MINISTRY OF HEALTH, ZANZIBAR

Zanzibar Integrated HIV, TB and Leprosy Control Programme

ANNUAL REPORT 2014

TABLE OF CONTENTS

ACRONYMS

AB	Abstinence and Being faithful
ACSM	Advocacy Communication and Social Mobilization
AFB	Acid Fast Bacilli
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
APR	Annual Progress Report
ART	Anti-Retroviral Therapy
ARV	Anti-Retro Viral
BCC	Behavioural Change Communication
CDC	Center for Disease Control and Prevention
CHBC	Community Home Based Care
CHS	College of Health Sciences
CME	Continuing Medical Education
CMS	Central Medical Stores
CPT	Cotrimoxazole Preventive Therapy
CTC	Care and Treatment Clinic
CTRL	Central Tuberculosis Reference Laboratory
DAC	District AIDS Coordinator
DACCOM	District AIDS Coordinating Committee
DHIS2	District Health Information System 2
DHMT	District Health Management Team
DLT	District Laboratory Technician
DMO	District Medical Officer
DNA	Deoxyrebo Nucleic Acid
DOTS	Directly Observed Therapy Short-course
DSO	District Surveillance Officer
DST	Drug Sensitivity Test
DTLC	District Tuberculosis and Leprosy Coordinator
EA	Evaluability Assessment

EID	Early Infant Diagnosis
EQA	External Quality Assurance
FBO	Faith Based Organization
FBT	Full Blood Tests
FXB	François Xavier Bagnoud
GFR	Global Fund Round
GLRA	German Leprosy Relief Association
HBC	Home Based Care
HBHTC	Home Based HIV Testing and Counselling
HBV	Hepatitis B Virus
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
HUWANYU	Huduma Wagonjwa Nyumbani
IBBSS	Integrated Bio-Behavioral Surveillance Survey
IC	Infection Control
ICAP	International Center for AIDS Care and Treatment Programs
ICT	Information and Communication Technology
IEC	Information Education Communication
INH	Isoniazid
IPC	Infection Prevention and Control
IPT	Isoniazid Preventive Therapy
IRCHP	Integrated Reproductive and Child Health Programme
KPs	Key Populations
LEC	Leprosy Elimination Campaign
MARPs	Most At Risk Populations
MAT	Methadone Assisted Therapy
MB	Multi Bacillary
MDR	Multi Drug Resistant

MDT	Multi Drug Therapy
M&E	Monitoring and Evaluation
MOH	Ministry Of Health
MOTT	Mycobacterium Other Than Tuberculosis
MSH	Management Science for Health
MSM	Men who have Sex with Men
MTB/RIF	Mycobacterium Tuberculosis/Rifampicin
NCDC	National Coordination for Drug Control
NGO	Non-Governmental Organization
NTLP	National Tuberculosis and Leprosy Programme
PB	Pauci Bacillary
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PHL	Public Health Laboratory
PHN	Public Health Nurse
PHO	Public Health Officer
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission of HIV
PMU	Procurement Management Unit
PT	Proficiency Testing
PWID	People Who Inject Drugs
RCH	Reproductive and Child Health
RHZE	Rifampicin+ Isonazid+ Pyrazinamide+ Ethambutol
RLT	Regional Laboratory Technician
RTI	Reproductive Tract Infection
RTLC	Regional Tuberculosis and Leprosy Coordinator
SI	Strategic Information
SOPs	Standard Operating Procedures

STI	Sexually Transmitted Infection
SWs	Sex Workers
TB	Tuberculosis
THMIS	Tanzania HIV and Malaria Indicator Survey
THPS	Tanzania Health Promotion Services
TOT	Training of Trainers
TWG	Technical Working Group
UMATI	Chama cha Uzazi na Malezi bora Tanzania
UNDAP	United Nations Development Assistance Plan
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Programme
ZAEYA	Zanzibar Youth empowerment Association
ZANA	Zanzibar Nursing Association
ZANGOC	Zanzibar NGO Cluster
ZAPHA+	Zanzibar Association of People living with HIV and AIDS
ZAYEDESA	Zanzibar Youth Education Environment Development Support Association
ZBC	Zanzibar Broadcasting Corporation
ZAIADA	Zanzibar Association of Information Against Drug Abuse and Alcohol
ZIHTLP	Zanzibar Integrated HIV, TB and Leprosy Programme
ZN	Ziehl–Neelsen
ZTLP	Zanzibar Tuberculosis and Leprosy Programme
ZYF	Zanzibar Youth Forum

EXECUTIVE SUMMARY

This report presents a summary of the activities of the Zanzibar Integrated HIV, TB and Leprosy Programme - MOH in dealing with HIV, TB and Leprosy diseases as of December 2014. It includes brief descriptions of the following implemented interventions and analysis of interventions: HIV care and treatment, Counselling and Testing for HIV infection, Prevention of Mother to Child Transmission of HIV infection (PMTCT), Home Based Care, Strategic Information of reports and surveillance of HIV and TB in the country, Information, Education and Communication, TB and Leprosy, Key Population, STI/RTI, as well as Management and Finance. The performance of the ZHITLP in dealing with the HIV, TB and Leprosy epidemic is summarized in each programme unit. The indicators assess progress made over time from 2012-2014.

An estimated 7,732 people were living with HIV in the Zanzibar in 2014. The overall prevalence was 1% in general population. However, Zanzibar is characterized as a concentrated type of HIV epidemic. The epidemic is characterized by high HIV prevalence in the Key Populations, namely Sex Workers (SW), People who Inject Drugs (PWID) and Men who have Sex with Men (MSM) with a prevalence of 19.3%, 11.3% and 2.4% respectively (IBBS 2012). The numbers of TB cases notified are gradually increasing for the last three years. The increase in the notification is largest in the group of smear negative and extra-pulmonary with age group 15-34 years observed to be most affected groups. The number of patients with multibacillary leprosy is still alarming (76% - 54%) which demonstrates increased risk of transmission in the community.

The following have been achieved regarding HTC. In the year 2014, the total number of clients referred to HTC services from different services was 123,456 compared with 115,565 clients in 2013. Over the years, the major source of clients for HTC services has remained to be self-referrals which accounts for about 64% of all clients, while the remaining sources (PITC, mobile and Home Based) accounts for about 36%. The number of site offering HTC services 97 HTC sites (37 VCT alone, 31 PITC alone and 29 both VCT & PITC).

The continued Prevention of Mother to Child Transmission services, as a treatment as prevention strategy, has resulted in increased number of i) PMTCT implementing sites from 153 in 2013 to 156 (95% of all health facilities) in 2014, ii) pregnant women tested for HIV (ANC+LD) by PMTCT services from 56,343/58,661(96%) in 2013 to 60,132/60132(100%) in 2014; iii) pregnant women received ARVs to reduce the risk of mother-to-child transmission of HIV from 248/352(70.5%) in 2013 to

287/361(78%) in 2014. The HIV early infants' diagnostic services started in 2007 and in 2014 a total number of 270/359(75%) infants were tested for HIV infection and among them 3% were positive and 100% started ART treatment.

Regarding HIV care and treatment services; As of December 2014, the number of health facilities providing and reporting HIV care and treatment services reached 11 facilities (10 Public and 1 NGO facility). A cumulative number of clients enrolled in HIV care and treatment increased from 6,998 in 2013 to 7,820 patients in 2014 of whom 5,375 (68 %) have ever been started on ARVs at these facilities. However, patients who are currently on ARVs have increased from 2,947 in 2012 to 3,107 in 2013 to 3,587 in 2014. Despite the noted success in the HIV care and treatment services, a number of significant challenges still exists including increased number of lost to follow up patients.

During the year 2014, a total of 8,862 STI episodes were reported countrywide, which is a decrease from 9,596 episodes reported in 2013. Of these episodes, 8,154 were syndromic and 708 are aetiological; vaginal discharge was 4,212 episodes and urethra discharge was 1,341. From the data, the major cause of STIs cases in 2014 appears to be the genital discharge syndromes, and to a lesser extent Inguinal Bubos and other aetiology diagnosis. The number of male condoms distributed has decreased from 131,272 pcs in 2012 to 116,382 pcs in 2013 to 88,502 pcs in 2014.

For Key Populations services; the number Key Population who received an HIV test in the last 12 months and who know their results were 1,427 clients in 2014. Among those 146 were MSM, 941 SW and 340 were PWID. Number of KPs who received an HIV test has increased from 969 in the year 2013. A total of 852 (59.8% of tested KPs) were reached through outreach services compared to 575 (40.2%) of VCT sites. The unit conducted Methadone Assisted Treatment (MAT) training to Health Care Workers (HCWs) in Unguja to enable them to provide quality and standard MAT services to the clients, whereby the Clinic was expected to start services earlier 2015.

As of December 2014, a total of 3,725 clients have been provided with HBC services in Zanzibar which is an increase from 3,019 clients reported in 2013. Among those received services in 2014, 2,052 were people living with HIV where 1,325 were females and 727 were males. Chronically Ill patients were 1,673 where 844 females and 829 males. As the HBC services being provided by different implementing partners, by the end of 2014, all partners were able to report services using National recording and reporting tool.

For TB services, a total number of all registered TB cases were 648, where number of new smear positive TB cases was 335. TB success rate was 90% which was the same as the cure rate i.e. 90%. Regarding TB/HIV collaborative activities, 618 TB patients tested for HIV and 113 (18.2%) were positive for HIV. Eighty percent of the co-infected patients started ART under one roof service. The number of patients with multibacillary leprosy is still alarming (76% - 54%) which demonstrates increased risk of transmission in the community. A total of 176 new leprosy cases (56.4% MB) were registered in 2014 compared to 100 cases registered in 2013. Among the registered, 79.6% had disability grade 0, 17% had disability grade 1 and 3.4% had disability grade 2.

Regarding surveillance and reporting, the programme conducted ANC surveillance survey 2014 among pregnant women as a proxy for HIV prevalence in general population. The biological results showed that HIV prevalence remained constant at 0.6% compared with the study in 2010 and 2008, Syphilis 0.3%, HBV1.7% and HCV 0.1%. In 2014, Evaluability assessment was conducted to determine whether the planned evaluation is justified, feasible and likely to produce useful information for PMTCT, HTC and Care and Treatment programmes. Process to develop evaluation protocols and hence to direct process evaluation exercise on the identified program area was ongoing.

In raising public awareness and facilitate changing behaviors that put individuals at the risk of contracting or transmitting HIV and other sexually transmitted diseases, the programme conducted sensitization meeting for community and religious leaders on importance of male involvement in PMTCT services. Also IEC/BCC staffs were trained on Reflection and Action for Change (REACH), also, training on shifting BCC to BC, m-Health and ART adherence. The programme also involves religious leaders (FBO) in abstinence and being faithful (AB) campaign therefore, spiritual, social and psychological counseling. Spiritual counseling was conducted to individual and groups at Mnazi Mmoja CTC, also home visits to the PLHIV in need of spiritual counselling and sensitization in School Health Clubs was conducted.

In programme management, the programme hired consultants to 1) assess TB laboratory network in Zanzibar, 2) assess Private Health Facilities' capacity to provide TB services, 3) conduct TB Infection Prevention and Control assessment in Health Care facilities and 4) document best practice for TB/HIV under one roof services. The programme also supported staff to attend national, regional and international meetings.

CHAPTER ONE:

GENERAL INSTITUTIONAL BACKGROUND INFORMATION

1.1 INTRODUCTION

The Zanzibar Integrated HIV, TB and Leprosy Control Program (ZIHTLP) is one of the development programs under the Directorate of Preventive Services and Health Education of the Ministry of Health (MOH) Zanzibar. It is a result of two combined programs, namely Zanzibar AIDS Control Program and Zanzibar TB and Leprosy Control Program. The two programs were officially joined in February 2012 in order to maximize provision of services for two interrelated diseases and to optimize utilization of resources. The program is mandated to coordinate health sector response of HIV, TB and Leprosy in the islands.

1.2 THE BURDEN OF DISEASES (HIV, TB, LEPROSY)

1.2.1 HIV SITUATION

The first three cases of AIDS in Zanzibar were diagnosed in 1986 at Mnazi Mmoja hospital. In response to that, the Zanzibar AIDS Control Program was established by the Government of Zanzibar under the Ministry of Health. The main task of the program was to control the HIV epidemic to the level that it is not a public health problem.

Through number of HIV surveys, it has been established that Zanzibar has a concentrated type of HIV epidemic. The epidemic is characterized by high HIV prevalence in the Key Populations, namely Sex Workers (SW), People Who Inject Drugs (PWID) and Men who have Sex with Men (MSM) and low prevalence in the general population. The prevalence is 19.3%, 11.3% and 2.4% among SW, PWID and MSM, respectively according to the Integrated Bio-Behavioral Surveillance Survey (IBBSS) that was conducted in 2011/2012. The prevalence is 1% in general population as per Tanzania HIV Indicator Survey of 2012 and 0.6% as per ANC surveillance of 2014. It is estimated that there are 7,732 living with HIV in 2014. This is according to the Spectrum projections conducted in 2014.

Zanzibar is one of the few countries to conduct two rounds of IBBSS for all three groups in Africa. The first round was in 2007 whereby the prevalence was 10.8%, 16% and 12.3% among SW, PWID and MSM, respectively. Compared with 2012, there was a significant increase in HIV prevalence among SW (10.8% vs 19.3%), non-significant increase among PWIDs (16% vs 11.3%) and significant decrease of HIV

prevalence among MSM (12.3% vs 2.6%). For the general population, there was a non-significant increase in HIV prevalence from 0.6% (THMIS, 2008) to 1% (THMIS, 2012). The HIV prevalence among pregnant women attending Antenatal clinic has remained stable at 0.6% as per ANC surveillance of 2010 and 2014.

1.2.2 TB SITUATION

TB remains a public health problem in Zanzibar. The number of TB cases notified are gradually increasing. For the last three years, 600 cases (37% of estimated cases) on average have been notified annually with more males being infected (60%) than females. However, this is below the global target of 70% case detection rate. The increase in the notification is largest in the group of smear negative and extra-pulmonary. Considering the age group specific notification, we observe that the group 15-24 and 25-34 years are the most affected groups. Also TB cases among children (0-14) seem under notified.

The situation with regard to MDR-TB indicates under notification of MDR cases. For the last five years, only two MDR cases are notified per year. Based on the drug resistant survey of 2007, the estimated MDR cases are 1.1% among new and 3.9% among retreatment cases. The notification of MDR cases are expected to increase by the recently introduced X-pert MTB/RIF test.

For TB/HIV, it is a policy since 2006 to screen all HIV patients for TB and to test all TB patients for HIV. For the last five years the screening of HIV patients for TB has increased to reach almost 100% and the proportion of TB patients tested for HIV has increased gradually to reach 94%. The TB/HIV co-infection has a range of 16%-19%. The proportion of HIV+ female TB patients is substantially higher than that of male TB patients, which reflects the general trend in HIV epidemic.

The proportion of cure rate has increased steadily from less than 86.8% in 2011 to 87% and 90.3% in 2012 and 2013, respectively. Also the death rate among TB patients is falling down from 7% in 2012 to 3.5% in 2013. Among TB patients co-infected with HIV the death rate has also decreased from 6.9 in 2012 to 2.6% in 2013.

1.2.3 LEPROSY SITUATION

The number of leprosy notified cases has increased. A total of 100 new cases, on average, are being diagnosed for the last three years. Generally, case finding is passive and carried out by DTLCs in collaboration with health care workers in health

facilities. Occasionally, the passive case finding is reinforced by mini LEC campaigns and house to house case finding.

The number of patients with multibacillary leprosy is still alarming (54% - 76%) which demonstrates increased risk of transmission in the community. The number of female patients with leprosy ranged between 34-38% and shows a downward trend. The case notification among children also increased, though majorities are diagnosed with paucibacillary leprosy. Leprosy cases among children accounts for 19% of new cases.

The proportion of patients with grade 2 disabilities fluctuates. Small proportion of patients with grade 2 disabilities was observed in years where there is active case finding through different strategies. In 2014, where house to house screening was conducted the proportion of patients with grade 2 has decreased to 3.4% compared to 12% in 2013 where there was no active case finding.

1.3 THE VISION

Zanzibar is free of new HIV, TB and Leprosy infections, people infected or affected by HIV, TB and Leprosy are not stigmatized or discriminated against and most at risk populations are accessing HIV, TB and Leprosy services and information.

