zanzibar IBBSSS report of 2012 in which case, sex workers were reported to have HIV prevalence of 19.3%. In the same report, people who inject drugs and men who sex with other men has HIV prevalence of 11% and 2.6% respectively.

Therefore, due to such alarming high prevalence of HIV in these groups which also signal the possibility of having high prevalence of other STI/RTIs, diagnosis of such infections among key populations should be an important undertaking.

5.2 STI Prevention, screening, and treatment

Effective prevention and treatment of STI among key populations requires attention to both symptomatic and asymptomatic infections. STI screening consists of either etiological Testing (lab tests) to identify the specific STI and/or syndromic diagnosis (presence of STI symptoms). Health care workers should ensure adequate:

- **screening and management of asymptomatic infections** – quarterly history taking, physical examination, and simple laboratory diagnostics (where available):
- **Management of symptomatic infections** – using national management flowcharts and laboratory diagnoses where available

5.2.1 Screening of STIs/RTIs among the key populations

To effect this, when attending a client from such groups for other health needs:

- Screening of STI/RTIs should be offered routinely as part of the comprehensive care for STI/RTIs including HIV.

[1] **WHO Media center. 2013. Sexually transmitted Infections. Fact Sheet no. 110. http://www.who.int/mediacentre/factsheets/fs110/en/**

[2] **Fleming Dt and Wasserheit JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. Sexually transmitted Infections. 1999;75(1):3. http://sti.bmj.com/content/75/1/3.long**

- Take note that, in some groups, infection sites can be different from the rest of population depending on sexual practices they practice. Such sites may include the anus, oral cavity, fingers, and the pharynx.
- Find out the level of knowledge the client has on different STI/RTIs aspects including but not limited to types of STI/RTIs, signs and symptoms of different STI/RTIs, treatment options, opportunities for treatment, opportunities for HIV counselling and testing, risk factors, and prevention mechanisms.
- Establish the sexual status of the client with respect to number of current sexual partners, types of sex involved, and types of other risky behaviours the client is involved.
- Inquire about history and/or current symptoms of STI/RTIs and whether received treatment of the most recent episode
- Establish condom use status of the client. In these regards, enquire about intimate partner violence if present.
- For female clients from these groups, provide cervical cancer screening program as per cervical cancer screening program guideline.
- Help the client plan for prevention mechanisms.

5.2.2 Screening for asymptomatic STIs

Many STI are more likely to be asymptomatic or be undetected in women than in men. As a result, seeking treatment can be delayed and can result in the development of serious complications: cervical cancer and pelvic inflammatory disease that can result in chronic pelvic pain, infertility, low birth weight, ectopic pregnancy and associated maternal mortality. [25]

5.3 STI Management and Clinical services for Key Populations

Sexually Transmitted Infections (STI) continue to remain a major public health concern: STI comprise of a range of infections (viruses, bacteria, fungi) predominantly transmitted through unprotected sexual contact with an infected person. Failure to treat STI can lead to various health complications and they have also been found to increase the sexual transmission and acquisition of HIV infection. [26] The 2012 IBBSSS reported high prevalence of STIs among FSW and MSM.

Syndromic approach is a cost effective intervention for management of STI/RTIs focuses on identification of symptoms and signs. Majority of STI present with symptoms that include urethral discharge, dysuria, genital ulcer/s, vaginal discharge and lower abdominal pain. Among Key population the management of STI/RTIs will focus on all STI syndromes including anorectal-related syndromes.

Elements of STI management

During STI screening and treatment, service providers are expected to ensure the 4Cs – compliance (i.e., adherence), condoms, counselling, and contact tracing (i.e., partner services). Service providers

[1]Wasserheit JN. The significance and scope of reproductive tract infections among Third World women. International Journal of Gynecology and Obstetrics (Supplement), 1989, 3:145–168.

[2]WHO. Management of sexually transmitted infections. Regional Guidelines. WHO Regional Office for South-East Asia, New Delhi, India. 2011.

should provide correct and timely information on the importance of adherence to STI treatment; promote, demonstrate, and distribute condoms and latex compatible other preventive devices; provide skills to negotiate condom use; counsel patients to prevent future STIs; and, if possible, identify and examine sex partners who may need treatment. It is therefore recommended that KPs should have:

- regular Medical check-up (RMC) once every quarter
- six-monthly syphilis screening
- for MSM and sex workers, lab Testing for STI as and when required
- linkages/referral for specialized treatment

5.4 Family Planning

Family planning is the process by which women and men make informed choices about their sexual and reproductive lives, including the timing and spacing of births, which can improve their own health and substantially increase their child's chances of survival and good health.[27]

Family planning includes barrier methods such as condoms and diaphragms, contraceptive pills (combined or progestin-only therapy), injectable contraceptives, and intrauterine devices (IUD). For female sex workers and females who inject drugs, the goal is to provide easy, free or affordable access to family planning services. Existing data suggest a large unmet need for family planning among women. Since female sex workers and women who inject drugs are highly stigmatized and engage in riskier sex, their unmet needs are likely to be higher.

5.4.1 Elements of family Planning:

Service providers should emphasize the need for dual protection (using both condoms and another FP method), since condoms are the only family planning method that can prevent HIV/STIs. Service providers should offer provider-initiated Testing and counselling on a quarterly basis to HIV negative female sex workers, females who inject drugs, and those with unknown status. Targeted outreach should be provided to female sex workers and females who inject drugs to increase correct knowledge of, and demand for, family planning. Provision of family planning should be aligned to national reproductive health guidelines.

5.4.2 Emergency Contraception

Emergency contraception (EC)—also referred to as the 'second option' or the 'morning-after pill'—is provided to women who are not currently using a contraceptive method and not already pregnant, to prevent pregnancy after unprotected vaginal sex. Female sex workers and females who inject drugs should have access to EC due to their increased likelihood of engaging in unprotected sex.

Currently no guidance exists on how frequently EC can be used. Therefore, service providers should use caution and monitor how many times EC is used by female sex workers and females who inject drugs, and encourage them to use long-term family planning methods (e.g., contraceptive pills, IUD, etc.), as EC is not a long-term family planning method.

[1] **ZIHTLP. 2016. National Guidelines for Management of STI**

Emergency contraception should be provided for free or at an affordable cost to female sex workers. When prescribing EC, service providers should:

1. Establish eligibility (exposure within last 5 days, not currently using a contraceptive method, or already pregnant);
2. Provide EC (1- or 2-day dose);
3. Provide family planning counselling and FP options;
4. Promote, demonstrate, and distribute condoms and other preventive devices; and
5. Conduct risk-reduction counselling and skills building to reduce unprotected sex.

Note: Programmes targeting sex workers should have strong links with health providers who prescribe and pharmacies that dispense EC without a prescription to ensure FSWs have access to EC within 120 hours of exposure. Give emergency contraceptives (EC) to non-pregnant female of child-bearing age in the case of sexual violence.