1.4 THE MISSION

To provide technical leadership and collaboration with other sectors and actors in ensuring that there is access, availability and equity of quality HIV/AIDS, TB and Leprosy services for general and most at risk populations.

1.5 PROGRAM GOAL

To provide technical leadership and collaboration with other sectors and actors in ensuring that there is access, availability and equity of quality of HIV,TB and Leprosy services for general and most at risk population.

1.6 PROGRAM CORE FUNCTIONS

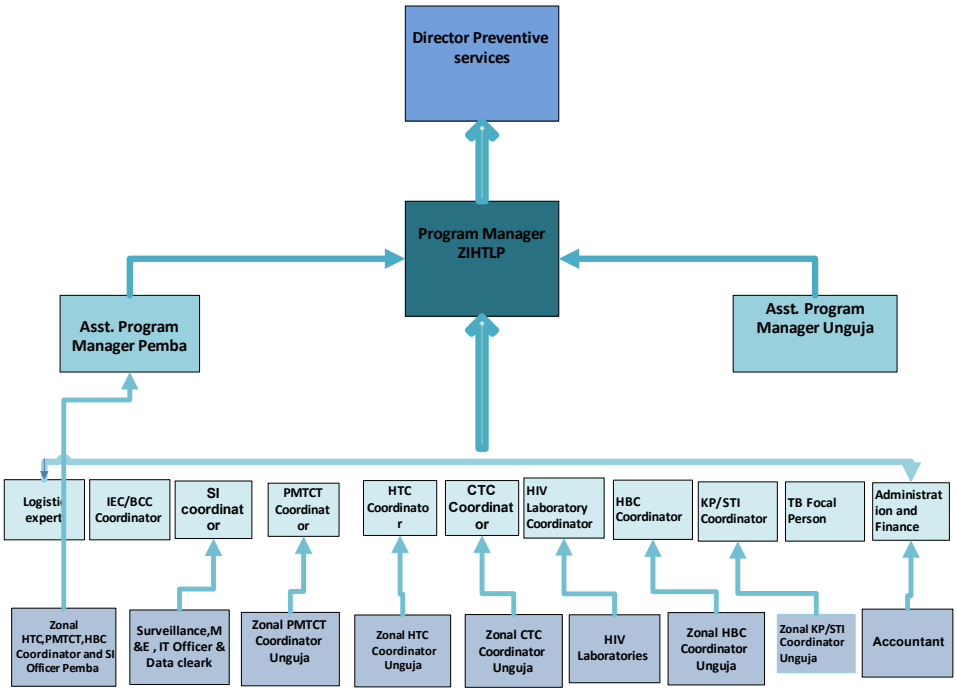
The ZIHTLP coordinates all activities pertaining HIV/AIDS, TB and Leprosy control in the country. It is also responsible for advising and guiding the MOH on health issues related to HIV, TB and Leprosy, building capacity of health care workers on the management of the three diseases, monitoring quality of services and strengthening strategic information system to monitor trends of the diseases. In line with above, the program ensures that control and prevention initiatives of HIV,

TB and Leprosy infection are in line with the Government key policy documents and the health sector strategic plan.

1.7 ORGANIZATIONAL STRUCTURE

This is an area of authority, responsibility and accountability. ZIHTLP contains eleven (11) technical units, each unit coordinated by coordinator. While the program manager is the overall in-charge of the program, coordinators oversee execution of program plans and implementation of activities under their respective program areas. They ensure that program plans are in line with the key strategic plans, develop and monitor adherence of the developed guidelines by service providers. Current program units are: HIV Counseling and Testing, Prevention of Mother to Child Transmission of HIV, HIV Care and Treatment, TB and Leprosy, Faith Based Interventions, Information Education Communication/Behavioral Change Communication, Key Populations & Sexually Transmitted Infections, Home Based Care, HIV Laboratory, Strategic Information and Program Administration and Finance. The following is the Organizational Chart of the program:

Figure 1.1 Organizational chart of the Zanzibar Integrated HIV, TB and Leprosy Program



1.8 STRUCTURE OF THE REPORT

The ZIHTLP annual report provides details on the progress of HIV, TB and Leprosy Program for the period of January – December 2014. The report is divided into seven chapters, which provide overview of implementation of program activities and the progress performance of each program unit.

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

CHAPTER TWO:

HIV PREVENTION SERVICES

2.1 HIV COUNSELING AND TESTING SERVICES

2.1.1 BACKGROUND

The HIV testing and counseling services are provided through three main approaches including:

1. Voluntary Counseling and Testing (VCT)
2. Provider Initiated Testing and Counseling (PITC)
3. Home Based HIV Testing and Counseling (HBHTC)

HTC services have been established in **97** sites which are located in all 10 districts of Zanzibar. These services are operating in Government facilities, NGOs, FBOs, Private hospitals and clinics. Amongst them, **37** sites provide VCT services alone, **31** provide PITC services alone and **29** provide both PITC and VCT services. In the year 2014, Home Based HIV Testing and Counseling (HBHTC) was implementing in six shehias (Kidimni, Jendele, Kiboje Muembe Shauri, Kiboje Mkwajuni, Miwani and Ghana) at the Central district of Unguja. A total of **123,456** clients were counseled and tested for HIV through HTC services, among them **1,381 (1.1%)** clients were diagnosed to be HIV positive.

In strengthening HTC services the following strategies have been put in place and operationalized:

- Strengthen capacity of health care workers (HCWs) to provide quality HTC services
- Procure and provide all the necessary equipment, reagents, supplies and accompanying technical support
- Strengthen linkages of HTC services with other HIV related services through a referral system
- Ensure demand creation of accessibilities and utilization for the use of HTC services through IEC/BCC.

2.1.2 GOAL

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

2.1.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

2.1.3.1 Objective 1: To improve quality of HTC service delivery

Activities Implemented

2.1.3.1.1 Conduct supportive supervision for counselling and testing services
Bi-annual supportive supervisions were conducted at **94** sites (**96.9%)** of VCT and PITC sites in Unguja and Pemba.

The objectives of the supervision were to monitor the progress of the delivered services and to support service providers to improve their performance in providing quality care.

Gaps observed during supervisions include:

- Improper filling of quantification book
- Inadequate skills on identifying Key Populations (KPs) and assessment of clients' risk behavior. This can lead to provision of improper preventive messages for VCT clients
- Shortage of skilled personnel due to several reasons including low number of trained staff, transfer and large number of staff who have gone for further study which leads to disturbance of services
- Low number of patients received PITC service
- Inadequate counseling skills for some of the providers, this is due to lack of refresher training/mentorship, in addition to that majority of providers have been trained a long time ago

Way forward:
Onsite feedback were conducted and agreed to continue comprehensive HTC services.

2.1.3.1.2 Conduct feedback meeting for HTC service providers

Four (4) feedback meetings were conducted for VCT and PITC services. Participants were from South and North Region Unguja and North Region Pemba. A total of **128** HCWs participated in the meetings including HTC service providers, laboratory technicians, peer counselors, hospital management and DHMTs members.

The objectives of the meeting were:

1. To provide feedback of supportive supervision

2. To share experience with service providers
3. To discuss successes and challenges faced by service providers when providing the services
4. To plan way forward to overcome the challenges for improving the quality of HTC services.

The issues discussed and agreed way forward were:

- Shortage of skilled personnel: It was agreed to increase number of PITC providers through Continuing Medical Education (CME) in the hospitals so as to reduce disruption of PITC services.
- Low number of patients received PITC service: It was agreed that hospital managers and DHMTs should conduct internal supervision within their wards and facilities to ensure PITC services are routinely recorded in their registers and PITC data is displayed to help providers to measure their performance. Also it was recommended that Ward Doctors should request PITC services as a routine investigation for all admitted patients.

2.1.3.1.3 Conduct Home Based HTC supportive supervision

Supportive supervision was conducted at Central district, Unguja in six **(6)** shehias (Kidimni, Ghana, Jendele, Miwani, Kiboje Mkwajuni and Kiboje Muembe Shauri). A total of **25** people agreed to be tested among **58** household supervised.

Challenge identified:

- Some HIV positive clients identified during Home Based HTC refused to be referred to CTC.

2.1.3.1.4 Conduct HTC stakeholders meeting

An HTC stakeholders meeting involving stakeholders who are providing HTC services, was conducted with the purpose of strengthening HTC services and increasing collaboration between HTC Unit and key actors. The objective of the meeting was to discuss progress, share experiences, successes and challenges in relating to the HTC service provision. A total of **44** participants attended the meeting including: ZIHTLP Coordinators, staff from Non-Governmental Organizations (NGOs), Board of Private Hospitals, Governmental Institutions such as ZAC, DMOs, Hospital Management Team, hospital in charges and ward in charges from Unguja and Pemba.

Issues discussed were:

- Low uptake of PITC services: It was agreed that Hospital Management and DHMTs should create a mechanism of replacing skilled personnel during the

transfer of the staff and HTC Unit should conduct mentorship for those sites which have shortage of counselors.

- Strengthening referral and linkages to CTC: The meeting agreed that, all clients identified to be HIV positive should be referred to CTC and feedback on the referral should be available
- Disorganization of mobile/outreach HTC services: Stakeholders agreed that all Institutions that receive ZIHTLP HIV test kits support should send their request of HIV test kits and monthly outreach schedule to ZIHTLP in the first week of every month.

2.1.3.2 Objective 2: To strengthen HTC services at facility level

Activities Implemented

2.1.3.2.1 Conduct Continuing Medical Education (CME) on PITC

Three days **(3)** Continuing Medical Education was conducted to health care providers from Mnazi Mmoja Hospital and North region due to shortage of PITC providers in some wards and facilities. A total of **74** HCWs participated.

The objectives of the CME were:

- To build capacity of health care providers to facilitate delivery of comprehensive care including PITC services at their health facility.
- To scale up PITC service and improve access of HTC services.

2.1.3.2.2 Distribution of HIV test kits and related supplies

HIV test kits and related supplies were distributed to all **97** HTC sites in Zanzibar including Government and Private health facilities, NGOs and Outreach services.

Table 2.1: Distribution of HIV test Kits (Determine), January – December 2014

	VCT/PITC sites Unguja & Pemba	Mobile VCT	Total
Number of sites receiving HIV test kits	97	56	**153**
Number of HIV test kits distributed	1,015	58	**1,073**

2.1.3.3 Objective 3: To increase access of HTC services

Activities Implemented

2.1.3.3.1 Conduct Home Based HTC services

Home Based HIV Testing and Counselling (HBHTC) was implemented in five **(5)** shehias of Central district. The rationale of initiating HBHTC in this district is due to high proportion of HIV infection (**2.6%)** and limited HIV related services. By December 2014, a total of **348** household were covered and **4,363** people were counselled and tested. Among them **13** clients were HIV positive.

2.1.3.3.2 Support VCT outreach services

In order to increase access of VCT services, outreach activities have been conducted in the community in collaboration with stakeholders from different sectors. Outreach services were conducted in different events and commemorations during village health day, Revolution day, World children's day, Mwenge day, routine activity and other events. The collaborators are ZANGOC, Zanzibar Youth Forum, DHMTs, ZAYEDESA, Bububu Military hospital, ZAPHA+, Zanzibar Madrasa Resource Centre, ZANA, IRCHP and KPs network.

Objectives of Outreach services:

- To educate youth about HIV transmission and prevention
- To increase access of VCT services closer to the community.
- To increase access and utilization of the services by KPs

A total **13,113** people (**8,390** men and **4,727** women) were counseled and tested in Unguja and Pemba. Among them**, 48** clients (**28** men and **20** women) were found positive HIV, and all were referred to CTC.

2.1.4 HTC SERVICES INDICATORS AND TREND FROM 2012-2014

	Indicator	Year		
		2012	**2013**	**2014**
1	Number of health facilities and sites offering HTC services	**79 HTC sites** (34 VCT alone, 18 PITC alone and 27 both VCT & PITC)	**97 HTC sites** (43 VCT alone, 27 PITC alone and 27 both VCT & PITC)	**97 HTC sites** (37 VCT alone, 31 PITC alone and 29 both VCT & PITC)
2	Number of individuals who received Testing and Counseling services for HIV and received their test results	**84,146**	**115,565**	**123,456**
	• Those tested positive	**1,468 (1.7%)**	**1,423 (1.2%)**	**1,381(1.1%)**

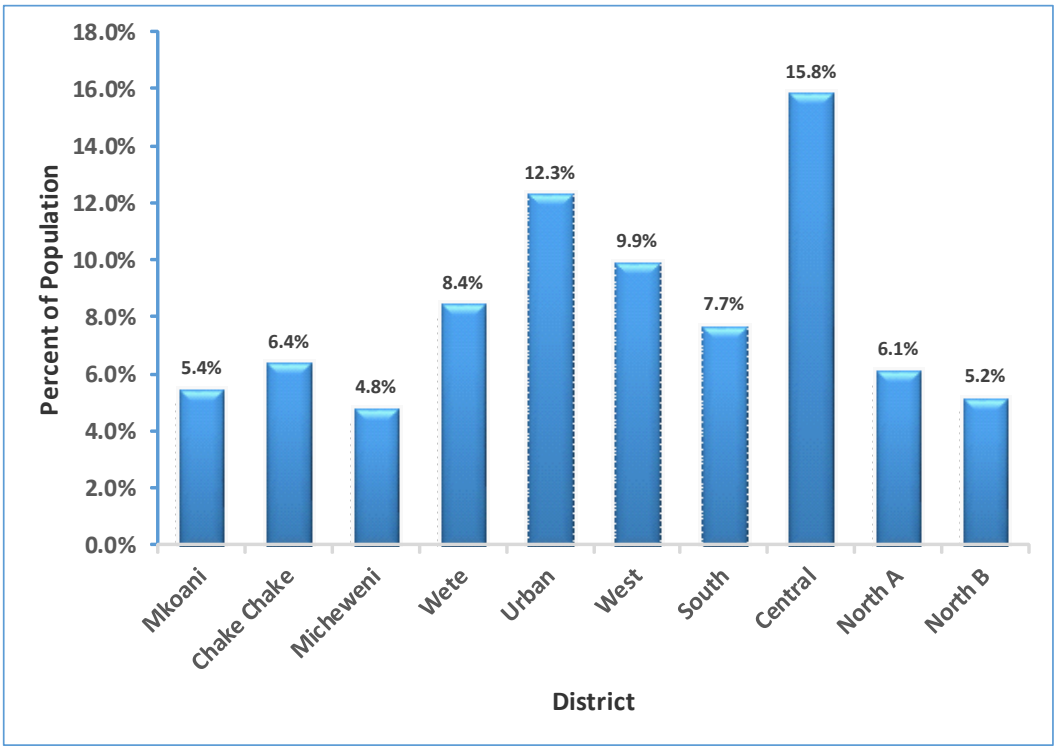
2.1.4.1 Number of sites offering HTC services

HTC sites currently exist in **97** sites. VCT sites decreased from **43** in 2013 to **37** in 2014 but increased number of sites provides PITC service alone from **27** to **31** and the sites provide both PITC and VCT services from **27** to **29**. Therefore accessibility of HTC services to the population has increased, hence facilitating utilization of the services.

2.1.4.2 Number of individuals received HTC services and received their test results

A total of **123,456** people were counseled and tested for HIV in Zanzibar; this is equivalent to **9.0**% of the Zanzibar population. This shows an increased number of people who were counseled and tested whereby in 2013 it was **8.6%.** Among the reason of increasing in the number of people counseled and tested is due to strengthening of HTC services through PITC services. By district, Central district had the highest proportion of people testing while Micheweni district had the least. (Figure 2.1).

Figure 2.1: Percent of population received HTC services by district, Zanzibar, 2014



Out of **123,456** people tested in 2014, a total of **1,381** people **(1.1%)** were identified to be HIV positive. HIV proportion among tested was higher in Unguja **(1.3%)** than in Pemba **(0.5%).** West and North A district had the highest HIV proportion among tested **(1.3%)** while Wete and Mkoani had the least **(0.3%).** All the districts in Unguja had higher HIV proportion than those of Pemba (Table 2.2).