Table…XX. Emergency Contraceptives and Doses

Type of contraceptive	Dose
Progestine only pills	Postinor 2®(Levonogestrel) 1tab every 12 hours (total 2 tabs per day) or 2 tabs once a day at the same time
Combined oral contraceptive pills with high dose of oestrogen (50µg)	Ovral® 2tabs every 12 hours (total 4 tabs per day)
Combined oral contraceptive pills with low dose of oestrogen (30µg)	Nordette® 4tabs every 12 hours (total 8 tab per day)

Note: The survivor can be given any of the above three regimens. EC is most effective when given within 120 hours (5 days) of assault.

SRH Consideration for Adolescent KP

In order to meet the educational and service needs of mature minor and sexually active adolescents, sexual and reproductive health services, including contraceptive information and services should be provided for adolescents without parental or guardian authorization/ notification (173).

Health care workers should prioritize adolescents, health needs and pay attention to signs of vulnerability, abuse and exploitation. Appropriate and confidential referral should be provided and link to other services and sectors for support (73).

Ref. 173 Ensuring human rights in the provision of contraceptive information and services Guidance and recommendations. Geneva, World Health Organization, 2014 (http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/, accessed 22 May 2014).

Ref. 73. Interagency Youth Working Group. Young people most at risk of HIV: a meeting report and discussion paper from the Interagency Youth Working Group, United States Agency for International Development, Joint United Nations Programme on HIV/AIDS Inter-Agency Task Team on HIV and

Young People, and FHI. Research Triangle Park, NC, USA, FHI, 2010.

5.5 Post-abortion Care

Several studies have shown that one of the most effective ways to curb abortion-related mortality and morbidity, regardless of prevailing abortion laws, is to provide high-quality post-abortion care. The goal of post-abortion care is to treat complications that arise from unsafe abortions and counsel the women on how to use family planning methods to prevent future unintended pregnancies and unsafe abortion.

Post-abortion care is the care given to women who have had an unsafe abortion. It consists of the emergency treatment of complications from an unsafe abortion, family planning counselling/ services, and provision of PITC. Post-abortion care should be provided to each sex worker when needed, with compassion and in line with national guidelines.

5.6 Cervical Cancer screening and treatment

Cervical cancer screening is the process of identifying precursor/precancerous lesions Cervical Intra-epithelial Neoplasia (CIN) or cancerous cells in the cervix. Human papillomavirus (HPV) is an STI and etiological agent of cervical cancer cases. Although there are over 100 HPV types, 20 are known to be cancer-causing, and of these, HPV 16 and 18 are responsible for about 70% of all cervical cancer cases worldwide.

Several techniques are used for cervical cancer screening to identify HPV or CIN. Papanicolaou smear (Pap smear) is the collection of a sample from the cervix to test for HPV infection. CIN or precursor cells can be identified through visual inspection of the ectocervix washed with acetic acid or visual inspection of an iodine painted cervix. Cervical cancer screening leads to early detection and treatment of CIN, decreasing the incidence of cervical cancer.

Risk factors that increase acquisition of HPV include multiple partners and infection with other STIs, including HIV. Risk factors that increase progression to precursor lesions or cancer include infection with HPV 16 or 18, family history of cervical cancer, immunosuppression (i.e., HIV positive status, pregnancy), diabetes mellitus, and smoking. Sex workers are at greater risk for acquiring HPV and more likely to be HIV infected, increasing their risk of progressing to cervical cancer.

It is recommended that cervical cancer screening and treatment be offered to all female sex workers as part of the desirable package of services.

Cervical cancer screening should be conducted in line with national guidelines. The type of screening technique will be determined by service providers and comply with national standards. Some methods (e.g., Pap smear) may not be cost-effective for routine administration, therefore other methods (e.g., visual inspection) may be warranted. It is important that a routine (e.g., annual) cervical cancer screening schedule is created for SWs based on local epidemiology and available resources.

Note: An HPV vaccine exists to prevent the four types of HPV linked to 80% of cervical cancer cases. Once the vaccine is available, service providers should consider vaccinating sex workers, females who inject drugs, and their female children.

5.6.1 Considerations for Adolescents and young people from KPs

- HPV vaccination does not replace cervical cancer screening. In countries where the HPV vaccine is introduced, screening programmes may need to be developed or strengthened

- The WHO recommended target group for HPV vaccination is girls ages 9–13 years who have not yet become sexually active, including those living with HIV

5.7 Screening for anal and Other Cancers

Screening for breast cancer, ano-rectal, and prostate cancer should be part of routine care, and links to treatment services should be provided.[28] People infected with HIV are at least 20 times more likely to be diagnosed with anal cancer than uninfected people. Like cancer of the cervix, anal cancer is associated with human papillomavirus (HPV). Screening can be performed for anal cancer and its precursors, known as anal high-grade squamous intraepithelial lesions (HSIL), particularly for men who have sex with men, transgender people and other people from key populations who are more likely to engage in anal sex.

Key Messages:

- KPs with symptomatic STI/RTIs should be properly examined including anal and oral examination for those practicing anal and/or oral sex and treatment provided according to national guidance for the syndromic management approach. Clinical examination of KPs will not be complete without anorectal examinations
- Community-based interventions help to ensure that the benefits of interventions for STI/RTIs management are sustained and risk of reinfection is minimized.
- Training is required for health-care workers to properly manage STI/RTIs among KPs
- KP friendly services should be provided for successful management of STI/RTIs.
- Healthcare providers should be respectful and sensitized to the need of KP clients and to be non-judgmental.
- Health care workers should provide active referral and linkages and integrate services to facilitate access to comprehensive health care for KP who have STI/RTIs.
- Healthcare providers should counsel KPs with STI/RTIs and their partners on compliance with treatment, risk reduction, and condom use.
- Healthcare providers should give follow-up appointments for re-assessment for all STI/RTI syndromes.
- KP women with lower abdominal pain, who have fever, missed period, abnormal vaginal bleeding, recent delivery, miscarriage or abortion should be referred to in-patient department for further Gynaecological assessment and investigations.
- Neonates with ophthalmia neonatorum should be re-examined 3 days after starting treatment and their parents should be treated for discharge syndrome
- Healthcare providers should offer KPs with STI/RTIs and their partners counselling and testing for HIV infection
- Provide periodic screening for asymptomatic STIs, particularly Syphilis, T. vaginalis, N. gonorrhea and C. trachomatis, among KP
- STI screening should not be coercive or mandatory.
- Mature minor and sexually active adolescents should receive sexual and reproductive health services, including contraceptive information and services without parental or guardian authorization/notification

[1]WHO. 2013. Implementing comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from collaborative Interventions. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1

CHAPTER SIX: COMMUNITY-BASED INTERVENTIONS FOR KPs

6.1 Community engagement and support

Community engagement and support evolves as a collective, social action process and is critically important to ensure equal access to health services for all KPs. An important part of the process of community engagement is helping KPs overcome their sense of isolation, identify with one another, and build social ties based on their shared experiences and progress towards access to health services. This intervention will bring good effect to KPs in tackling the structural constraints of access to health services and improve their social wellbeing. Community engagement is more likely to produce better health and social outcomes. The overall aim is to create social and behavioural changes to improve access to health services, reduce the risk of becoming HIV infected and overall improve quality of life. The advantages of community engagement may reduce the underlying conditions of vulnerability faced by KPs, and lessen the risks of becoming HIV infected.

Community engagement and support provides the opportunity that can encourage and support behaviour change, such as the community norms around safer sex behaviours which in turn ensures their contribution in the response to HIV in their community.

A range of interventions to be delivered through community engagement and support can include:

- Raise awareness of KPs to access friendly health services through the process of ongoing engagement with service providers and community stakeholders to develop appropriate targeted intervention for KPs that address their specific health needs.
- Establish a safer and non-discriminatory environment where KPs can access friendly health services.
- Improving living conditions of KP, strengthening strategies for equal access to health services and reducing stigma and discrimination are regarded as critically important.

6.2 Drop in centres

Safe spaces (also known as drop-in centres (DIC)) should be established to bring community members together. Safe spaces are areas that provide community members with a comfortable place to relax, rest, get information, and interact with each other and with the programme. Given the extreme and rampant human rights violations of key populations, safe spaces are often the only places key population members can access health care, legal counselling, and other HIV-prevention services.

Evidence shows that DICs build solidarity and collective identity, which is very important for community empowerment.

The role of drop-in centres is critical given the fact that male and female sex workers/MSM/ PWID, especially those who operate from streets, do not have a place where they can safely rest, wash, or meet. Safe spaces may be located near programme-operated STI clinics, or even in the same building. There are practical advantages to co-locating safe spaces with clinics, such as the convenience of linking between community activities and programme services. Nevertheless, care should be taken to ensure that safe spaces remain a distinct community area. It is often important to separate an implementing organisation's office from the safe space and ensure that community leaders have clear responsibility for managing activities at the safe space.

In establishing and operation DIC programmes should:

- Determine and document leadership roles and responsibilities in running the centre.
- Establish a DICs governing committees comprising key population representation which will oversee aspects of running the DIC.
- Consider offering basic services such as water, bathrooms
- Provide condoms, safe injection equipment and other prevention commodities.

6.3 Community Rehabilitation Services for PWIDs/ PWUDs - SOPs

Community Rehabilitation services for PWUDs/PWIDs refer to specific integrated services in the community for people affected by drug use and dependence in the community which provides a continuum of care from outreach and low threshold services, through outreach work, recovery oriented system of care, aftercare and integration of clients back to their societies. It involves the coordination of a number of community health, social and other non- specialist services needed to meet the patient's needs. Strong support is also given to the patient's family and the community to address the drug and alcohol problems in their complexity and to ensure efficient and long-term results.

Meaning of Community Rehabilitation Service for PWUDs/PWIDs

- Located in the community
- Community empowerment: Mobilisation of community resources and participation
- Bio-psycho-social approach
- Primarily outpatient setting
- Continuum of care
- Integrated in community health and social services

Community Based Rehabilitation services should aim at:

- Help patients develop the skills to manage their drug and alcohol dependence and related problems in the community.
- Stop or reduce the use of drugs and alcohol
- Respond to a wide range of individual needs and ensure the best possible outcomes
- Actively involve local organizations, community members and target populations in the establishment of an integrated network of community-based services in a manner that is empowering
- Integrate drug and alcohol treatment and rehabilitation programmes into community health and social services and provide sustainability and accountability to the community.

6.4 Referral and Linkage Mechanisms

Many of the key interventions, particularly biomedical interventions, might be provided through referrals and linkages to appropriate facilities. In such cases, implementing organizations should:

- Ensure that the services are appropriate and acceptable to key populations, by building capacity of organisations in the referral network
- Provide an appropriate range of services, and ensure confidentiality between organisations
- Establish effective referral and linkage systems to facilitate the use of these services by

key populations reached by the programme

- Develop mutually supportive relationships between the implementing organisation, the community members, and the service providers, and
- Establish an effective system for making and tracking referrals and service delivery by systematically documenting the referral process (who was referred, from where, to where, and was the referral successful); and
- Enlist feedback on services from the target population and organisations in the referral network.

A referral network includes making and tracking referrals, establishing a referral directory, and monitoring the referral process. Referral networks are usually developed for a defined, smaller geographic area, and not for the entire country or district. The referrals process ensures the KP easily access the HIV/STI-related services. A structured understanding describing the relationship between organisations/service providers should be developed to strengthen referral mechanism. This understand ensures that organisations/ providers collaborate and avoid duplication of services to increase efficiency and improve programme.

In developing a referral network to create a referral network, service providers will:

- Map the catchment area, noting entry points to services (trained staff, time of day, etc.), possible barriers to services (cost, location, etc.), and stakeholders/gatekeepers that need to be contacted (madams, law enforcement, etc.).
- Define the target population (type of key population, structure, etc.) and geographic coverage area.
- Identify a coordinating body (most likely, a governmental body) that will manage and monitor the referral network (who was referred, when, and to what services) in the geographic coverage area.
- Identify the needs to be met by the referrals (i.e., components of the HIV/STI package not provided by the individual referring programme).
- Identify and sensitize the staff of organizations to provide non-judgmental services.
- Develop a structured understanding between organisations within the referral network.
- Create a referral directory that contains the name, location, hours of operation, services provided, cost, and point person of each organisation within the referral network.
- Produce a standard referral form and register to be used by all organisations within the referral network to track referrals (ZIHTLP-approved forms).
- Create a feedback mechanism for client and programme follow-up on the referral service and process.

6.5 Outreach services

Outreach is one of the key delivery mechanisms within targeted intervention focused on providing information and services (including BCC) at the convenience of the KPs – that is reaching out to location where KPs can be reached. Outreach is a process and not a one-time activity. In Zanzibar context, outreach services will involve health care workers reaching out to KPs using mobile clinics, visiting sober houses, drop in centre and other settings where KPs are found.

Outreach programs can provide a range of services including, but not limited to:

- Community-based HIV Testing and counselling
- Peer-led outreach for KPs
- Promotion, demonstration and distribution of reagents and commodities (condoms, syringes and other preventive devices) for KPs
- Psychosocial and Community Support (family support)
- Home-based care and emotional support
- Registration, risk assessment and risk reduction inputs through one to one and one to group repeated BCC sessions, providing HIV prevention education and addressing stigma and discrimination
- Dissemination of HIV risk reduction information (IEC materials) and targeted media
- Distribution of condoms
- Training on correct use of condoms
- Provision of referrals and linkage to HIV testing, other HIV prevention programs, drug and alcohol treatment, TB, STI screening and treatment and HIV health care and treatment that provide services that are non-discriminatory and responsive to the needs of KPs

Considerations for Adolescents from KP

The service delivery approaches and considerations discussed in this chapter for all key populations are applicable for adolescents from key populations. It is essential that services for adolescents from key populations are designed and delivered in ways that take into account the multiple, overlapping vulnerabilities that confront adolescents from key populations and the diversity of their needs, based on their age, their specific behaviours and the complexities of their social and legal environment.