Table 2.2: HIV proportion among tested by district, Zanzibar, 2014

District	Number tested for HIV	Number HIV positive	Percent positive
North A	6,863	86	1.3
North B	4,481	53	1.2
Urban	29,726	363	1.2
West	39,854	530	1.3
Central	12,568	147	1.2
South	3,134	38	1.2
Unguja	**96,626**	**1,217**	**1.3**
Wete	9,315	27	0.3
Micheweni	5,068	27	0.5
Chake Chake	6,326	46	0.7
Mkoani	5,432	19	0.3
Pemba	**26,141**	**119**	**0.5**
Outside Zanzibar	**689**	**45**	**6.5**
Total	**123,456**	**1,381**	**1.1**

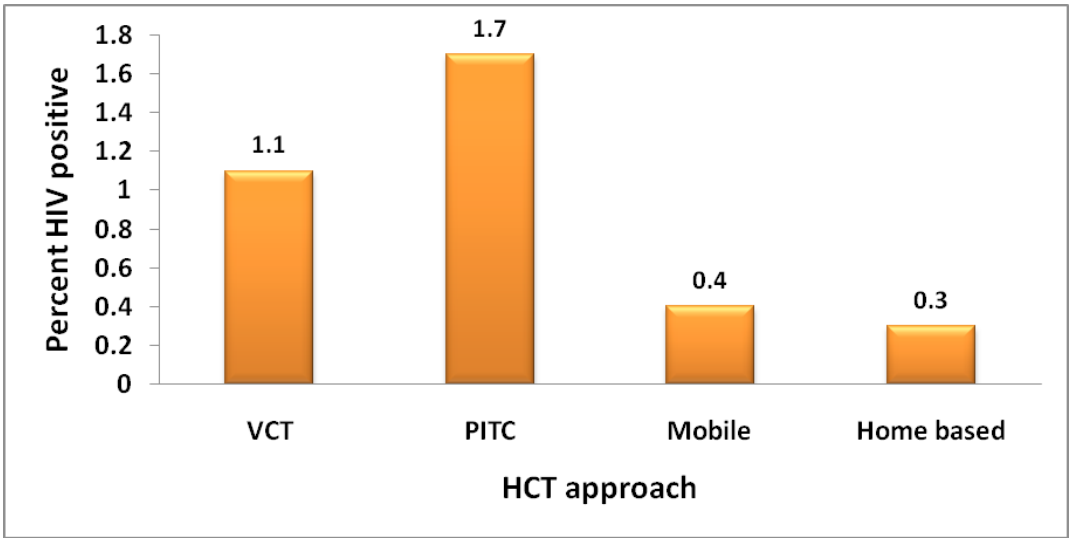
Out of all the people tested **60,070 (48.7%)** were females and **63,386 (51.3%)** were males, with HIV proportion being higher among females **(1.5%)** than males **(0.7%).**

Table 2.3: HIV proportion among tested by age and sex, Zanzibar, 2014

Age Group (Years)	Female			Male			Total		
	Number tested for HIV	Number HIV positive	Percent Positive	Number tested for HIV	Number HIV positive	Percent Positive	Number tested for HIV	Number HIV positive	Percent Positive
0-4	1,981	20	1.0	2,114	15	0.7	4,095	35	0.9
5-14	1,646	22	1.3	1,506	17	1.1	3,152	39	1.2
15-24	27,011	187	0.7	18,108	30	0.2	45,119	217	0.5
25-34	18,412	364	2.0	24,739	158	0.6	43,151	522	1.2
35-44	7,106	207	2.9	10,281	149	1.4	17,387	356	2.0
45+	3,914	120	3.1	6,638	92	1.4	10,552	212	2.0
Total	**60,070**	**920**	**1.5**	**63,386**	**461**	**0.7**	**123,456**	**1,381**	**1.1**

Of the people tested, **23.8%** (**27,865/123,456**) were reached through PITC approach while the majorities, **63.7%** (**78,111/123,456**) were reached though VCT approach. However, HIV proportion among those tested through PITC was higher (**1.7%)** than the proportion for those tested through **VCT (1.1%)** (Figure 2.2).

Figure 2.2: HIV proportion among tested by HTC approach, Zanzibar, 2014



2.1.5 ACHIEVEMENTS

- Increased number of people received counseling and testing from 115,565 in 2013 to 123,456 in 2014

2.1.6 CHALLENGES

- Inadequate counseling skills for some of the providers, this is due to lack of refresher training/mentorship

2.1.7 WAY FORWARD

- To conduct PITC training and VCT refresher training.

2.1.8 PLANS FOR 2015

- To conduct PITC training to new providers in the existing sites

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

2.2.1 BACKGROUND

PMTCT unit was first established in 2005 with purpose of preventing vertical HIV transmission from mother to child. Following the adaptation of new WHO recommendation of option B+ into the Zanzibar PMTCT guidelines, all pregnant and lactating women with HIV infection are eligible to lifelong ART regardless of WHO Clinical Stage or CD4 count; this emphases to Elimination of New Pediatrics HIV infections and improving care for infected partners and their children.

In 2014, a total of 60,132 pregnant women from ANC clinics, labour and delivery were counselled and tested for HIV which was equivalent to all women estimated to be pregnant in 2014. The proportion of pregnant women accessing PMTCT services considerably increased from 56,343 (in 2013) to 60,132 (in 2014).

The PMTCT Unit has been strategically using different approaches to improve and increase access to and utilization of PMTCT services, through the following strategies:

- Capacity building
- Advocacy
- Integration of PMTCT services into HIV service networks
- Procurement of essential reagents and other commodities – Securing all relevant commodities and supplies, and other equipment to enhance PMTCT services.

2.2.2 GOAL

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

2.2.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

2.2.3.1 Objective 1: To improve quality of existing PMTCT services

Activities implemented

2.2.3.1.1 Conduct new PMTCT training for HCWs

Twelve days training on PMTCT was conducted in Unguja involving a total of 35 HCWs from PMTCT sites. The purpose of this training was to impart HCWs with knowledge and skills on PMTCT services and enhance capacity of the existing PMTCT sites. The

selected sites had inadequate number of HCWs trained on PMTCT because majority of trained HCWs in these sites were transferred to other health facilities.

2.2.3.1.2 Conduct training on HIV Early Infant Diagnosis (EID)

Five days training on HIV Early Infant Diagnosis was conducted in Unguja. A total of 35 health care workers participated in the training for the purpose of building their capacity and being able to establish these services in their respective PMTCT sites. PMTCT unit intended to scale up and strengthen EID services in PMTCT facilities. The training was also composed of providers from existing EID sites for the purpose of strengthening these sites by having more staff trained on EID.

2.2.3.1.3 Conduct Adherence counseling training for PMTCT service providers

PMTCT unit conducted **5** days adherence counseling training for PMTCT service providers. The purpose of the training was to build capacity of PMTCT providers to provide effective adherence counseling for HIV positive pregnant and breast feeding women attending RCH clinics, in supporting implementation of option B+ where all HIV positive pregnant and breast feeding mothers are started ARV immediately after being diagnosed. A total of **30** PMTCT providers participated in the training (**25** from Unguja and **5** from Pemba).

The adherence counseling training is very crucial for PMTCT providers to enhance their capacity on provision of quality services for infected pregnant women.

2.2.3.1.4 Conduct Supportive Supervision

PMTCT unit conducted supportive supervision to PMTCT sites in Unguja and Pemba. A total of **46** sites which provide PMTCT services were supervised (14 sites in Unguja and 32 in Pemba). The supervision involved two teams of supervisors with the aim of monitoring implementation of PMTCT option B+, and provide on job training on the areas which were not well performed. The following issues were observed:

- All sites provide group and individual pre and post-test counseling and couple counseling for those who came with their partner
- Most of the sites' providers are aware of PMTCT interventions and comprehensive care even though there are few HIV infected mothers
- Majority of sites do perform HIV test using national algorithm.
- All sites have ANC registers and monthly summary forms.

Challenges

- Majority of the sites have quantification books but they are not filled properly and regularly

- External quality assurance is done in almost all PMTCT sites but only two sites had documented the EQA
- ARV prophylaxis for infants was not available in some of the sites supervised
- PMTCT mother and infant follow up registers are not filled properly in some facilities.

2.2.3.1.5 Conduct feedback meeting with PMTCT service providers

Two **(2)** feedback meetings were conducted in Unguja and Pemba. The objectives were to share best practices, knowledge and to find solution for the identified gaps during supervision.

Some of the suggestions to improve the identified challenges include:

- To conduct mentorship to the sites with poor performance on PMTCT services to encourage utilization of Job aids for pre-test information and to strengthen counseling and referral mechanism to increase retention of HIV positive mothers and their infants.
- Facility that identify HIV positive pregnant/lactating woman should inform PMTCT Coordinators for further follow up.
- All HIV positive pregnant women should receive their ART at PMTCT sites as refilling instead of going to CTC.

2.2.3.1.6 Conduct mentorship to PMTCT service providers

Mentorship was conducted in 35 health facilities (15 in Unguja and 20 in Pemba). Areas mentored include filling of registers through using PMTCT guides and how to conduct HIV testing.

After mentorship, service providers were expected to improve quality of PMTCT services by appropriate pre and post-test HIV counseling, correct implementation of PMTCT option B+ and proper filling of registers through PMTCT guides.

2.2.3.1.7 Attend orientation meeting of Score Card at Shinyanga

One day orientation meeting which was organized by Ministry of Health and Social Welfare Tanzania Mainland was held at Shinyanga. Zonal PMTCT Coordinators and IRCHP M&E officer from Zanzibar attended that meeting. DACs, RCH Coordinators and Pharmacists from Tanzania mainland also attended. The objective was to orient the participants on how to fill in PMTCT score card. The score card has been simplified with color coding to track the performance of district health management teams;

also this card can be used by Health facility, District, Regions and National level to monitor PMTCT services.

Recommendation

- ZIHTLP/IRCHP should adopt and develop score card system to measure performance of PMTCT services.

2.2.3.1.8 Procurement of PMTCT reagents and other commodities

In the year 2014, PMTCT unit procured and distributed a number of items as summarized in Table 2.4 below.

Table 2.4: Items procured and distributed by PMTCT unit, Zanzibar-2014

Item	Quantity
Determine HIV test kits	620 kits of 100 tests
Unigold HIV test kits	214 kits of 20 tests
Syphilis test kits	1,085 kits of 50 tests
Gloves	924 cartons
Vaccutainer tubes and needles	480 packs of 100 pieces
Micro pipette	21 pieces
Microtips (yellow tips)	45 packs of 1000 pieces

2.2.4 PMTCT SERVICES INDICATORS AND TREND FROM 2012 - 2014

Indicators		2012	2013	2014
		n/N (%)	n/N (%)	n/N (%)
1	Number of health facilities providing RCH services that also provide both HIV testing and counseling and ARVs for PMTCT on the site	137/156 (88%)	153/156 (98%)	156/164 (95%)
2	Number and percent of pregnant women who were tested for HIV and know their results	46,221/54,352 (85%)	56,343/58,661 (96%)	60,132/60,132 (100%)
3	Number and percent of known positive pregnant women	281/326 (86%)	347/352 (98%)	359/361 (99%)
4	Percent of HIV positive pregnant women who receive ARVs to reduce the risk of mother-to-child transmission of HIV	211/326 (65%)	248/352 (70.5%)	287/361 (80%)

5	Percent of HIV positive pregnant women delivering in health facilities	173/326 (53%)	231/352(66%)	291/361(81%)
6	Percent of male partners of pregnant women who are tested for HIV in last 12 months	1,785/54,352(3.3%)	1,804/58,661(3%)	1,643/60,132 (3%)
7	Percent of infants born to HIV-positive pregnant women who are started on Cotrimoxazole within two months of birth	170/281 (60%)	195/347(56%)	194/359 (54%)
8	Percent of infants born to HIV positive mothers who receive HIV antigen test (DNA PCR) within 2 months of birth	148/281(53%)	252/347(73%)	270/359 (75%)
9	Percent of HIV-positive infants started on ART	6/7 (85.7%)	15/18 (83.3)	9/7 (128%)

2.2.4 .1 Number of health facilities providing RCH services that also provide both HIV testing and counseling and ARVs for PMTCT on the site

Health facilities providing RCH services with HIV testing, counseling and ARVs for PMTCT increased from 153 (2013) to 156 2014. Ninety two (92) health facilities are in Unguja while 64 are in Pemba. This shows that the coverage of PMTCT services is well distributed, which enables increasing number of pregnant women to get PMTCT services across Zanzibar.

2.2.4.2 Number and percent of pregnant women who were tested for HIV and know their results

Utilization of PMTCT services showed upward trend from 96% (56,343/58,661) in 2013 to 100% (60,132/60,132) in 2014. This may be contributed by increasing number of health facilities providing PMTCT services and improved awareness and utilization of this service among Women of Reproductive Age. However, this increment can also be due to increased tendency of retesting of HIV by pregnant women and their being counted as new and reported more than once while they were already reported.

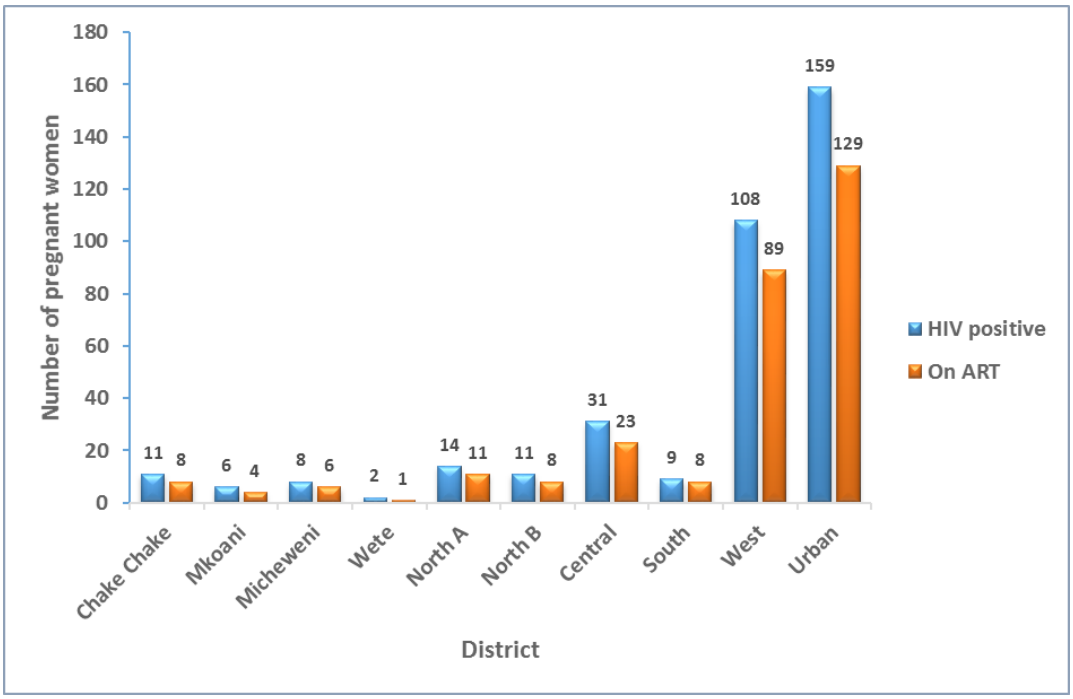
2.2.4.3 Number and percent of known positive pregnant women

The number and proportion of known positive pregnant women has increased from 98.5% (347/352) in 2013 to 99% (359/361) in 2014. The increased proportion might be due to increase accessibility to PMTCT services and awareness.

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

The proportion of HIV positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission of HIV has improved from 70.4% (248/352) in 2013 to 80% (287/361) in 2014. The increase in those who received ARVs may be attributed to improved escorted referral.

Figure 2.3: Number of HIV Positive Pregnant women who received ARVs to reduce MTCT by District in 2014



2.2.4.5 Percent of HIV positive pregnant women delivering in health facilities

Proportion of HIV positive pregnant women delivering in health facilities increased from 66% (231/352) in 2013 to 81% (291/361) in 2014. This is probably due to demand creation of free delivery services for pregnant women.

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

Male involvement in PMTCT services is still low, whereby there is slight decrease of male involvement from (1,804/58,661) 3.1% in 2013 to 2.7% (1,643/60,132) in 2014. This shows that male partners' utilization of RCH/PMTCT services need special attention to explore the underlying factors.

2.2.4.7 Percent of infants born to HIV positive pregnant women who started on cotrimoxazole prophylaxis within two months of birth

The proportion of exposed infants starting on Co-trimoxazole prophylaxis within the first 2 months of birth relatively decreased from 56% (195/347) in 2013 to 54% (194/359) in 2014. This may be contributed by poor follow up of infants born to HIV positive mothers.