Additional considerations and approaches for adolescents from key populations include:

- Acknowledge and build upon the strengths, competencies and capacities of adolescents from key populations, especially their ability to articulate what services they need. Engage them in decisions about services, recognizing their evolving capacity and their right to have their views taken into account. This is an important consideration when addressing issues of parental consent for services and treatment.

- Ensuring that services are friendly to adolescents and young people from key populations.

- Ensuring that services are as comprehensive as possible so as to address overlapping vulnerabilities.

- Provide developmentally appropriate information and education for adolescents from key populations, focusing on skills-based risk reduction. Information should be disseminated through multiple media, including the Internet, mobile phone technology and participatory approaches.

- Provide psychosocial support, through counselling, peer support groups and networks, to address self-stigma and discrimination and other mental health issues. Additional provision of counselling for families, including parents – where appropriate and requested by the adolescent – may be important to support

and facilitate access to services, especially where parental consent is required.

- Support access to livelihood development and economic strengthening, and encourage adolescents to stay in school or, if out of school, to return to school, where appropriate.

- Address social norms and stigma concerning sexuality, gender identities through supportive information for families, training of educators and health-care providers and nondiscrimination policies in employment.

Key Messages:

- Community engagement is key to help KPs overcome their sense of isolation, identify with one another, and build social ties based on their shared experiences and progress towards access to health services.
- Drop-in Centres (DICs) serves as safe spaces that provide KP with a comfortable place to relax, rest, get information, and interact with each other and with the programme.
- Outreach is one of the key delivery mechanisms within targeted intervention focused on providing information and services (including BCC) at the convenience of the KPs – that is reaching out to location where KPs can be reached.
- Implementers should a) ensure that the services are appropriate and acceptable to key populations, b) provide an appropriate range of services, and c) have effective referral and linkage systems to facilitate the use of these services by key populations reached by the programme.

[1]**WHO. 2013. Implementing comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from collaborative Interventions. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1**

CHAPTER SEVEN: CRITICAL ENABLERS AND PROGRAMME MANAGEMENT

Introduction

Law and policies can help to protect the human rights of key populations. Policy-makers, parliamentarians, religious leaders, and other public figures should work together with civil society and KPs networks to confront stigma, discrimination, and violence against KPs, and abolish punitive legal and social norms and practices that stigmatize and marginalize KPs.

7.1 Creating Enabling Environments

KP have rights to health, dignity, and life free from violence, discrimination, and stigma. The Zanzibar National HIV Strategic Plan III recognizes key populations' heightened HIV risk and vulnerability and ensures that integrated, high quality health services are available, affordable, and accessible for sex workers, MSM, PWID and students in correctional facilities. Programmes should be put in place to provide legal literacy and legal services to KPs so that they know their rights and applicable laws, and can be supported to access services.

7.2 Reducing stigma and Discrimination

WHO recommends that health services should be made available, accessible, and acceptable to key populations based on the principles of avoidance of stigma, non-discrimination, and the right to health. Complementary actions should be undertaken to reduce stigma related to HIV or KP in health care settings and communities. Programmes should be put in place to sensitize and educate health care providers on non-discrimination and KPs' right to high-quality and non-coercive care, confidentiality, and informed consent. Key population groups and organisations should be made essential partners and leaders in designing, planning, implementing, and evaluating health services.

7.3 Violence Prevention and response

KP are usually victims of abuse including gender based violence. HIV prevention policies and programmes focusing on key populations should incorporate violence prevention and response strategies. The key strategies include raising awareness, affirming key populations' identity and rights, and participatory documentation of threats and advocacy for an enabling environment.

7.4 Community Empowerment

Community empowerment is a collective process through which the structural constraints to health, human rights, and well-being are addressed by key populations to create social and behavioural changes and access to health services to reduce the risk of acquiring HIV.[29] Community empowerment is a necessary component of key population interventions and whenever possible should be led by CSOs working with key populations.

The interventions to be delivered through community empowerment model include:

- engagement with local CSOs and key populations to raise awareness and advocate for provision of friendly KP services,
- establishment of community-led drop-in and rehabilitations centres,
- formation of collectives and referral directory that determine the range of services to be provided, outreach Community empowerment interventions seek to create a safe space, utilizing solidarity and collective efficacy to advocate for increased power and control in society, and to challenge power structures that deny that group control and justice.

- Community Empowerment, Ownership, and Leadership the interventions delivered through a community empowerment model include sustained engagement with local key populations to:
- Raise awareness about their rights
- Facilitate meaningful participation
- Establish key-population-led services
- Form collectives/networks and coalitions that determine the range of services to be provided

7.5 Meaningful participation of key populations

To ensure that there is meaningful participation of key populations, implementers and policy makers would first have to respect them, have faith in their capacities, and provide them the space and mentoring support to participate equally. Meaningful Participation of Key Populations is a process that takes significant time and effort, especially since sex work, same-sex relationships, and drug use are usually stigmatized and criminalized. Hence KP programme should:

- respect and build trust with key populations
- understand the needs and concerns of key populations and working with them throughout the process of developing and implementing an intervention
- cultivate a programme that is informed and respond to the needs of key populations
- ensure CSOs working with key population are respected as important partners

7.6 Mapping Stakeholders and Advocacy

It is important to sit with key populations and map the perpetrators of violence and influencers who can change the situation. It is also pertinent to rank the perpetrators to understand which perpetrators to prioritize for advocacy. Advocacy with power structures, stakeholders, and law enforcement agencies is a key strategy for violence prevention and mitigation.

Advocacy with stakeholders to prevent violence against key populations. These stakeholders can include media, religious leaders, civil society, elected representatives, and county officials, Advocacy may include change in laws and policies that criminalize key populations or that are used to harass and abuse key populations, or change in law-enforcement practices that harass or abuse key populations and deny them their human rights, or even countering stigma and discrimination against key populations.

Advocacy and sensitization activities may involve workshops, public campaigns, SBCC material and mass media. Key issues to address include: violence against KPS and social and human rights of member of KPs.

Success advocacy should also build partnerships and networks with organisations that work on human rights and HIV, for joint advocacy efforts with their community members.

7.7 Coordinating KP activities

The ZIHTLP, CNCDC and ZAC are the main coordinators of KP program in Unguja and Pemba. The KP Coordinator is responsible for overseeing KP activities including monitoring and evaluation. It is crucial to strengthening KP coordination and mapping of stakeholders. At national level, the KP TWG should coordinate all implementing partners and provide guidance to the national KP response.

Key Messages:

- Policy-makers, parliamentarians, religious leaders, and other public figures should work together with civil society and KPs organisations to confront stigma, discrimination, and violence against KP, and abolish punitive legal and social norms and practices that Stigmatize and marginalize sex workers.
- Meaningful participation means involving KP groups and bringing them to the table to design and implement programmes.
- Programmes that are led by key populations are more likely to align with their needs, perceptions, and experiences
- The CNCDC, ZIHTLP and ZAC are the main coordinators of KP program in Zanzibar

CHAPTER EIGHT: MONITORING AND EVALUATION OF KP INTERVENTION

8.1 INTRODUCTION

Monitoring and evaluation (M&E) of the KP programme is an essential part of programme implementation. M&E is required in order to manage and be accountable for resources, improve service delivery, and ultimately assess programme outcomes and impact. M&E provides information to policy makers about effectiveness and sustainability of programmes. It allows implementers and donors and other key stakeholders to track the trend of HIV epidemic among KPs and to assess the extent to which programming is implemented and objectives are being achieved. Information obtained from M&E ensures that programmes are accountable to the beneficiaries that they serve. Furthermore, HIV/STIs surveillance and routine monitoring plays an important role to support assessment of trends in the epidemic and establish links between implementation, resources and results.

8.2 Data Collection

Health sectors (HIV/STI and TB) and other related interventions and programmes targeting KPs will be coordinated by ZIHTLP, CDCNC and ZAC. Since KP programme is implemented at both community (CSOs) and health facility settings, data will be collected in both settings. Information in this chapter should guide all partners involved in the HIV response for KPs in Zanzibar in how to contribute to one national M&E system by developing sustainable M&E capacity for programme improvement, coordination, and management, as well as accountability and information sharing in the country.

KPs programme data are collected through the community and facility based routine data that emanate from all implementers, while episodic data on KPs are generated from research, national surveillances and survey. Data collection and reporting is informed by approved KP indicators that measure progress towards achievement of the set targets.

Different data collection tools (hard and electronic copy) will be used in collecting the KP data depending on the type of KP data to be collected. Data will be collected and stored in a national database to avoid loss of information or breakdown of data flow.

All implementers should collect routine programme data by using the standard data collection tools. Data collection, analysis, interpretation and reporting will be done using both manual and electronic systems.

8.2.1 Data Collection Tools

The standard data collection tools to be used for KP programming include:

1. **Client Recording Card**: This form summarizes client information into one source document for a health facility or organization implementing KP programming. Community Outreach Workers will fill this card during each visit. The client card records client information at the first contact and during follow ups. The purpose of this card is to record and maintain client

information which includes demographic information, drug and sexual risk behaviors, and other information over a period of time.

2. **Follow up form:** The form is filled during subsequent client's visit to reflect the progress made as a result of the interventions provided. The client record form is kept at all points of service, including DICs.
3. **Referral form:** This form is used to refer client to other services such as HIV and AIDS testing and counselling, STI screening, ART, TB screening, viral hepatitis B and C screening, drug dependence treatment, drug addiction counselling, social services, and others.
4. **KP Register:** This register summarizes client information on prevention services provided to KPs. The KP facility register will capture summary data of each client and will be used to feed into the database. Initially new KP data from Client record card will be fed into the database and thereafter follow up form will be used to enter data each time services are provided to KP.
5. **Quarterly KP Reporting Form:** This form is filled by KP implementers at the end of each quarter. Most of the information on this form will be summarized from the Client Record Form. Information collected through the organization or community will be compiled and submitted ZIHTLP on a quarterly basis with the respective client form used to generate the summary report

Information to be collected includes:

- Socio-demographic information: age, sex, marital status, education level, occupation
- Drug use risk behaviours: use of unclean needles/syringes, sharing of needles/syringes and other injection equipment
- Type of drugs used: cannabis, khat, alcohol, benzodiazepine (Valium), cocaine, etc.
- Sexual risk behaviours: number of sexual partners, anal sex practices, and condom use
- Previous and current HIV and drug use services accessed
- Services provided to KPs: HIV and AIDS testing and counselling, STI screening, ART, TB screening, viral hepatitis B and C screening, drug dependence treatment, drug addiction counselling, social services, and others

8.2.2 Data recording

Routine recording of KP services shall use standardized data collection tools, which are developed by ZIHTLP in collaboration with KP stakeholders basing on WHO guidelines. Recording of HIV services which are not exclusive for KPs including adolescents and young people, such as HIV care and treatment, will be conducted using available routine recording systems. Service provider will record KP information when providing services. The Implementing Partner M&E officer will record and enter data into the KP database and DHIS2.

8.2.3 Data storage

Data collected from facility and community based KP services should be stored in the respective registers, monthly summary forms and electronically databases. All data collected are confidential, and shall be treated with the same level of protection as all other medical records. Records should only be accessed by persons who are authorized to do so. Data shall be stored in a lockable file cabinet, on a password-protected, secure computer, or in other secure locations so that the information will remain protected when the site is closed or the designated provider is not present.