2.2.4.8 Percent of infants born to HIV positive mothers who receive HIV antigen test (DNA PCR) within 2 months of birth

Proportion of infants born to HIV positive mothers and received HIV antigen test (DNA PCR) within 2 months of birth increased from 73% (252/347) in 2013 to 75% (270/359) in 2014.

2.2.4.9 Percent of HIV positive infants started on ART

The number of HIV positive infant has decreased. The percentage of infants enrolled on ART has increased from 83.3% (15/18) in 2013 to 128.5% (9/7) in 2014. The high percentage of infants started on ART of more than 100% may be contributed by the infants diagnosed last year but were started on ART in 2014.

2.2.5 ACHIEVEMENTS

- Decreased Maternal To Child HIV Transmission from 6.8% 2013 to 2.7% 2014
- All identified HIV positive infants were initiated on ART

2.2.6 CHALLENGES

- Loosing mothers and their infants to follow-up of PMTCT
- Low male involvement
- Low number of HIV exposed Infants who were started on Cotrimoxazole

2.2.7 WAY FORWARD

- Establishing of mother-infant case based surveillance
- Strengthening advocacy for male involvement: Male involvement and participation in the RCH/PMTCT services with their spouse, together with couple counseling and testing for HIV increases use of the interventions for HIV prevention

2.2.8 PLANS FOR 2015

- Deployment of PMTCT focal person for follow up HIV positive pregnant women and their infants
- Establish integrated CTC service in RCH Clinics

2.3 KEY POPULATIONS SERVICES

2.3.1 BACKGROUND

Key Populations (KPs) are populations that are at higher risk of being infected by HIV. They play a key role in driving HIV epidemic and their involvement in HIV interventions is vital for an effective and sustainable HIV response. Also they are at higher risk of acquiring other infections such as syphilis and viral hepatitis. In Zanzibar three groups have been documented to be at higher risk of HIV infection including Men having Sex with other Men (MSM), Sex Workers (SW) and People Who Inject Drugs (PWID). Ministry of Health through Zanzibar Integrated HIV, TB and Leprosy Programme (ZIHTLP) is mandated to coordinate and implement all health services related KPs interventions in Zanzibar.

HIV related interventions for KPs started in 2003 by involving peer educators in conducting home visit activities at community level so as to identify other KPs and provide HIV/STIs prevention education and condom distribution as well as refer detected HIV positive clients to care and treatment and other related clinics. To date there are a number of local NGOs, government ministries and departments in collaboration with other KPs stakeholders continuing to implement KPs intervention in Zanzibar.

2.3.2 GOAL

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

2.3.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

2.3.3.1 Objective 1: To expand access and improve quality of HIV services for KPs

Activities Implemented

2.3.3.1.1 Conduct sensitization workshop on the importance of KPs services for She has, religious leaders and Ward Counselors

One day sensitization meeting per district was conducted in Unguja. A total of **150** key community leaders at ward and shehia levels from six districts of Unguja (South, West, Central, Urban, North A and North B" were sensitized on the importance of KPs interventions in the Isles. These include district administrative officers, DACCOM, religious leaders, Shehas, and Ward counselors from these districts of Unguja.

The objective of the meeting was to orient these leaders on KPs and their importance in STI and HIV interventions including the importance of establishment

of Methadone Assisted Treatment (MAT) services in Zanzibar so as to facilitate programs ownership at district and community level.

At the end of the meeting, participants were expected to continue sensitizing others in their catchment areas on the importance of HIV health related interventions to KPs.

2.3.3.1.2 Conduct supportive supervision of KPs activities at facilities (NGOs) and hot spot outreach services

Bi-annual supportive supervisions to NGOs implementing KPs interventions and outreach services were conducted in Unguja and Pemba. A total of **28** facilities and six hot spots (two times per year) were supervised. The objective of the supervision was to assess types and quality of services offered to KPs as well as assist service providers in improving quality of service provision to the targeted populations.

The types of services provided differ from one organization to another depending on the category of KPs served. Most of the services offered to KPs include; HIV education, HIV counseling and testing, STI, TB and viral hepatitis education, escorted referrals of KPs for further investigation and management of health problems, distribution of condoms and KPs targeted IEC/BCC materials.

Major findings identified during supervision include;

- Low coverage of KPs interventions conducted by NGOs
- Peer education are not conducted by relevant peer educator
- Lack of coordination between stakeholders working with KPs in Pemba

2.3.3.1.3 Conduct peer educators' supportive meeting

One day peer educators' supportive meeting was conducted in Pemba. A total of **36** peer educators, outreach workers and other staff from ZAYEDESA, ZANGOC, KPs Network, Clinicians and peer educators from Care and Treatment Clinics (Chake Chake, Mkoani,Wete and Micheweni), managers of the sober houses from Mkoroshoni, Ndugukitu, Mkoani, Sober No. 2 Wete and Limbani participated in the meeting. The objective of the meeting was to discuss various issues on KPs interventions implemented by different stakeholders. This platform was also used to update peers educators on the new, current and emerging HIV, STIs, TB and viral hepatitis information.

Among the issues discussed include scale up of youth friendly clinic whereby it was discussed that UMATI decided to scale up youth friendly clinic by recruiting one

clinician, some peer educators and outreach workers. In doing so, they requested the ZIHTLP to support them with technical assistance and essential supplies such as STI drugs and condoms. Representatives from ZIHTLP agreed and promised to supply them with condoms and train their clinicians on STI management.

2.3.3.1.4 Conduct KPs stakeholders meeting

Bi-annual KPs stakeholders' meetings were conducted. A total of **70** service providers and officers from different NGOs and government institutions working with KPs attended. The main objective of these meetings was to strengthen coordination and feedback mechanism among key implementers. Among the issues discussed include:

- Number of KPs referred to CTC by NGOs: It was reported that the numbers of referred KPs by NGOs do not match with the number of KPs registered in CTC. It was agreed to improve communication between NGOs and CTC staff, improve documentation and feedback sharing among the responsible unit.
- Peer educators working with more than one NGO at a time: It was discussed and agreed that ZAC should conduct peer educators mapping so as to know who is working with which organization to avoid duplication of tasks and data per peer educator.

2.3.3.2 Objective 2: To improve availability and accessibility of KPs interventions

Activities Implemented

2.3.3.2.1 Provide KPs friendly services

Mnazi Mmoja and ZAYEDESA KPs friendly clinic continue offering services to the targeted populations. Services that are currently offered include:

- STIs management
- Screening and vaccination of viral hepatitis
- TB screening and management
- HIV counseling and testing

A total of **108 (80** others and **28** KPs) clients attended the clinic with different health conditions as indicated in Table 5 below. It was noted that the number of clients who attended KPs friendly clinic has been fluctuating (**102** in 2012, **120** in 2013 to **108** in 2014). The fluctuation is attributed to the shortage of funds for NGOs (E.g. KPs Network) working with KPs who refer KPs to these clinics but also due to shortage of STI drugs and stigma from some health care workers.

Table 2.5: Number of cases diagnosed at the KPs friendly clinic at MMH, 2014

Category	Diagnosis					
	Attended	Vaginal discharge	Urethral discharge	Genital Ulcer	Pelvic inflammatory disease	Genital warts
PWID	4	0	2	1	1	0
SWs	19	12	0	3	2	2
MSM	5	0	5	0	0	0
Others	80	40	24	4	5	7
Total	**108**	**52**	**31**	**8**	**8**	**9**

2.3.3.2.2 Conduct HBV screening and vaccination for KPs in Mnazi Mmoja Hospital

Hepatitis B virus screening and vaccination continues to be offered to KPs at Mnazi Mmoja Hospital and in some sober houses in Unguja. The objective of these services was to screen KPs in Zanzibar as they are known to have high infection rate of viral hepatitis compared to other populations. A total of **101** clients tested negative for viral hepatitis B and received vaccine against HBV as indicated in the Table 6 below. The number of KPs who were tested and received HBV vaccine has increased from **43** in 2013 to **101** in 2014.

Table 2.6: Number of KPs screened and Vaccinated for Hepatitis B at Mnazi Mmoja Hospital Unguja, 2014

Category	Tested		Results		HBV vaccination		
	Male	Female	HBV +ve	HBV –ve	1st dose	2nd dose	3rd dose
PWID	19	2	1	20	20	4	4
SU	36	0	0	36	36	23	9
SWs	19	19	0	38	38	6	3
MSM	7	0	0	7	7	4	3
Total	**81**	**21**	**1**	**101**	**101**	**37**	**19**

2.3.3.3 Objective 3: To enhance staff capacity on KPs interventions

Activities Implemented

2.3.3.3.1 Conduct Methadone Assisted Treatment (MAT) training to HCWs in Unguja

Fourteen (**14**) days MAT training for HCWs was conducted. A total of **20** HCWs including social workers from ZAYEDESA, ZYF and Kidongo Chekundu Mental Hospital, Clinicians, Medical Doctor, Laboratory Technician, Nurses, Receptionist, Pharmacist and Pharmaceutical Technicians attended. The training was divided into two parts, **10** days for theoretical sessions and **4** days for field work at Muhimbili, Mwananyamala and Temeke MAT clinics and some sober houses and Kidongo Chekundu MAT building in Unguja. The objective of this training was to build capacity for the potential MAT clinic staff in Unguja so as to enable them to provide quality and standard MAT services to the clients (heroin users). MAT services in Unguja will officially start in February, 2015. The target is to recruit and offer MAT service to **200** clients for the year one of 2015.

2.3.4: KEY POPULATIONS SERVICES INDICATORS AND TREND FROM 2012-2014

Indicators	Year		
	2012	**2013**	**2014**
Number and percentage of KPs who received an HIV test in the last 12 months and who know their results	**1,563**	**969**	**1,427**
a) MSM	401	121	146
b) SWs	787	360	941
c) PWID	375	488	340

2.3.4.1 Number of KPs who received an HIV test in the last 12 months and who know their results

Number of KPs who received an HIV test has increased from **969** in the year 2013 to **1,427** in 2014. The increase in number of KPs who received HTC services was contributed by the increased number of outreach interventions conducted by NGOs (ZAYEDESA and ZYF) as they were given special target of KPs to be reached and offered KPs related services by their funder ICAP.

Table 2.7: Number of KPs and their category who received an HIV test, 2014

KPs category	Outreach services			VCT clinics		
	Number Tested	Number Positive	Percent Positive	Number Tested	Number Positive	Percent Positive
PWIDs	138	0	0.0%	202	10	5.0%
MSM	44	2	4.5%	102	4	3.9%
SW	670	15	2.2%	271	13	4.8%
Total	**852**	**17**	**2.0%**	**575**	**27**	**4.7%**

The results shows that a total of **852** (59.8% of tested KPs) were reached through outreach services compared to **575** (40.2%) of VCT sites. But also it was noted that big number **(27)** of HIV positive KPs were detected through VCT compared to **17** KPs who were tested through outreach services as indicated in the Table 2.7 above.

2.3.5 CHALLENGES

- Low turn up of KPs attending KPs friendly clinic
- Stigma by some of HCWs to KPs
- Low enrollment of key populations to CTC
- Low number of KPs screened and received vaccination for Hepatitis B
- Low number of KPs completed Hepatitis B vaccination

2.3.6 WAY FORWARD

- Provide stigma reduction campaign to HCWs
- Strengthen mobile HBV testing and vaccination to KPs in Unguja and Pemba
- Strengthen mobile HTC to KPs
- Strengthen referral of KPs to CTC

2.3.7 PLANS FOR 2015

- Establish MAT services to heroin users at Kidongo Chekundu MAT clinic in Unguja

2.4 SEXUALLY TRANSMITTED INFECTIONS SERVICES

2.4.1 BACKGROUND

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

Effective management of STIs and RTIs is one of the cornerstones of their control, as it prevents the development of complications, decreases the spread of those infections and HIV in the community and offers unique opportunities for targeted educations about reproductive health. Early and appropriate treatment of STIs/ RTIs at the first contact between patients and HCWs is an important public health measure. Condom programming including promotion and distribution is another cornerstone of prevention of HIV and other STIs. STIs/RTIs services are provided in all **233** (**150** in Unguja and **83** in Pemba**)** health facilities in Zanzibar.

2.4.2 GOAL

The goal of STIs services is to reduce new HIV and Sexually Transmitted Infections and to provide care and treatment to all people in Zanzibar.

2.4.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

2.4.3.1 Objective 1: To expand quality of STIs services and increase its utilization

Activities Implemented

2.4.3.1.1 Conduct STIs supportive supervision at health facilities

Fourteen (**14**) days of STI supportive supervision was conducted in **43** health facilities in Unguja. The objective of this supervision was to observe the quality of STI services provision and help service providers in improving the provision of STI/ RTI services by adhering to proper use of national STI guidelines and monitoring tools. The major challenges observed included:

- Poor partner tracing in some of the facilities
- Poor utilization of STI guidelines
- Improper filling of STI monitoring tools

Onsite feedback was provided in each health facility that was visited, whereby strengths and challenges encountered were discussed. Demonstration on how to fill monitoring tools and brief orientation on using STI guideline especially STI cases flow charts was done.

2.4.3.1.2 Objective 2: To reduce new sexually transmitted infections among Zanzibaris

Activities Implemented

2.4.3.2.1 Condoms Distribution

It is evidenced that consistent and correct use of condoms can provide dual protection hence reduce the transmission of HIV and STIs. Condom programming to prevent HIV infections and STI is complementary to other preventive strategies such as promotion of voluntary abstinence, being faithful to one sexual partner, delayed age of the onset of sexual activity and prevention of mother to child transmission (PMTCT) of HIV. During this year, the unit was able to distribute a total of **88,502** pieces of male condoms through various condom outlets as indicated in Table 8 below. There is a decrease in number of condoms distributed in this year compared to 2013 whereby **116, 382** pieces of condoms were distributed. This decline was mainly due to stock out of the male condoms in few months as well as reduction of number of outreach sessions conducted by local NGOs working with KPs in Zanzibar.

Table 2.8: Number of male condoms distributed by different outlets, 2014

Type of outlet	Facility	Total
NGOs	ZAYEDESA, ZAEYA, UMATI, KPs Network and ZAPHA+	34,184
Health Facilities	Mwembeladu, Mnazi Mmoja CTC/VCT, Kivunge Cottage, Rahaleo, Al Rahma, Chwaka, Unguja Ukuu, Mwera, Donge Vijibweni, Michamvi Bwejuu, Paje, Jambiani, Kibuteni, Kizimkazi Mkunguni, Kizimkazi Dimbani, Muyuni, Uroa and Pwani Mchangani	22,494
Outreach	Peer education	18,720
Army forces	Bububu Hospital, JKU and TPDF Welezo	9,216
Other	Zanzibar University, Urban West Regional Commissioner's Office, National Coordination for Drug Control Zanzibar, Sober houses	3,888
Total		**88,502**

2.4.4 STIS SERVICES INDICATORS AND TREND FROM 2012 - 2014

	Indicators	Year		
		2012	2013	2014
1	Number of health facilities providing STIs care and treatment with staff trained on STIs care and treatment	50	85	85
2	Number of women and men with an STI presenting at health facilities who are appropriately diagnosed according to the national guidelines	9,492	9,596	8,862
3	Percentage of sexual partners of an individual with an STI treated at health facilities whose sexual partners are notified of their infections	12.5% (1,184/9,492)	10.7% (1,029/9,589)	9.8% (868/8,862)
4	Number of male condoms distributed	131,272 pcs	116,382 pcs	88,502 pcs

2.4.4.1 Number of health facilities providing STIs care and treatment with staff trained on STIs care and treatment

Compared to 2013, number of health facilities providing STI services with trained staff has remained the same (**85)**. This is because there was neither new STI trainings nor STI refresher trainings conducted during the year which was due to lack of funds.

2.4.4.2 Number of women and men with an STI presenting at health facilities who are appropriately diagnosed according to the National guidelines

A total of **8,862** patients were diagnosed with STI cases and treated. Among them, **2,054** (**23**%) were males and **6,808** (**77**%) were females. However, compared to 2012 and 2013 data, there was slight decrease in number of STI cases diagnosed (**9,596** in 2013 to **8,862** in 2014). This was caused by shortage of STI drugs. Table number 9 below illustrates the number of STI cases diagnosed and treated by gender and age. Vaginal discharge syndrome (**48**%) had the highest number followed by female with lower abdominal pain (**22**%).

Table 2.9: Number of STI cases diagnosed and treated by age and gender, Zanzibar, 2014

Diagnosis	Age (years) and gender						Total
	Male			Female			
	0-14	15 -24	25 +	0 -14	15 -24	25 +	
Syndromic Diagnosis							
Genital Ulcer (GU)	4	26	77	4	67	96	**274**
Inguinal Bubos (IB)	6	4	10	1	7	8	**36**
Lower abdominal pain (LAP)				32	711	1,171	**1,914**
Vaginal Discharge (VD)				56	1,688	2,468	**4,212**
Urethral Discharge (UD)	10	311	1,020				**1,341**
Painful Scrotal Swelling (PSS)	8	56	87				**151**
Neonatal Conjunctivitis (0-28 days)	226						**226**
Total Syndromic Diagnosis	**254**	**397**	**1,194**	**93**	**2,473**	**3,743**	**8,154**
Aetiological Diagnosis							
Gonorrhea	2	18	81	1	82	94	278
Syphilis	0	6	15	0	10	17	48
TrichomonasVaginalis	1	11	14	3	46	56	131
Chlamydia	3	4	6	0	11	10	34
Candidiasis	0	9	18	3	55	99	184
HIV	0	1	11	1	2	5	20
Hepatitis B	0	3	6	0	2	1	12
Hepatitis C	0	0	0	0	0	1	1
Total Aetiologic diagnosis	**6**	**52**	**151**	**8**	**208**	**283**	**708**
Total Aetiologic&Syndromic diag.	**260**	**449**	**1,345**	**101**	**2,681**	**4,026**	**8,862**

In terms of distribution, the Urban district was observed to report high number of STI cases **2,173** (**25**%), followed by West district and Central District with **1,740** (**20**%) and **1,424** (**16**%) respectively; whereas Micheweni and Mkoani districts were observed to have few cases **275** and **298** respectively (**3**%) of STI cases as indicated in the Table 2.10 below.

Table 2.10: Number of STI/RTI cases by district, Zanzibar, 2014

Diagnosis	Districts by Zone										
	Pemba				Unguja						Total
	Chake	Micheweni	Mkoani	Wete	North A	North B	Central	South	West	Urban	
Syndromic diagnosis	532	272	297	593	768	497	1,209	416	1,522	2,048	8,154
Aetiologic diagnosis	36	3	1	0	97	11	215	2	218	125	708
Total	**568**	**275**	**298**	**593**	**865**	**508**	**1,424**	**418**	**1,740**	**2,173**	**8,862**
% of all STI cases	**6**	**3**	**3**	**7**	**10**	**6**	**16**	**5**	**20**	**25**	**100**

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

In 2014, the total number of STI cases whose sexual partners were notified of their infections was **868.** Compared to 2012 and 2013, the number of sexual partners treated decreased from **1,184** in 2012, **1,029** in 2013 to **868** in 2014. This was due to lack of counseling skills to encourage index patients to bring his/her partner(s).

2.4.4.4 Number of male condoms distributed

Number of male condoms distributed through various condom outlets in Zanzibar has declined from **131,272** in 2012, **116,382** in 2013 and **87,958** in 2014 respectively. This was due to frequent stock out of the male condoms.

2.4.5 CHALLENGES

- Reluctance of the sexual partners to access management of STIs (partner tracing)
- Insufficient supplies of STI drugs in most of the health facilities
- Shortage of condoms supplies
- Shortage of trained STI providers in Unguja and Pemba

2.4.6 WAY FORWARD

- Facilitate procurement and supply of STI drugs to all health facilities in Unguja and Pemba
- Strengthening capacity building on quality STI services provision by HCW to clients
- Ensure availability of condoms

2.4.7 PLAN FOR 2015

- To review STI guideline
- Conduct STI trainings to HCWs

2.5 INFORMATION, EDUCATION AND COMMUNICATION/BEHAVIOR CHANGE COMMUNICATION

2.5.1 BACKGROUND

There is widespread knowledge of HIV prevention methods. About 69% of women and 77% of men know that a person's chance of getting the HIV virus can be reduced by using condoms. Also 84% of women and 87% of men know that the chance of becoming infected with the HIV virus is reduced by limiting sexual intercourse to one uninfected partner who has no other partners. The vast majority of Tanzanian adults know that people infected with HIV do not necessarily show signs of infection while 80% of women and 86% of men know that a healthy-looking person can have the virus that causes AIDS.

About 85% of women and 79% of men know that HIV can be transmitted through breastfeeding; 68% of women and 63% of men know that the risk of mother-to-child transmission (MTCT) can be reduced by the mother taking special drugs during pregnancy. HIV related educational programmes have been developed and aired through the mass media; 48% of women and 62% of men have seen or heard an HIV programme on TV or on the radio or in a magazine in the past 12 months **(THIMS, 2011/12)**. Condom uses differ among KPs in Zanzibar; it is higher among SW (78.9%) compared to MSM (25.6%) and PWID (17.5%) **(IBBSS 2011/12)**.

Based on these data, it is necessary to raise public awareness and facilitate changing those behaviors that put individuals at the risk of contracting or transmitting HIV and other STIs.

2.5.2 GOAL

To bridge the existing gap of information and services within the Program's units so that the intended populations both General and Key Populations are changing their behaviors positively from the risk behaviors and accessing the related services that could help in HIV prevention in Zanzibar.

2.5.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

2.5.3.1 Objective 1: To empower the community to develop culturally appropriate approaches in prevention of HIV transmission

Activities Implemented

2.5.3.1.1 Conduct sensitization meeting for community and religious leaders on importance of male involvement in PMTCT services

Ten **(10)** sensitization meetings, one per each district (6 Unguja and 4 Pemba)

were conducted. A total of **324** community leaders, religious leaders, traditional healers and traditional birth attendants were sensitized on importance of male involvement in PMTCT services (Unguja **180** and **144** Pemba).The objective of these meetings were to sensitize them on importance of male involvement in ANC services particularly PMTCT services. During the meetings, some of the main reasons for low male involvement were explored. These include:

- Services are not user-friendly to male partners,
- Men are bread-winners and therefore they have no time for waiting,
- Men do not understand the importance of attending clinics with their partners
- Culturally, society perceives that ANC clinics are for women.
- Once a woman status turn out to be HIV negative at ANC, male partners assume to be in the same status

During these meetings, importance of male involvements in ANC were discussed, and participants were expected to use different societal fora to sensitize the community members on importance of male involvements in ANC services.

2.5.3.1.2 Participate in Reflection and Action for Change (REACH) training

Two IEC/BCC Unit staff participated in **3** days training conducted by Pathfinder International, in Dar es Salaam, Tanzania. The aim of the training was to learn a new behavioral change tool known as "Reflection and Actions for Change" (REACH) that promotes shifting from BCC to BC approach that will help Peer Educators in their Key Populations interventions. Following this training, we expected to train peer educators from Key Populations to use this tool in their interventions to facilitate the trend of the behavior change in Zanzibar.

2.5.3.1.3 Participate in BC/BCC, m-Health and ART adherence workshop

A total of **21** stakeholders participated in **3** days workshop on BC/BCC, m-Health and ART adherence conducted by Pathfinder International in Zanzibar (8 ZIHTLP IEC/BCC staff, 3 Health Promotion, 1 ZAC, 1 NCDC, 3 CTC, 2 ZBC and 3 from NGO's). The aim of the workshop was to learn how to shift from BCC to BC, m-Health technology as an interactive Behavior Change tool and adherence to treatment for People Living with HIV. At the end of the workshop, participants are expected to have capacity to introduce m-Health technology in their programs particularly HIV.

2.5.3.1.4 Participate in World AIDS Day Commemoration

World AIDS Day commemoration was held on 1st December 2014 at Wara, Chake Chake, South region in Pemba. The theme of this year was the continuation

of previous year commemoration to "attain three zeros", meaning no new HIV infections, no new AIDS deaths and no more stigmas to People Living with HIV. During the commemoration educational materials with different HIV and TB related messages including brochures, pamphlets, posters and booklets were distributed.

2.5.3.2 Objective 2: To raise public awareness about behaviors that put individuals at the risk of contracting or transmitting HIV and other STDs

Activities Implemented

2.5.3.2.1 Printing of IEC/BCC materials

The Unit re-printed **seven (7)** types of IEC materials i.e. brochures and distributed them to targeted populations. The aim of these materials is to raise awareness and provide wide knowledge and understanding on HIV, HBV and PEP services in Zanzibar. The following table describe the materials re-printed and distributed in 2014.

Table 2.11: Re-printed IEC/BCC materials by theme, 2014

Type of Materials	Theme	Target populations	Number printed
Brochure	1.Pata huduma za PITC (Receive PITC services)	General Population	3,200
	2.Pata ushauri nasaha na pima VVU kujua afya yako (Receive HIV counseling and testing services to know your status)	General Population	3,200
	3.Fahamu kuhusu VVU na UKIMWI (Understand HIV and AIDS)	General Population	3,200
	4.Tukapime VVU kwa pamoja kabla ya ndoa (Before marriage let us test for HIV)	General Population	3,200
	5.Pata huduma ya PEP kuzuia VVU (Receive PEP service to prevent HIV infections)	General Population	3,200
	6.Jikinge na maambukizi ya homa ya ini B (Prevent yourself from hepatitis B infections)	General Population	3,200
	7.Mahusiano ya Virusi vya homa ya ini B na UKIMWI (Relationship between Hepatitis B and AIDS)	General Population	3,200

2.5.3.2.2 Distribution of IEC/BCC materials

A total of **29,867** IEC/BCC materials (**27,990** brochures and **1,877** posters) were distributed to targeted populations. Some of the materials distributed in this year

were the remaining stock from previous year. The aim of these materials is to raise awareness and provide wide knowledge and understanding on HIV, HBV, PEP and TB services. The following table describe the materials distributed in 2014.

Table 2.12: Distributed IEC/BCC materials by theme, 2014

Type of Materials	Theme	Target populations	Number distributed
Brochure	1. Pata huduma za PITC (Receive PITC services)	General Population	2,965
	2. Pata ushauri nasaha na pima VVU kujua afya yako (Receive HIV counseling and testing services to know your status)	General Population	6,491
	3. Fahamu kuhusu VVU na UKIMWI (Understand HIV and AIDS)	General Population	5,492
	4. Tukapime VVU kwa pamoja kabla ya ndoa (Before marriage let us test for HIV)	General Population	1400
	5. Pata huduma ya PEP kuzuia VVU (Receive PEP service to prevent HIV infections)	General Population	2,965
	6. Jikinge na maambukizi ya homa ya ini B (Prevent yourself from hepatitis B infections)	General Population	4,466
	7. Mahusiano ya Virusi vya homa ya ini B na UKIMWI (Relationship between Hepatitis B and AIDS)	General Population	1,400
	8. Tumia dawa za kupunguza makali ya VVU kwa usahihi (Use ARV appropriately)	PLHIV	1,568
	9. Tumia dawa za kupunguza makali ya VVU na kifua kikuu kwa usahihi (Use ARV and TB drugs appropriately)	PLHIV, TB patients	920
	10. Epuka kifua kikuu sugu (Avoid chronic TB)	PLHIV, TB patients	223
Poster	1. Acha unyanyapaa (Stop Stigma)	General Population	504
	2. Pima VVU kwa pamoja kabla ya ndoa (Before marriage let us test for HIV)	General Population	648
	3. 'PEP' ni mkombozi wangu dhidi ya maambukizi ya VVU (PEP is my savior against HIV infections)	Health Care Workers	725

2.5.4 CHALLENGES

- Shifting from BCC to BC in implementing behavioral change interventions is still a challenge
- Inadequate fund to implement IEC/BCC activities

2.5.5 WAY FORWARD

- Gradually shifting from BCC to BC approach in behavioral change interventions.
- Program to mobilize resources for IEC/BCC

2.5.6 PLANS FOR 2015

- Introduction of m-Health technology in HIV prevention, care and support.
- Develop, print and distribute different types of IEC/BCC materials in relation to Program areas including TB/HIV, PMTCT and MAT.

2.6 FAITH BASED INTERVENTIONS (AB)

2.6.1 BACKGROUND

Faith based interventions within the Ministry of Health are coordinated by the Faith Based Organization Technical Working Group (TWG) which was formed on 6th January 2006. The main purpose of this TWG is to support youth and faith-based initiatives that positively promote abstinence, faithfulness, partner reduction, and delayed sexual debut in a holistic manner as an important strategy for the prevention of new HIV infection in Zanzibar. The team has been working in collaboration with Zanzibar Integrated HIV, TB and Leprosy Programme (ZIHTLP), and its members are drawn from Christian and Muslim institutions. The involvement of religious leaders in abstinence and being faithful (AB) campaign therefore, has been complementing other prevention strategies used by different partners to reduce new HIV infections in Zanzibar.

The HIV Faith Based Intervention targets youths and adults by focusing on the following:

- Spiritual, social, psychological and health gains associated with abstinence and faithfulness;
- Personal risk assessment;
- Adherence to faith-based teachings on abstinence and faithfulness contained in the Qur'an and Bible;
- Awareness about the role of abstinence and faithfulness in the prevention of unplanned pregnancies and prevention of sexually transmitted infections, including HIV & AIDS;
- Promotion of spiritual and pre-marriage counseling for couples

2.6.2 GOAL

The goal of the FBO TWG is to bridge gaps of information and services within the Ministry of Health so that the intended populations change their behaviors in accessing the related services that could help in HIV/AIDS prevention in Zanzibar.

2.6.3 OBJECTIVE AND ACTIVITIES IMPLEMENTED IN 2014

2.6.3.1 Objective 1: To empower the community to develop culturally appropriate approaches in prevention of HIV transmission

Activities Implemented

2.6.3.1.1 Conduct FBO Technical Working Group meetings

A total of 4 FBO TWG meetings were conducted. The purpose of the FBO TWG meetings was to plan and review the implemented activities with the aim of assessing success, challenges and plan for the way forward. Issues discussed include the performance assessment of School Health Clubs, availability of IEC/BCC materials for school health clubs, as well as Spiritual Counseling services at CTC Mnazi Mmoja Hospital.

In regard to the school health clubs, the performance assessment revealed that all clubs were in need of HIV CD films to ensure that the TV and CDs machine provided to them are fully utilized. It was therefore decided that the produced JINASUE film should be made available to all school health clubs as soon as possible.

In reference to the shortage of different pamphlets and leaflets at School Health Clubs, it was decided that clubs should approach other institutions with similar interest which are working in school programmes especially those focusing on health issues like Red cross, ZAIADA, UMATI, ZAC, ZANGOC, ZAYEDESA and others for relevant pamphlets and CDs.

On Spiritual Counseling services in Mnazi Mmoja Hospital and Community Home Visits, major issues which came up were that of stigma and discrimination. It seems that stigma is still prevailing in some areas within the community. It was suggested that FBOs should consider promoting VCT and continuing the fight against Stigma and Discrimination in the community and to their respective institutions.

2.6.3.1.2 Conduct Spiritual Counseling sessions at Mnazi Mmoja Gold Standard Centre

Based on religious concept, TWG continued to provide spiritual counseling to HIV patients and other clients. The main purpose of spiritual counseling was to remedy mental stress as well as social difficulties with the aim of enabling a client to live positively. Approaches which are used to provide spiritual counseling include individual, couples and groups.

Clients were referred for spiritual counseling for different reasons including psychosocial problems, advice on various medical issues and desired spiritual uplifting and encouragement.

A total of **1,347** individuals and **13** group counseling sessions were conducted. Among the individual clients counseled 862 came for HIV test, 16 were PLHIV, 43 students came for HIV test for clinical examinations, 48 were couples who went for HIV test before marriage and 21 people came for HIV test before surgical operations.

Occasionally FBO TWG conducted health education talks with people who attended CTC and VCT at Mnazi Mmoja Hospital. A total of 5 health talks were convened and 89 people received health education on religious perspective.

Major issues discussed in the counseling sessions included adherence to treatment, support required by PLHIV from the community, family problems, hard life and earning as well as stigmatization.

Main challenges in the spiritual counseling were ARVs adherence during the holy month of fasting (Ramadhan) whereby some clients changed time of taking drugs despite of spiritual counseling. Other challenge was that children on ARVs whose mothers have been divorced or neglected were suffering a lot and were not properly looked after.

2.6.3.1.3 Conduct Supportive Supervision to School Health Clubs

Supervision to 24 School Health Clubs both in Unguja and Pemba were conducted. The objective of this activity was to assess the effectiveness of the school health clubs in raising awareness on HIV prevention as well as promote AB to students who are in and out of schools.