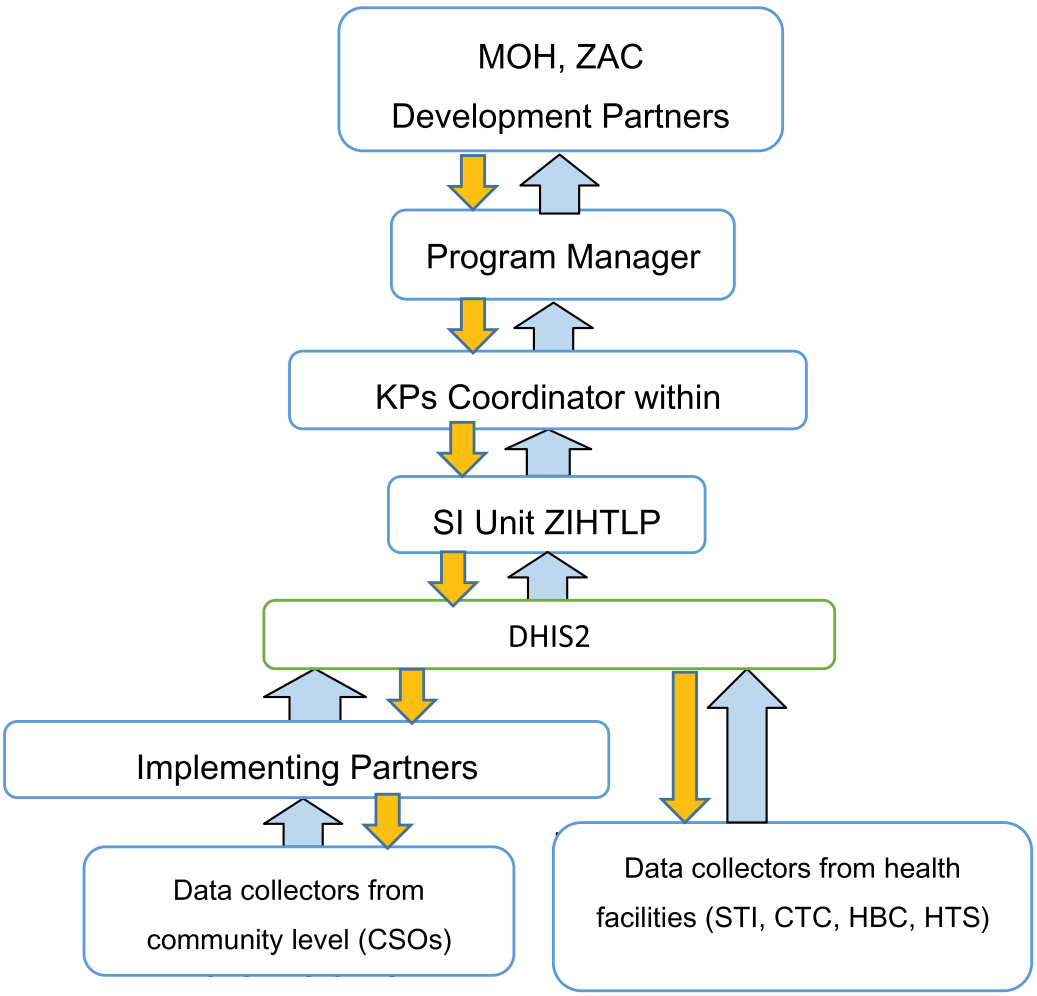
8.2.3 Data reporting

Quarterly reporting form will be used to report KP data. All Monitoring and Evaluation officers working with CSOs providing KP community services will be responsible for compiling quarterly reports. The reports should include age desegregation to support the analysis and interpretation of KP data including adolescents and young people programme performance. These reports will form part of progress reports that will be produced regularly by all implementers. In area where the electronic KP database has been establishing, routine data will be directly entered into the database. All implementers of the KP interventions should report all KPs related data to ZIHTLP. The KP data that is submitted to ZIHTLP should get the authority from Organization's Executive Officer and the report must be the same to what submitted to any other development partners as part of reporting requirements.

8.2.4 M&E Reporting Flow of KPs-related Interventions

The ZIHTLP Monitoring System is a routine data source for KP interventions. It is a data collection and reporting system that is used to collect routine KP related data to measure the output-level indicators in the M&E set of KP - indicators. All implementers of KP related interventions are required to complete report on their implementation quarterly and annually.

Figure 4: Data flow for implementers who report on KP Interventions



KP Data that need to be submitted to ZIHTLP by Implementers of KP interventions will be in manual (hard copy), and electronic forms. Nevertheless, submission of electronic information will be made parallel with the stamped paper documentation so as to ensure that, documentation is made officially. This will improve the sense of ownership and ensure the quality of KP data provided by an organization.

The Strategic Information Unit within ZIHTLP in collaboration with M&E officers who are responsible for reporting should be responsible for compilation of KP data. This will ensure that, multi-sectoral involvement of all key actors.

Frequency of data collection is mainly determined by the requirement of reporting of the progress of the implementation of KP related activities towards achievement of the set target. Therefore, the national implementation report shall be produced on quarterly, semi-annual and annual basis considering that data collection will be done on monthly basis. The survey data will be reported based on their availability that is either periodically or annually.

All stakeholders must adhere with the following timeframe in data submission: -

- Quarterly implementation reports from implementers of KP interventions using standardized reporting template to be submitted to the ZIHTLP within 7 days after the end of the quarter
- Annual implementation reports from implementers of KP interventions using standardized reporting template to be submitted to the ZIHTLP within 15 days after the end of the financial year period (financial year ends by 30th June each year). This is a cumulative annual report;

8.3 Data quality assurance

It should also be taken into consideration that; data quality assurance is a crucial aspect in order to realize the real progress in the implementation of KPs related interventions. The Strategic Information Unit within the ZIHTLP and therefore, shall collect, analyze and periodically conduct quality assurance of the data collected from KP implementers.

8.4 Data storage

Stakeholders could use existing database that enables them access relevant strategic information on KPs interventions for improved decision making at all levels of implementation. KP data will inform the national Health Sector M&E framework. It should also be noted that, all verified KP data will be stored in their specific database such as HTS, MAT and KP databases within ZIHTLP. KP implementers should establish a mechanism to continuously monitor quality of KP data generated and address obstacle or producing high quality strategic information for KP-related interventions. ZIHTLP and its stakeholders should work together to ensure that, KP data quality assurance is maintained.

8.5 Information Dissemination and Use

ZIHTLP is also responsible for developing and operationalizing an information management system to capture KP data and generating report, conduct quarterly supportive supervision and data audit. Reports must be disseminated for use at each level. At service provision points in

communities, organizations, and health facilities, reports are synthesized and interpreted to come up with actionable statements that will be used to improve KP services. Actionable statements will be discussed in the community, organization, and health facility settings to determine strategies for improvement. At district and regional levels, aggregated reports will be interpreted and disseminated within district health teams.

Dissemination of reports is expected to serve the following purposes:

- Provide feedback to various implementers on lessons learned, efforts made, progress, gaps, and challenges faced in the national response to HIV
- Share and use data and information for better targeting and planning of HIV interventions that target KPs at district and community levels in the country
- Provide feedback on the efforts and resources committed to the national response and highlight issues that still require intervention
- Raise awareness and public commitment to the national response
- Enhance networking, harmonization, and resource mobilization for the national response

8.6 Supportive Supervision and Mentorship

Supportive supervision will be done regularly. This process will involve a structured approach to facilitate health service providers to improve their work performance continuously. It should be carried out in a respectful and non-authoritarian way to promote quality outcomes through strengthening communication, identifying and solving problems, facilitating team work, and providing leadership and support. Mentorship is described as a process of practical training and consultation that fosters on-going professional development to yield sustainable high quality health outcomes.

It is crucial that all supervisors and mentors adhere to the implementation of the supportive supervision and mentoring of HIV and AIDS services using national level standardized tools for each intervention. In order to ensure that KP data generated and reported by KP implementers is of good quality, ZIHTLP M&E staff and all other implementers whether from private or public will undertake supportive supervision and mentorship visits to KP implementers each quarter. A standard national supervision tool should be used to monitor progress of implementation in all settings.

8.7 Evaluation of KP interventions, research and learning

Where necessary, stakeholders have to develop and implement research agenda that ZIHTLP has established, this could be done by identifying key evaluation and research areas of interest, questions and produce products to meet their needs. It could be helpful, if stakeholders could as well develop an inventory of research and researchers in their sectors, and make sure that, their research agenda are linked with national research strategy developed by ZIHTLP in collaboration with its stakeholders who implement KP related interventions.