During supervision visits, TWG conducted an assessment on the performance of clubs and the utilization of the equipment provided to them such as television and DVD machine. It was found that the clubs are very alive and equipment were kept well but were not fully utilized due to lack of HIV CDs to play.

2.6.4 ACHIEVEMENTS

- Distribution of JINASUE CDs to all established 24 school health clubs as well as to all religious institutions in Unguja and Pemba.

2.6.5 CHALLENGES

- Limited IEC/BCC materials to support FBO activities
- Limited financial resources to support FBO TWG activities in Unguja and Pemba
- Lack of coordination with other partners with similar interest who have school programs
- Absence of guideline/standard for other stakeholders to comply on implementing school health clubs interventions
- Stigma and discrimination is still prevailing in some areas within the community as a result there is low number of men who attend at RCH Clinic with their wives and children. Also both some infected husbands as well as wives are not willing to disclose their HIV status after being tested positive because of fear of divorce, blame and other social problems
- Inadequate ARVs adherence during the month of fasting despite of spiritual counseling.
- Children on ARVs whose mothers have been divorced and neglected are suffering a lot and are not properly cared.

2.6.6 WAY FORWARD

- Assess and determine the effectiveness of IEC/BCC materials distributed including JINASUE film
- Involve more partners/stakeholders to support School Health Clubs especially in providing IEC/BCC materials.
- Promote psychosocial support to PLHIV and their families
- Develop guideline/standard for other stakeholders to comply on implementing school health clubs interventions
- Raise awareness to the Religious institution and community at large to fight stigma
- Secure financial resources to support FBO TWG activities in Unguja and Pemba
- Conduct TWG performance assessment

CHAPTER THREE:
HIV CARE, TREATMENT AND SUPPORTING SERVICES

3.1 HIV CARE AND TREATMENT SERVICES

3.1.1 BACKGROUND

HIV care and treatment (ART) services were established in 2005 at Mnazi Mmoja Hospital. The goal is to reduce HIV/AIDS related morbidity and mortality through provision of quality care and support to people living with HIV and AIDS, provision of ART to eligible patients and improve linkages with other HIV related services. Currently, there are eleven Care and Treatment Clinics in Zanzibar, seven in Unguja (Mnazi Mmoja, Mwembeladu, Bububu, Kivunge, Makunduchi, Al Rahma, and ZAYEDESA) and four in Pemba (Chake Chake, Wete, Micheweni and Mkoani). ART services are provided in 9 public hospitals, one private hospital and one NGO.

As of December 2014, a total of **7,820** patients have been enrolled in care and treatment clinics (CTC) of whom **5,375** (68%) have ever been started on ARVs at these facilities. However, patients who are currently on care are **4,798** which is **62%** of patients estimated to be HIV infected (**7,732**) in Zanzibar in 2014 according to spectrum estimates conducted in 2013. Patients who are currently on ARVs are **3,587.**

3.1.2 GOAL

The goal of HIV care and treatment services is to reduce HIV related morbidity and mortality in Zanzibar.

3.1.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

3.1.3.1 Objective 1: To strengthen existing ART services

Activities Implemented

3.1.3.1.1 Conduct supportive supervision to Care and Treatment clinics

A total of four supportive supervisions to all seven care and treatment clinics including under one roof TB/HIV clinic in Unguja and three supportive supervisions to all four Care and Treatment Clinics including under one roof TB/HIV clinic in Pemba were conducted using supervision tool. The supervision team constituted of CTC coordinator, clinician, nurse counselor, laboratory technician, pharmacy technician and M&E personnel. The objective of supervision was to monitor the standards and quality of services provided in CTCs according to the new Zanzibar ART guidelines. During the supervision the CTCs were found to some extent to comply with the ART guidelines, however the following gaps were observed:

- Incorrect identification of sero-discordant couple for ART initiation
- Poor follow up and documentation of TB suspect patients
- Children below two years were not started on Protease Inhibitors (PI) based regimen
- Few patients have HUWANYU (Huduma za wagonjwa nyumbani) numbers documented in CTC2 card

To overcome the identified challenges emphasis was made on importance of proper follow up and documentation of TB suspect patients, linking patients with HBC providers and documentation of patients' HUWANYU numbers, and proper Pediatric ART management based on current guidelines. Protocol for identification of sero-discordant as criteria for ART initiation was also elaborated.

3.1.3.1.2 Conduct on job training to HCWs

Six days on job training was conducted to health care providers, from the identified CTC refilling centers. Prior to on job training, health care providers including pharmacist, clinicians, nurses and lab technicians from the expected refilling sites received comprehensive ART training. The purpose of the training was to enhance their capacity on provision of quality care and treatment services.

Refilling centers are expected to reduce inconveniencies of long distance in accessing care and treatment services, addressing lost to follow up challenge and improve retention on care. The proposed refilling sites are Muyuni, Mahonda and Uzini health facilities located in South, North B and Central districts, respectively.

3.1.3.1.3 Feedback supportive meeting

One day supportive meetings to care and treatment service providers were conducted in Unguja and Pemba following all supportive supervisions. The objectives of the meetings were to provide feedback of supportive supervision, provide an opportunity of sharing experience, best practices and challenges experienced by different CTCs. A total of 63 providers from Unguja and 45 from Pemba, including clinicians, nurse counselors, pharmacy staff, laboratory technicians, data clerks, orderlies, peers and representative from District Health Management Teams (DHMT) attended the meetings. During all these meetings presentations from all care and treatment clinics indicating patient status, enrollment, retention on care, and CD4 monitoring were made. This aimed at showing the performance in each CTC and discussing successes and challenges based on such performances. Care and treatment targets for October 2014 to September 2015 were also shared.

Other issues discussed during the coordination meetings include:

- HUWANYU numbers: Although there are HBC focal person in each CTC, many patients are not enrolled in HBC services. It was reported that CHBC providers do not go to CTC for tracking of patients, they also don't send patients' HUWANYU numbers to be registered in CTC2 cards. It was recommended that all CHBC need to be encouraged to send their patients' HUWANYU number to care and treatment clinics.
- Lost to follow up: During the presentations, it was noted that there is increased number of patients who are lost to follow up, it is assumed that lost to follow up is contributed by lack of disclosure of patients' HIV status to the family members, use of alternative medicines, mobile HIV patients, and early initiation of ARVs. Some of the suggestions made were to actively conduct defaulter tracing, engage actively home based care providers and peers from when the patients have been enrolled into care, strengthening adherence and ongoing counseling and develop IEC/BCC materials indicating impact of poor adherence.
- Proper pediatric ART management: Emphasis was made to clinicians to ensure that they provide proper management particularly to the children based on current guidelines.
- Identification of sero-discordant couple for ART initiation: Protocol for identification of sero-discordant as a criteria for ART initiation was also elaborated and emphasis was made to ensure that confirmation for the sero-discordant criteria is made before initiation of ARVs.

3.1.3.1.4 Establishment of new care and treatment clinic

ZIHTLP in collaboration with ZAYEDESA established new care and treatment clinic at Miembeni ZAYEDESA's office. The services started on 22nd January 2014 and are provided once a week with care and treatment providers from Mnazi Mmoja hospital. Before official opening of the clinic, all staff working at ZAYEDESA were oriented on care and treatment services.

3.1.3.1.5 Conduct 31s training to care and treatment providers

Five days 3Is training was conducted. A total of **35** CTC providers (**25** from Unguja and **10** from Pemba) participated in the training. The objective of this training was to equip health care workers with knowledge and skills to enable them to:

1. Develop, implement, and monitor infection control (IC) procedures at their respective facilities
2. Identify organizational and infrastructure requirements to implement IC

practices at the health facility level

3. Use the Intensified Case Finding strategy to identify TB suspects and fast-track their waiting room time at the respective health facilities
4. Describe TB modes of transmission and control procedures at their respective health facilities
5. Assess risk of TB transmission in the health facility
6. Assess environments where TB exposure occurs and be able to apply appropriate infection control measures in those settings
7. Identify the role of health care workers in preventing the spread of TB
8. Identify settings and patients in whom Isoniazid Preventive Therapy can be used

Following this training participants are expected to improve TB IC procedures to reduce TB transmission as well as to use intensified case finding and Isoniazid Preventive Therapy to reduce the burden of Tuberculosis among patients with HIV.

3.1.3.1.6 Conduct pilot study on HBV/HIV co-infection among HIV clients attending Mnazi Mmoja care and treatment clinic

Pilot study on HBV for PLHIV in Mnazi Mmoja CTC started on 16th July 2012. The objective of the study is to determine Hepatitis prevalence among HIV patients. Patients who test negative for HBV receive vaccination and those positive are initiated/shifted to proper ARV regimen. Up to December 2014 a total of **2,359** patients have been enrolled, **766** have received vaccination and those positive are receiving treatment according to Zanzibar ART guidelines.

3.1.3.1.7 Conduct home visiting to track loss to follow up patients

In collaboration with peers and CHBC providers, care and treatments clinic staff conducted home visit for patients who are bed ridden and those who default from the clinics. A total of **434 patients** who were lost to follow up from all care and treatment clinics except Makunduchi have been visited during this year. Makunduchi clinic had no new patients who were lost to follow up during the period. In addition **9** patients who are bed ridden from Mnazi Mmoja clinic were visited. The table below indicates number and results of tracking lost to follow ups.

Table 3.1: Implementation of home visiting to trace loss to follow up patients from ten Care and Treatment Clinics, 2014

Clinic	Patient who were visited at home	Wrong address	Death	Returned to clinic	Refused to come back to clinic	Travel with no information	Other reason
Mnazi Mmoja	217	17	13	41	23	31	92
Mwembeladu	68	12	1	15	33	7	0
Kivunge	64	0	1	27	32	4	0
Bububu	33	14	0	7	0	10	2
Al Rahma	18	2	0	2	11	2	1
ZAYEDESA	5	1	0	0	3	1	0
Chake Chake	10	0	0	2	8	0	0
Micheweni	2	0	0	0	2	0	0
Wete	15	0	0	8	7	0	0
Mkoani	2	0	0	0	2	0	0
TOTAL	**434**	**46**	**15**	**102**	**121**	**55**	**95**

3.1.3.2 Objective 2: Improve linkages with HIV/AIDS and other related programs

Activities Implemented

3.1.3.2.1 Conduct meeting between ZIHTLP, PMU and CMS Staff

One coordination meeting for ZIHTLP, Central Medical Store and Procurement Unit of MOH staff was conducted. The aim of this meeting was to discuss various issues related to procurement and supplies of HIV related commodities. During the meeting, some of the issues discussed include presentation on status of HIV commodities in CMS, delayed procurement procedures, and collection of expired drugs from facilities stores.

To avoid procurement delays, it was suggested that PMU staffs need to be updated on whatever is going on concerning procurement of any commodity. In addition PMU is in the process of recruiting contract manager, civil engineer and quantity surveyor. This in turn is expected to minimize delays in procurement.

From this meeting a team of three people representing ZIHTLP, PMU and CMS were assigned to follow up with Chief Pharmacist on procedures for collecting, storing and disposing expired drugs.

3.1.3.2.2 Conduct collaboration meeting between CTC and TB clinic staff

Two collaboration meetings between CTC and TB Clinic staff were conducted, one in Unguja and one in Pemba. Aim of the coordination meetings was to discuss implementation of TB/HIV Under one roof services, enhance collaboration, referrals and linkages between CTC and TB clinics. The meeting involved clinicians, counselors, TB DOTS nurses, TB clinics staff, DTLCs and ZIHTLP staffs.

Major issues discussed were:

- Poor follow up of TB suspects patients from HIV care and treatment clinics in Pemba: It was reported that poor follow up of TB suspect is contributed by delay and loss of sputum results from laboratory and difficulties in interpreting and diagnosing TB based on chest X-rays. Hence it was agreed that all sputum samples sent to laboratory should be returned back to CTC by dispatch book. Clinicians from TB clinic/DTLC should attend eligibility meetings at CTCs to assist and have joint decisions on interpretation of chest X- rays.
- To increase diagnosis of TB cases from TB suspect patients in Unguja: Presentation on new TB diagnostic algorithm for HIV patients was made. It was agreed that sputum samples from all HIV care and treatment clinics in Unguja should be sent to Mnazi Mmoja main laboratory for gene expert and DTLC should be responsible for sample collection. It was also noted that Makunduchi CTC need mentorship on using scoring chart for paediatric diagnosis.

3.1.3.2.3 Conduct coordination meeting between CTC staff and ZAPHA+ members

During this year four meetings between CTC staff and ZAPHA+ members were conducted, two meetings in Pemba and two meetings in Unguja. The objective of the meetings was to discuss success and challenges faced by patients in receiving care and treatment services. Participants in these meetings were CTC, HTC and HBC Coordinator, CTC staff, ZAPHA+ members, CHBC providers and expert patients.

The following were among the issues discussed during the meetings:

- Tracking of lost to follow up patients: It was noted that follow up of lost to follow up patients is still a challenge due to several factors including:
    - Peer educators are less motivated compared to previous years which make lost to follow up exercise slow due to low incentives.
    - Some lost to follow up patients refusing to be followed at home particularly pregnant mothers and PWID, some of the reasons

including lack of disclosure.

- For Pemba CHBC reported that, many of them are not provided with transport allowance for following up their patients and there are no CHBC providers in some Shehias.

- Home visiting for TB patients: It was reported that very few TB patients have been attached with CHBC. Hence CHBC providers were requested to follow up on TB patients if they accept, just like they do for patients with other chronic illnesses. This follow up should be documented.
- CTC refilling centers: participants were notified on the preparations for establishment of refilling centers in Central, North B and South districts and were requested to sensitize their patients to be ready to use those clinics in order to reduce inconvenience of long distance and burden of transport cost.

3.1.3.2.4 Conduct collaboration meeting with HIV units and other stakeholders

One collaboration meeting with between ZIHTLP units and other stake holders was conducted. The meeting involved participants from ZIHTLP, DHMTs' staff, representative from HTC, PMTCT and CTC providers from Unguja and Pemba, Key population, and representative from ZAPHA+. The aim of the meeting was to discuss various cross cutting issues related to HIV services, strengthening referral and linkages on HIV related services and discuss challenges in accessing care and treatment services.

Some of the issues discussed were:

- Challenges faced by HTC, PMTCT and KPs clients in accessing care and treatment services
- Retention challenges
- Recording of KPs data at care and treatment clinics

Following this meeting it was suggested that all CTC clients should be linked with HBC services, and there is a need of strengthening communication between CTC and HBC providers. It was also suggested that system of escorted referral should be scaled up to include HTC clients.

3.1.4 HIV CARE AND TREATMENT INDICATORS AND TREND, 2012-2014

	Indicator	2012	2013	2014
1	Number of health care facilities that have the capacity and conditions to provide basic HIV counseling and testing and to manage HIV and AIDS clinical services.	10	10	11
2	Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	78.7	79.8	73.1
3	Number of PLHAs attending HIV treatment and care settings, who were screened for TB symptoms, in the preceding 12 months	3,735/3,844 (97.1)	4,390/4,396 (99%)	4,786/4,798 (99%)
4	Number (%) of adults and children with advanced HIV infection currently receiving ART	2,947	3,107	3,587
5	Number of health facilities providing comprehensive TB/HIV collaborative activities	1	2	2

1. Number of health facilities that have the capacity and conditions to provide basic HIV counseling and testing and to manage HIV and AIDS clinical services

By 2014, eleven ART clinics were operational in both Unguja and Pemba. All clinics carry out HIV testing with six clinics carrying out full-blood tests (FBT) including CD4 counts. Of these eleven clinics, nine are public, one private hospital and one NGO. The clinics are distributed in all 4 districts in Pemba and 4 out of 6 districts in Unguja. Districts which lack CTC are North B and Central. There was decreased enrollment of 831 patients in 2014, compared to 962 patients enrolled in 2013.