Coordination with development partner, with coordinated and focused data collection of KP interventions, protocols, ethical clearance, analysis, and reporting system should be well prepared before conducting a survey/ surveillance. To monitor the trends of epidemic, IBBSSS after 5 years

8.8 KP monitoring indicators

KP Indicators were selected from sets of validated indicators for monitoring KP programmes and agreed upon by all stakeholders. Some key indicators for KP programme are:

1	Number of KP who received HTC services and received their result during the reporting period	10	1.Number of condoms distributed to KP members during the reporting period
2	Number of KP tested HIV positive during the reporting period	11	2.Percentage of KP members who reported using a condom during their last high risk sexual encounter
3	Number of HIV positive KP linked to Care and treatment services	12	3.Percent of Key Populations who are living with HIV
4	Number of KP clients newly initiated on ART during the reporting period	13	4.Number and percent of KPs immunized for HBV (completed 3 doses)
5	Number of KP clients current on ART during the reporting period	14	5.Number of Key Populations accessing services at KPs friendly clinics
6	Prevalence of HIV among KPs (IBBSSS)	15	6.Percent of sex workers reporting the use of a condom with their most recent client
7	Number of people who inject drugs (PWID) receiving opioid substitution therapy (OST).	16	7.Percent of MSM reporting the use of a condom the last time they had anal sex with a male partner
8	Number of female KP clients who received modern family planning method within reporting period disaggregated by method	17	Percent of people who inject drugs reporting the use of a condom the last time they had sexual intercourse
9	Number of condom outlets available in catchment areas.	18	Percent of people who inject drugs reporting using sterile injection equipment the last time they injected

8.9 Roles and Responsibilities of Key Stakeholders

1.4.1 ZIHTLP

- Ensure harmonization of KP monitoring and evaluation system using national indicators and standard reporting and recording tools
- Manage all aspects of the implementation of M&E framework for KP reporting.
- Develop, print and distribute data collection tools for monitoring of KP interventions
- Take note of details of distribution of data collection tools for KP interventions
- Build the capacity of all stakeholders on KPs reporting system.
- Provide technical guidance in all queries relating to KPs reporting system.
- Advocate with development partners and all implementers in terms of KPs reporting system and their requirements.
- Liaise with management and M&E Focal Persons to ensure their active involvement in KP reporting system.
- Develop a database and operationalize an information management system to capture KPs reporting forms, participatory supervision visit data.
- Ensure that updated KPs data and report are sent to all relevant stakeholders for use.
- Compile and analyses quarterly and annual reports or any other information products generated from KP interventions.
- Manage the dissemination of the information products generated by KPs reporting system

8.9.1 KP Programme Implementers

- Adhere to the harmonized KPs monitoring system using national indicators and establish a reporting mechanism to ensure that their KP data are captured and reported on time
- Orient relevant staff members in reporting system and requirements of KP interventions.
- Collect individual data through their Organization's functioning monitoring system for KPs
- Compile and submit quarterly and annual Reporting Form within required deadline to the M&E officers and strategic information unit at ZIHTLP.
- Participate in data quality assurance (participatory supervision visits) for those implementers who have submitted reporting forms on KP interventions.
- Attend the monthly and quarterly feedback workshops organized by ZIHTLP and its partners
- Review the stakeholder's current monitoring system and assess whether all necessary KP data are collected by the implementing Organization.
- Create and review all individual data collection tools that are used by the Organization to ensure that the necessary KP data are collected and stored appropriately.
- Train and orient all relevant staff members in the completion of the data collection forms for KPs reporting.
- Provide any additional KP data requested by ZIHTLP and answer questions where necessary.
- Ensure that reporting on KP monitoring data becomes a part of regular management meetings at the Organization.
- Inform ZIHTLP that there is a new M&E Focal Person should the Focal Person leave the Organization or management assigns a new M&E Focal Person.

Key Messages:

- Different data collection tools (hard, soft and electronic copy) will be used in collecting the KP data depending on the type of KP data to be collected.
- All implementers of the KP interventions should report all KPs related data to ZIHTLP.
- Quarterly implementation reports from implementers of KP interventions using standardized reporting template to be submitted to the ZIHTLP within 7 days after the end of the quarter
- Share and use data and information for better targeting and planning of HIV/AIDS interventions that target KPs at district and community levels in the country
- All implementers should adhere to the harmonized KPs monitoring system using national indicators and establish a reporting mechanism to ensure that their KP data are captured and reported on time

ANNEXES

Annex 1: Components within Comprehensive Package of HIV Interventions for People Who Inject Drugs

HIV Prevention	HIV Care and Treatment	Structural Intervention	Complementary Health Interventions
• HTC every 6-12 months, delivered through health services and community based services • PITC should be offered to all PWIDs • Prevention and treatment of STI • Condom programs for PWIDs and their sexual partners (both male and female condoms) • 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 • 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 • ART for all PWIDs living with HIV • Diagnosis and treatment of opportunistic infections • Cotrimoxazole prophylaxis PLHIV with CD4 count below 350 • 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	• 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 • Linkage to IGA groups for recovery PWIDs	• 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 • Cervical cancer screening for female drug users

Annex 2: Components within Comprehensive Package of HIV Interventions for Men Who have Sex with Men

HIV Prevention	HIV Care and Treatment	Structural Intervention	Complementary Health Interventions
• HTS, with the aim of individuals voluntarily accessing HTS 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 (STI), 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 other preventive devices, 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) • PMTCT services for female partners of MSM if planning on having children	• HTS • ART for all MSM living with HIV • Diagnosis and treatment of opportunistic infections • Cotrimoxazole prophylaxis for PLHIV (CD4 count below 350) • 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	• 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 social media based and/ or physical spaces for MSM to seek information and referrals for care and support Empowerment for MSM through development of peer networks	• 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 3 to 6 months testing

Annex 3: Component within Comprehensive Package for Sex Workers

HIV Prevention	HIV Care and Treatment	Structural Intervention	Complementary Health Interventions
• HTS 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 STI, 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 • 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	• HTS • 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	• 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/ partner • 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, counselling and contraception • PITC delivery of testing for asymptomatic syphilis infection • Linkage for legal support • Refer to IGA groups/formation of IGA groups among sex workers • Cervical cancer screening

Annex 4: KP Client recording form

KEY POPULATION CLIENT RECORDING FORM									
Taarifa za taasisi						Jina la mjazaji fomu _____ _____			
Jina la Taasisi _____									
						Tarehe ya tukio _____/_____/_____ (dd/mm/yyyy)			
Mkoa _____ _____		Wilaya _____ _____				Aina ya Shughuli : □ Huduma masafa/ MobileHTS		□ Huduma za kituoni	
						Kijiji/Mtaa _____	Wiliya	Mkoa	
TAARIFA ZA MTEJA NA MWENENDO WA TABIA									
SEHEMU 1: TAARIFA BINAFSI ZA MTEJA									
1. 1 TAARIFA BINAFSI ZA MTEJA						1.3 Elimu			
a. Namba ya Utambulisho. ……/……/……/……..		b. Jinsi	[ ] Me	[ ] Ke		[ ] 1. Hajasoma		[ ] 5.Elimu ya juu	
c. Hali ya ndoa [ ] Hajaoa/Hajaolewa [ ] Ameachika [ ] Mjane [ ] Anaishi na bibi/bwana [ ]						[ ] 2. Elimu ya msingi		[ ] 6. Elimu ya dini	

Tarehe ya Kuzaliwa (dd/mm/yyyy) ……/……/…… Umri_____						[ ] 3. Elimu ya sekondari			
d. Anuani ya mteja/Mtaa_____ (Gheto/Camp/ Bar)_____						[ ] 4. Elimu ya secondary ya juu		_____	
e. Simu ya Mteja _____ Simu ya mtu wa karibu wa mteja _____						1.4 Ajira			
1.2 Kundi la Mteja						[ ] 1. Ameajiriwa	[ ] 4. Kibarua		
PWID	[ ]	SW	[ ]	PCF	[ ]	[ ] 2. Amejiajiri			
PWUD	[ ]	MSM	[ ]			[ ] 3. Hana ajira		_____	
SEHEMU 2: MATUMIZI YA DAWA ZA KULEVYA NA TABIA HATARISHI									
Uchunguzi wa awali wa mteja									
2.1 Mteja amewahi kutumia dawa za kulevya kwa mfano, unga, vidonge, kokeni?					Ndio [ ]	Hapana [ ] Kama hapana nenda SEHEMU 3			
2.2 Aina gani ya dawa za kulevya alizotumia mwezi mmoja uliopita?									
2.2.1 Heroin		[ ] Kwa Kujidunga [ ] Njia nyingine			2.2.2 Khat/Mirungi [ ] 2.2.5 cocaine		[ ] Kwa Kujidunga [ ] Njia nyingine [ ]		
2.2.3 Benzodiazapine (Valium)		[ ] Kwa Kujidunga [ ] Njia nyingine			2.2.4 Pombe [ ] 2.2.6 Marijuana [ ]				
2.2.7 (Nyengine, ainisha) [ ] By Injecting [ ] Other		[ ] Kwa Kujidunga [ ] Njia nyingine							
2.3 Mteja aliwahi kujidunga dawa za kulevya katika kipindi cha miezi 12 iliyopita japo mara moja?						Ndio [ ] Hapana [ ]			

2.3.1Mteja amewahi kuchangia bomba la sindano mara ya mwisho alipojidunga? Ndio [ ] Hapana [ ] Kama jibu ni hapana endelea swali 2.5							
2.4 Kama jibu ni ndiyo kwenye 2.3.1, muulize mteja ni kwa njia gani alisafisha sindano? Unaweza kuchagua zaidi ya njia moja (1,2 au 1 na 2), au 3. [ ] 1.Blichi [ ] 2.Kwa njia nyingine __ [ ] 3. Hakusafisha				2.5. Mteja aliwahi ku ovadozi? ? Ndio [ ] Hapana [ ]			
SEHEMU 3: TABIA HATARISHI ZA NGONO							
3.1 Mteja aliwahi kutumia kondomu na mwenza wake mara ya mwisho alipofanya ngono ndani ya mwezi mmoja uliopita?				3.2 Mteja amewahi kufanya ngono kinyume na maumbile? Ndio [ ] Hapana [ ]			
[ ] 1. Ndio [ ] 2. Hapana [ ] 3. Hakujamiana 4. [ ] Hajawai kufanya ngono				3.3 Kama ndio, mteja alitumia kondomu katika kufanya mapenzi kinyume na maumbile katika tendo lamwisho? Ndio [ ] Hapana [ ]			
			Idadi				*Idadi*
3.1.1 Idadi ya wapenzi aliojamiana nao ndani ya mwezi mmoja uliopita				3.1.2 Idadi ya wapenzi aliotumia nao kondomu wakati wa kujamiana ndani ya mwezi mmoja uliopita			
SEHEMU 4: UPATIKINAJI WA HUDUMA ZA VVU NA UKIMWI							
4.0. Mteja kama alishawahi kupima virusi vya ukimwi?				4.2. Kama anaishi na maambukizi ya VVU, Mteja amejiunga na kliniki ya huduma na tiba ya watu wanaoishi na VVU (CTC) ?			
[ ] 1. Ndio	Kama ndio andika mwezi na mwaka (mm/yyyy):_____/_____/_____			[ ] 1. Ndio			
[ ] 2. Hapana				[ ] 2. Hapana	Kama jibu ndio, tarehe ya mwisho ulipotembelea kliniki ya huduma na tiba		

4.1. Hali ya Mambukizi						(dd/mm/yyyy):_____/_____/_____			
[ ] Anaishi na maambukizi	[ ] Hataki kusema		[ ] Hana maambukizi	[ ] Hajui		kama jibu ni hapana, sababu ya kutojiunga na huduma na tiba			
SEHEMU 5: TAARIFA ZA HUDUMA NA RUFAA									
Huduma	Elimu/ Taarifa aliyopewa mteja (√)	Nyenzo alizopewa mteja (√)	Rufaa aliyopewa mteja (√)	Huduma		Elimu/ Taarifa aliyopewa mteja (√)	Nyenzo alizopewa mteja (√)	Rufaa aliyopewa mteja (√)	
Maabukizi ya VVU				Pamba na Jiki,					
Ufuasi katika huduma na tiba				Vituo vya usaidizi kwa watumiaji wa dawa ya kulevya (Sober)					
Kifua kikuu				Kilainishi					
Magonjwa ya kujamiana				Kondomu za kiume					
Homa ya ini B na C				Kondomu za kike					
Ushauri nasaha na upimaji wa VVU				Hudama za kijamii					
Kituo cha huduma za uraibu wa Heroin (MAT)				Uchunguzi wa saratani ya shingo ya kizazi					
Kupunguza tabia hatarishi za kujamiana				Huduma ya afya ya uzazi					
Unyanyasaji wa kijinsia				Kiliniki ya Magonjwa ya ngono (STI)					
Huduma ya CTC				Kliniki ya Kifua kikuu					

Annex 5: Client Unique ID card

Unique Identifier	MKOA	NUMBER
Jina la Mteja: Asha	MJINI MAGHARIBI	15
Jina la Baba wa Mteja: Bakari	KUSINI UNGUJA	11
Jina la Mama wa mteja: Mariam	KASKAZINI UNGUJA	07
Herufi mbili za mwanzo za mteja: AS	KASKAZINI PEMBA	06
Herufi mbili mwanzo za Baba wa mteja: B	KUSINI PEMBA	10
Herufi mbili za mwanzo za Mama wa mteja: I	OTHERS	00
Mkoa aliozaliwa mteja: 15		
Nambari ya utambulisho wa mteja itakuwa: AS/BA/MA/15		