Table 3.2: Patients enrollment by age group in CTC, Zanzibar, 2014

Name of CTC	Age Group (Years)									
	<1		1-4		5-14		≥15		Total	
	M	F	M	F	M	F	M	F	M	F
Mnazi Mmoja	3	4	3	6	7	7	92	217	105	234
Kivunge	0	0	0	1	0	1	12	26	12	28
Mwembeladu	1	0	3	0	1	2	26	134	31	136
Al Rahma	0	0	0	0	0	0	13	20	13	20
Bububu	0	0	1	0	2	0	32	72	35	75
Makunduchi	0	0	0	0	1	1	7	16	8	17
ZAYEDESA	0	0	0	0	0	0	16	34	16	34
Chake Chake	0	1	2	0	0	0	13	11	15	12
Wete	0	0	1	0	0	2	9	9	10	11
Micheweni	0	0	0	0	0	0	4	6	4	6
Mkoani	0	0	1	2	0	0	3	6	4	8
Total	9		20		24		778		831	

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

For each group of patients who start ART at the same period/month (cohort), they are monitored for survival and computed to determine the proportions that are alive after a period of 6, 12, 24, or 60 months. The table below shows the proportion still alive and on treatment at 12 months for each care and treatment center.

It is observed that in this reporting period overall percentage of patients who are still alive and known to be on treatment 12 months after initiation of antiretroviral therapy has decreased from 78.5% in 2012, 79.8% in 2013 to 73.1 in 2014. The decreased 12 month retention is contributed by high number of patients who are lost to follow up and deaths resulting from late diagnosis of HIV/AIDS. Among non-retained patients 76% were lost to follow up and 14% were deaths.

Table 3.3: Percent of HIV patients alive after 12 months initiation of ART by CTC, 2014

Name of CTC	Number of patients started on ART from Jan – Dec 2013	Number and percent of patients alive by Dec 2014
Al Rahma	20	17(85%)
Bububu	99	69(69.7%)
Mnazi Mmoja	408	285(69.9 %)
Mwembeladu	185	153(82.7 %)
Kivunge	59	41 (69.5%)
Makunduchi	17	12 (70.6%)
Unguja	**788**	**577 (73.2%)**
Chake Chake	31	21 (67.7%)
Mkoani	12	9 (75%)
Wete	26	19 (73.1)
Micheweni	10	8 (80%)
Pemba	**79**	**57 (72.2%)**
Zanzibar	**867**	**634 (73.1%)**

Cohorts of Jan-Dec 2013, reported in 2014

3. Number of PLHIVs attending HIV treatment and care settings, who were screened for TB symptoms, in the preceding 12 months, 2014

An HIV infected client attending care and treatment services are screened for TB at each visit. These include patients on ART, not on ART, on IPT or stopped IPT, adult male, female and children, with the exception of those on TB therapy. Five screening questions are asked to the client for yes or no response. On answering yes to one of the question the client is referred for further TB examination (sputum or X-ray) followed by treatment if TB infection is diagnosed. Percentage of patients screened for TB has increased from 97.1% in 2012 and has stabilized at 99% in 2013 and 2014. The table below shows the number of HIV patients who were screened for TB out of those who received care during the period and those started on TB treatment

Table 3.4: Number of HIV patients screened for TB by facility, Zanzibar, 2014

CTC	No of patients who received care during the period	Screened for TB		Started on TB treatment	
		<15 years	≥15 years	<15 years	≥15 years
Al Rahma	153	6	112	0	2
Bububu	451	21	428	1	6
Kivunge	250	22	226	1	6
Mnazi Mmoja	2,604	221	2,380	6	50
Mwembeladu	724	41	683	0	4
Chake Chake	215	21	190	3	6
Mkoani	44	5	39	0	0
Wete	150	22	128	0	1
Micheweni	62	9	53	1	1
Makunduchi	77	5	72	0	1
Zayedesa	68	0	67	0	0
Total	**4,798**	**373**	**4,413**	**12**	**77**

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

As of December 2014, a total of **7,820** patients have been enrolled in care and treatment clinics (CTCs) of whom **5,375** (68.7 %) are patients who were ever started on ARVs at these facilities. However, patients who are currently on ARVs are **59% (3,587/6,053)** of patients estimated to be in need of treatment according to spectrum 2013.

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

Currently there are two sites providing comprehensive TB/HIV activities (Mnazi Mmoja and Chake Chake hospitals). TB patients who are diagnosed as HIV positive are treated at TB clinic and receive ARV drugs there until they finish TB treatment when they are referred to CTC. Number of patients who received ART at TB/HIV has increased from **71** patients in 2013 to 76 in 2014.

3.1.5 ACHIEVEMENT

- Establishment of new HIV care and treatment clinic in NGO

3.1.6 CHALLENGES

- Increased number of lost to follow up patients
- Tracing the lost to follow up patients

3.1.7 WAY FORWARD

- Each CTC to conduct analysis of their lost to follow up patients and develop facility strategies to decrease lost to follow up.
- Encourage more patients to be linked with HBC services and ensure all clients receiving HBC services have HUWANYU numbers.

3.1.8 PLAN FOR 2015

- Establishing care and treatment refilling sites

3.2 LABORATORY SERVICES

3.2.1 BACKGROUND

The structure of laboratories in Zanzibar is a four-tier system consisting of Referral, District, Cottage and Primary level laboratories. Laboratory services support HIV prevention, care and treatment in undertaking the following functions:

a. Diagnose HIV infected clients
b. Staging of HIV infected patients for treatment eligibility
c. Monitor treatment efficacy for patients who are on treatment or follow up disease progression for those who are not yet on treatment
d. Monitor HIV drug resistance in patients who are on treatment or in the community

The main strategies used by laboratory unit are provision of guidance on HIV/AIDS related laboratory trainings; technical assistance and leadership in assuring highly functional and operational testing systems, assuring quality systems integration and building the capacity of health laboratories to support HIV/AIDS prevention, care and treatment in Zanzibar.

3.2.2 GOAL

The main goal of ZIHTLP laboratory unit is to oversee and strengthen the national HIV laboratory related services.

3.2.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

3.2.3.1 Objective1: Provide technical assistance in assuring highly functional and operational testing systems

Activities Implemented

3.2.3.1.1 Conduct samples testing to supports care and treatment services

In the year 2014, a total of **29,775** blood samples were tested in care and treatment laboratories. Among them 7,782 for CD4 counts, 4,088 for hematological analysis and 17,905 for clinical chemistry analysis to support care and treatment services as shown below:

Table 3.5: Number and type of tests conducted in Care and Treatment Laboratories, Zanzibar, 2014

Period (Quarter)	Type of test			
	CD4	Haematology	Chemistry	Total
January – March, 2014	2,114	304	6,612	6,916
April – June, 2014	1,676	903	4,218	6,797
July – September, 2014	2,001	1,359	1,708	5,068
October – December, 2014	1,991	1,522	5,367	8,880
TOTAL	**7,782**	**4,088**	**17,905**	**29,775**

Table 3.5 shows that, there was an increased number of tested samples for CD4 analysis from 5,572 in 2013 to 7,782 in 2014 while chemistry analysis increased from 17,854 (2013) to 17,905 samples in 2014. Hematological analysis, increased from 1,281 (2013) to **4,088** in 2014. This increment was due to the availability of reagents in all CTC laboratory sites. This year we have experienced the smooth flow of reagents and supplies for CTC laboratory services compared to the year 2013.

3.2.3.1.2 Transport DBS samples for HIV DNA PCR testing

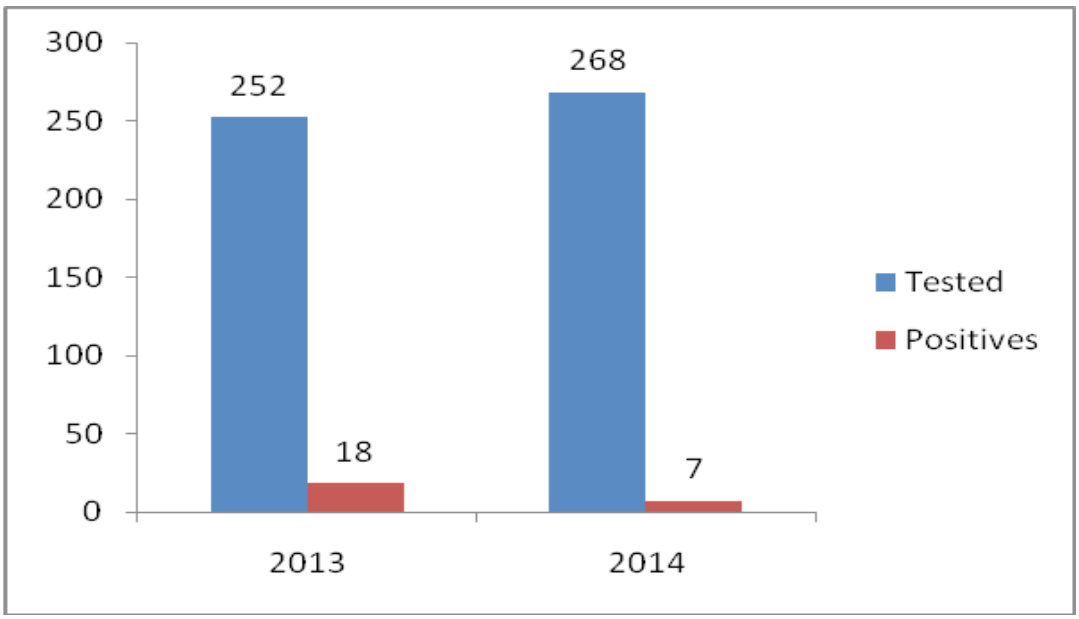
The laboratory unit collected and transported 270 dry blood spot samples from exposed infants to Muhimbili National Hospital, Dar es Salaam for HIV DNA PCR testing. The results for 268 samples were received and 7 (2.6%) samples were found to be HIV positive and two sample results were not received as shown below.

Table 3.6: Number of DBS samples transported for HIV DNA PCR testing, Zanzibar, 2014

Period	Number of samples transported	Number of results received	HIV positive samples
Jan –March 2014	54	54	3
April –June 2014	75	74	3
July - Sept 2014	80	80	1
Oct- December 2014	61	61	0
Total	**270**	**268**	**7(2.6%)**

During this reporting year, low percent of HIV positive infants was observed (2.6% out of 268 samples) compared to 2013 whereby 18 infants (6.8%) were found positive out of 252 tested as indicated in Figure 3.1 below.

Figure 3.1 DBS samples tested vs HIV positivity, 2013 and 2014



3.2.3.2 Objectives 2: Capacity building

Activity implemented

3.2.3.2.1 Conduct training on laboratory quality system for laboratory technicians

Two sessions of five days training on laboratory quality system were conducted, one in Unguja and one in Pemba. A total of 60 laboratory technicians were trained, 30 in each session. The objective was to impart knowledge on how to apply Quality System Elements in daily laboratory practices. By the end of the training, participants were familiar with 12 elements of quality system and were able to apply quality system element in daily laboratory activities for the improvement of quality of laboratory.

3.2.3.2.2 Conduct training on HIV rapid tests for laboratory technicians

HIV rapid testing training was conducted in two sessions one in Unguja and one in Pemba. A total of 60 participants attended. The objectives of the training was to impart participants with the knowledge on theory and practical aspects of HIV rapid testing. At the end of the training participants were able to provide accurate, reliable and timely HIV test results.

3.2.3.3 Objective 3: Strengthening national health laboratory services

Activities Implemented

3.2.3.3.1 Conduct supportive supervision to CTC laboratory services

Laboratory unit conducted supportive supervision in laboratories with capacity to perform monitoring tests in supporting care and treatment services. The aim of this supervision was to assess and evaluate laboratory services delivered by all laboratories providing CTC services in order to identify gaps, propose solutions, provide guidance and constructive technical advices on the provision of quality laboratory services. The supervision was conducted by a team of four laboratory technologists. The CTC laboratories supervised were Mnazi Mmoja, Mwembeladu, Kivunge cottage, Makunduchi cottage, Bububu Military, Chake Chake, Mkoani, Wete and Micheweni Hospitals. The supervision was conducted using supervision tool with twelve elements of quality checklist.

The supervision team found that:

- Adequate trained staff on HIV related services are available in 9 laboratories visited
- Staff follow safety precautions during their procedures
- 2 of 9 laboratories have organization structure in place with clear job description.

Some gaps identified are:

- Procedures were done below standards which compromise the quality of laboratory
- Improper recording of the analysis and controls
- SOPs were not available at the site
- Waste management is poorly handled.

The way forward following this supervision was to conduct mentorship in order to improve and enhance quality services.

3.2.3.3.2 Conduct mentorship to CTC laboratories

Five days mentorship was conducted to four laboratories namely Mkoani, Micheweni, Wete and Chake Chake in Pemba whereby a specific tool was used. The supervision report highlighted some of the challenges and gaps which needed mentoring in order to improve care and treatment laboratory services.

Table 3.7: Issues and action points taken during mentorship of CTC laboratories in Pemba

(Mkoani, Micheweni, Wete and Chake Chake), Zanzibar, 2014

No.	Issues	Action Point
1	Sample transportation logs are in place but not used	Emphasized to use sample transportation logs whenever samples are transported to other laboratories for analysis
2	Staff personnel files are in place but not completed	With assistances of mentors, put all needed personnel documents in staff personnel files
3	Job descriptions are in place but not given to individual staff	Recommended to ensure that each staff is given his/her signed job description
4	SOPs are not updated and not used by staffs	Instructed to use updated SOPs
5	Clinical Chemistry tests are not performed because Chemistry machine is out of order and need major repair or replacement at Wete Hospital	Recommended to send CTC samples for chemistry analysis to Chake Chake while the Chemistry machine is awaiting for services or replacement
6	ABX Micro-60 Hematology analyzer is not working due to lack of reagents at Micheweni	Follow up of the procurement of reagent packs for ABX Micro – 60 has been done in order to sustain CTC services.
7	FACS count machine was not working at Wete	Fixed and is now working properly
8	Quality controls are not done and recorded in all laboratories mentored	Recommended to perform quality control samples on daily basis. QC recording sheets were given.
9	Maintenance logs for some machines were misplaced	New equipments maintenance logs were given and instructed on how to fill it properly
10	Results dispatch log not in place	Recommended to establish results dispatch log

3.2.3.3.3 EID supportive supervision

Supportive supervision was conducted in 18 PMTCT sites which provide EID services in order to support smooth EID service delivery, identify problems, propose solutions and provide guidance on the provision of quality EID services.

A total of eighteen (18/145) PMTCT sites were visited namely: Mnazi Mmoja, Mwembeladu, SDA, Rahaleo, Shaurimoyo, SOS, KMKM, Magogoni, Kivunge cottage and Mahonda for Unguja and Makangale, Micheweni, Mtambwe, Wete, Mkoani, Mtambile, Chake Chake, and Gombani for Pemba.

General findings:

- All visited sites have infant follow up registers
- Supplies for collection and transportation of DBS are available at all sites
- In some of the sites, the registers are correctly filled

Some challenges observed:

- Some sites miss some of information during the filling of the infant follow up registers
- In some of the sites, the trained staff were transferred to other sites, while the new allocated staff are not trained, hence hampering the implementation of EID services
- In other sites, only one staff was trained and when he/she is on annual leave the services collapse e.g. in Micheweni there was no service even for PMTCT for about two months.

Way forward:

- Conduct regular supportive supervision in EID services
- Conduct on job training on proper filling of infant follow up registers

3.2.3.3.4 Installation of SMS printers

ZIHTLP in collaboration with THPS has installed 15 SMS printers in 15 sites of Unguja and Pemba to facilitate receiving of DBS results from Muhimbili National Hospital. The SMS printers were installed at Mnazi Mmoja, Mwembeladu, Fuoni, Chukwani, Mahonda, Kivunge, KMKM Kibweni, Mwera, Muungoni and Makunduchi for Unguja and Chake Chake, Wete, Konde, Micheweni and Mkoani for Pemba. Results of DBS has started to flow through SMS printers in some sites.

3.2.4 LABORATORY SERVICES INDICATORS AND TREND FROM 2012- 2014

Indicator	Year		
	2012	2013	2014
1. Number of laboratories with capacity to perform clinical laboratory tests for care and treatment services	**9** out of **10**	**10** out of **10**	**6** out of **10**
2. Number and percent of laboratories that implement three Laboratory Quality Management elements	**3**	**5**	**10**
3. Number of HIV testing sites participating in proficiency testing for HIV testing	**167** (**56** for HCT &**111** for PMTCT)	**212** (**56** for HCT &**153** for PMTCT)	**0**

3.2.4.1 Number of laboratories with capacity to perform clinical laboratory tests for care and treatment services

Six out of ten CTC laboratories provide HIV related tests which include CD4, Chemistry, Hematology and syphilis tests for monitoring of HIV patients. For this year the indicators was focused on the full-fledged laboratory tests for staging and monitoring of HIV patients at the site.

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

There are ten laboratories which practice three laboratory quality management elements that include safety precautions, availability of SOPs and implement proficiency tests. These laboratories are Mnazi Mmoja, Bububu, Mwembeladu, Kivunge, Makunduchi and KMKM for Unguja, and Chake Chake, Vitongoji, Micheweni and Wete for Pemba.

3.2.4.3 Number of HIV testing sites participating in proficiency testing for HIV testing

For the period of January - December 2014 there was no proficiency testing panel which was distributed due to the lack of supplies for preparation of PT panels. Also there was a shortage in HIV test reagent in the sites to perform the test.

3.2.5 ACHIEVEMENT

- Installation of 15 SMS printers which help in receiving DBS results as early as possible.

3.2.6 CHALLENGES

- Delay in receiving DBS sample results
- Lack of HIV DNA PCR machine in Zanzibar, leads to delay in managing HIV infected infant

3.2.7 WAY FORWARD

- Facilitate with partners the availability of HIV DNA PCR machine for infant diagnosis
- DHMTs to discuss with stakeholders on staff transfer trained on specific skills to provide specific services

3.2.8 PLANS FOR 2015

- Support PMTCT and VCT laboratory related activities
- Strengthening of laboratory services

3.3. HOME BASED CARE SERVICES

3.3.1 BACKGROUND

Zanzibar started Home Based Care services in 1988 for AIDS patients only. To date, HBC services have been established in all **10** districts of Zanzibar for HIV/AIDS patients and other patients with chronic illnesses. ZIHTLP implements Home Based Care services in cooperation with community volunteers and peers from PLHIV. These community HBC providers are working under the supervision of facility based providers. Each health facility has a contact person (facility focal person) who is answerable for all HBC services within the catchment area of the facility. Increased access to care and treatment in many settings has strengthened HBC services and has increased awareness and acceptance of HIV/AIDS services creating a continuum of care that requires good coordination and harmonization of HBC services.

3.3.2 GOAL

The goal of Home Based Care is to provide comprehensive home based care to chronically ill including HIV/AIDS and TB patients

3.3.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

3.3.3.1 Objective 1: To monitor quality of HBC services

Implemented activities

3.3.3.1.1 Conduct bi-annual home base care (HBC) supportive supervision to HBC providers in health facilities

Biannual facility based supportive supervision was conducted in Unguja and Pemba. The aim of the supportive supervision of the health care provider was to improve performance of home based care service delivery including filling of monitoring tools for proper record keeping. A total of **87** (**61** in Unguja and **26** in Pemba) health facilities were visited.

The findings from the supervision were as follows:

- All health facilities have adopted the HUWANYU numbers
- Some health facilities' reports match with monthly follow up forms and registration.
- Some of the health facilities were missing registration forms, their monitoring tools are not kept in good places and hence it's not easy to find them when needed.
- Home based care supervisors failed to distinguish the data needed to be filled on items describing "patients currently receiving HBC " and "patients visited" in HBC summary report

- Data are not verified by DSO during collection of report form resulting in inaccurate data in report.
- Irregular supervision to community volunteers by facility level supervisor and delayed submission of follow up report forms.

It was recommended that DHMTs should make close follow up of health facilities' HBC services supervisors so as to ensure regular supervision to the CHBC providers is conducted, and HBC report forms are submitted timely.

3.3.3.2 Objective 2: To increase capacity of HBC implementers at district level

Implemented activities:

3.3.3.2.1 Conduct bi-annual supportive meetings with district supervisors, facility-based HBC providers and CHBC leaders in District

The HBC unit conducted twelve meetings with district supervisors and facility-based HBC providers from health facilities providing HBC services in Unguja (**2** meetings in each district). The objective of the meetings was to provide supportive supervision feedback and provide an opportunity for sharing of experience, best practices and challenges experienced by different facilities among participants. A total of **420** providers attended the meeting (**35** participants each meeting).

Issues discussed during the meeting were:

- Six new facilities started providing HBC services: HBC services have been scaled up to Bweleo, Welezo, Chuwini, and St Camillus for West district, Mental hospital and Kwamtipura in Urban district. Providers in these facilities were provided with on job training prior to establishment of HBC services at their sites. However during the meeting they requested more mentorship and comprehensive HBC training, so as to provide quality HBC services.
- Lack of transport allowance for some of community providers: Red Cross provides support to only **80** CHBC providers located in Unguja while a total of **210** providers did not have any support of transport allowance. Among these **90** volunteers are from Unguja and 120 volunteers are from Pemba.
- HBC unit requested CHBC providers to be patient while efforts of mobilizing resources are in progress

3.3.3.2.2 Conduct Home Based Care coordination meeting with stakeholders

Coordination meeting with HBC stakeholders of Unguja and Pemba was conducted. The meeting objectives were:

- To discuss achievement and challenges faced in implementing HBC services and find possible solution.
- To share experiences with other stakeholders.

The meeting involved different organizations such as ZAPHA+, Tanzania Red Cross Society implementing Life Program, Muftis office, Zonal Medical Officers from Unguja and Pemba and the staff from Zanzibar Integrated HIV/TB and Leprosy program (ZIHTLP). Among the key issues discussed were review of Home Based Care guideline and harmonization of HBC tools.

3.3.3.3 Objective 3: To support HBC services

Implemented activities

3.3.3.3.1 Procurement and supply of Home Based Care kits

Distribution of HBC kits

A total of **144** Home Based Care kits were procured and distributed to **128** health facilities (**74** in Unguja and **54** in Pemba) and **16** HBC kits were distributed to the care and treatment clinics.

3.3.4 HBC SERVICES INDICATORS AND TREND FROM 2012- 2014

Indicator	2012	2013	2014
1. Number of skilled facility based HBC providers	204	204	187
2. Number of skilled community based HBC providers	290	290	378
3. Number of adults and children provided with home based care (HBC) services	2,947	3,019	3,725
4. Number of people receiving food/nutrition supplements	161	1,004	0

3.3.4.1. Number of skilled facility based HBC providers

A total of **187** health providers have received training on HBC services. Among them **17** are retired health workers and remaining **150** were active in providing HBC services in 2014 and their distribution by district is as shown in Table 3.8 below.

Table 3.8: Number of health facilities and respective active providers implementing HBC services per district, Zanzibar, 2014

District	Number of HBC sites	Number of HBC providers active in field
Urban	14	11
West	18	17
South	11	14
Central	21	25
North A	13	13
North B	11	9
Chake Chake	13	14
Wete	16	18
Mkoani	13	16
Micheweni	11	13
Total	**141**	**150**

3.3.4.2. Number of skilled community based HBC providers

The programme supports a total of **412** skilled community volunteers providing HBC services, **247** in Unguja and **165** in Pemba. The following table show the distribution of community volunteers by district:

Table 3.9: Number of CHBC providers by district, Zanzibar, 2014

District	Number of community volunteers (CHBC)
Urban	50
West	65
North A	35
North B	30
Central	31
South	36
Chake	42
Wete	46
Mkoani	37
Micheweni	40
Total	**412**

3.3.4.3. Number of adults and children provided with home based care (HBC) services

A total of **3,725** patients received HBC services in which **2,052** were people living with HIV (**1,325** females and **727** males) and chronically ill patients were **1,673** (**844** females and **829** males). See table 3.10 below:

Table 3.10: Number of clients who received HBC services by disease category, sex and age in Zanzibar, 2014

Age (years)	HIV patients		Other diseases		Total
	M	F	M	F	
0 – 4	29	40	10	12	**91**
5 – 14	138	143	72	56	**409**
≥ 15	560	1,142	747	776	**3,225**
Total	**727**	**1,325**	**829**	**844**	**3,725**

Among the services provided by caregivers to patients include: basic nursing care, health and hygiene education, psychosocial and spiritual support, referral to health centers, assistance with household duties, monitoring drug compliance and escort to clinics where needed. During this reporting period, different services have been provided as indicated in table below:

Table 3.11: Number of clients received HBC services by age Zanzibar, 2014

Age (years)	*Services provided (frequencies)*										
	Counseling	Body hygiene	Cloth changing	Wound dressing	Feeding assistance	ARV problems solved	Physical exercises	Referrals	Others services	Transfer out	Transfer in
0 – 4	297	71	39	0	38	52	92	32	21	297	71
5 – 14	3,608	601	233	7	157	224	544	653	132	3,608	601
≥ 15	24,606	3,523	1,422	657	945	735	5,889	5,209	1,283	2,4606	3,523
Total	**28,511**	**4,195**	**1,694**	**664**	**1,140**	**1,011**	**6,525**	**5,894**	**1,436**	**28,511**	**4,195**

3.3.5 ACHIEVEMENTS

- Scale up of HBC services to six facilities in collaboration with DHMT
- Reviewed HBC guidelines with support from Pathfinder International

3.3.6 CHALLENGES

- Lack of transportation allowance for **210** volunteers
- Few patients have HUWANYU number documented in care and treatment clinics card (CTC 1 &2)

3.3.7 WAY FORWARD

- Strengthen communication and conduct quarterly data review between CTC HBC focal person, CHBC providers and HBC facility supervisors.

- Continuing to mobilize recourses for supporting the remaining HBC volunteers' transport allowance

3.3.8 PLAN FOR YEAR 2015

- Orientation training on the revised guidelines to Home Based Care services providers.

CHAPTER FOUR:
TUBERCULOSIS AND LEPROSY SERVICES

4.1 BACKGROUND

The Ministry of Health launched the Zanzibar Tuberculosis and Leprosy Programme (ZTLP) in 1987 as a single combined programme. The Ministry is collaborating with various international and local development partners in implementing control of TB and leprosy in the country. The program is also collaborating with other units and program within the Ministry of Health to scale up public private partnership.

The programme is charged with the responsibility of facilitating early diagnosis, treatment and cure of as many tuberculosis and leprosy patients as possible so as to reduce the incidence and prevalence of these diseases until they are no longer a public health problem in the country. In recognition of this, TB/HIV collaborative activities have been incorporated as major components of the Zanzibar TB and Leprosy Programme (ZTLP) and Zanzibar AIDS Control Programme (ZACP). TB/HIV collaborative activities were first introduced in 2005 following the implementation of National TB/HIV Guideline. In 2012, the programme was integrated with Zanzibar AIDS Control Programme.

4.2 GOAL

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

4.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

4.3.1: Objectives 1: Pursue high quality DOTS expansion and enhancement

Implemented activities

4.3.1.1 Conduct TB contact tracing

In collaboration with DHMTs and DTLCs, TB and leprosy public health officers (PHOs) conducted Tuberculosis contact tracing for new smear positive, retreatment and MDR TB in different villages of Unguja and Pemba, where smear positive TB patients live with their families. The aim was to trace and identify all household members living with smear positive TB patients who had TB presumptive symptoms in order to diagnose, give early, proper and adequate treatment for those confirmed with TB, so as reduce transmission of TB in the communities.

In this reporting year, total of 360 smear positive TB patients including MDR TB patients were traced in their homes in Unguja and Pemba. A total of 1,695 house

hold members were given health education on TB symptoms, transmission and the importance of treatment adherence.

Among the 1,695 house hold members, 167 were TB suspects, 24 people were diagnosed with Tuberculosis through sputum smear examination, 3 patients were diagnosed through X ray and one child was diagnosed by score chart. All of them started anti TB treatment and 202 under five children were given Isoniazid (INH) prophylaxis as reflected in table 4.1 below.

Table 4.1: Summary of contact tracing findings for 2014, Zanzibar

Description	Frequency
Smear positive TB patients traced	360
House hold members reached	1,695
Presumptive TB symptoms (suspect)	167
Confirmed smear positive TB patients	24
Smear negative (Pulmonary)	3
Diagnosed by score chart	1
Under five given chemoprophylaxis	202

4.3.1.2. Conduct laboratory training on ZN florescent microscopy and EQA

Five days training on laboratory ZN florescent microscopy and EQA was conducted for laboratory technicians and technologist from different diagnostic centers in Unguja and Pemba. A total of 60 participants were trained (30 Unguja and 30 Pemba). The objective of the training was to provide basic information on ZN fluorescent microscopy and EQA to laboratory technicians. At the end of the training participants were expected to improve quality of TB laboratory services so as to facilitate early detection of TB.

4.3.1.3 Conduct laboratory supportive supervision

Laboratory supportive supervision was conducted by Regional laboratory coordinators (RLTs) of Unguja and Pemba together with District laboratory coordinators (DLTs) to all laboratories performing TB sputum investigation in both private and public facilities. The aim of this supervision was to assess the performance of laboratory technicians on provision of quality TB laboratory services to their respective centers. During this reporting year the supervisors managed to supervise 45 out of 51 diagnostic centers (29 in Unguja and 16 in Pemba). Six of 51 laboratories were not functioning due to ongoing renovations, and two facilities had no laboratory technicians, hence these facilities were not supervised.

During the supervision most laboratories were performing well, however the key challenge identified was low number of sputum smear sent to laboratory for investigation. The proposed way forward was for DTLCs to strengthen mentorship to all health care providers (clinicians) so as to increase TB suspicious index. The program discussed with DHMTs and DMOs on solving the problem of lack of technicians and following these discussions the problem has been resolved in both sites.

4.3.1.4 Conduct External Quality Assurance (EQA)

External Quality Assurance (EQA) of the lab tests was conducted quarterly for all TB microscopy diagnostic centers, whereby slides tested were randomly selected from each diagnostic centre and sent to first reader within the district (DLT) for quality assurance. This is to make sure that test results are accurate and hence strengthen the performance of the technologist. For the discordant result the slides are sent to second reader and if confirmed positive follow up is made to trace the patient. A total of 906 slides (763 in Unguja and 143 in Pemba) were sent for EQA and there were no discordant results.

4.3.1.5 Conduct supportive supervision at all levels

TB Central unit team, Regional and District TB and Leprosy Coordinators (RTLC, DTLC) conducted supportive supervision in different health facilities providing TB and leprosy services in both islands (Unguja and Pemba). These included public and private health facilities. Central and regional levels conducted their supervision on quarterly basis while district level conducted on monthly basis.

The aim of the supervisions were to assess the performance of RTLCs, DTLCs and other health care workers working in TB, TB/HIV and leprosy within the district health facilities.

During this reporting period a total of 112 facilities were supervised by central unit team, among them 68 in Unguja and 44 in Pemba, 75 health facilities were supervised by regional TB/leprosy coordinator and 251 health facilities were supervised by District TB and leprosy coordinators of Unguja and Pemba in their respective health facilities/districts.

Key challenges found were:

- Absence of updated TB cough registers in most of health facilities in Pemba
- Absence of and poor utilization of HMIS TB reporting forms

- Low knowledge on leprosy management among health care providers
- Low participation of peripheral health facilities in sputum collection exercise

The identified challenges were discussed and the team came up with the following solutions: DTLCs and RTLCs should distribute cough books and TB reporting forms in all health care facilities, as well as strengthen sputum collection system and mentorship on proper filling of HMIS forms.

4.3.1.6. Conduct feedback meetings for health care providers

Feedback meeting were conducted in Unguja and Pemba following supportive supervisions to health facilities providing TB, TB/HIV and Leprosy services. The aims of the meetings were to discuss the gaps and challenges facing service providers, and to plan way forward to overcome the challenges for improving quality TB and leprosy service. Participants were health facility in charges, laboratory technicians, PHN B and public health officers. The issues that was discussed and the agreed way forward are explained below:

- Low number of TB suspects who are examined for TB: Suggestion made was prescribers should increase TB suspiciousness among coughing patients attending their respective health facilities by requesting sputum examination and following the diagnostic algorithm accordingly. Also it was recommended that all clinicians should utilize the present cough registers for all coughing TB suspects and make close follow up as well as increase community TB awareness by providing health education.
- It was noted that health care providers in the facilities are not preparing TB and leprosy HMIS quarterly reports because the forms were too long and complicated to them: The agreed way forward was to review the current report forms, and conduct refresher training and mentorship to health care providers.
- TB and leprosy registers and patient treatment cards are not updated. The proposed way forward was every health care provider should immediately update the cards and register soon after giving care to his/her patient and DTLCs should strengthen supervision and mentorship.

4.3.1.7 Conduct mentorship to staff in health facilities

Mentorship to health facilities providing TB and leprosy services was conducted for the purpose of addressing gaps identified during supportive supervision, and to build capacity of health care providers to provide appropriate services to TB, TB/HIV and leprosy patients. The mentorship was conducted to 35 health facilities in Unguja and Pemba for fourteen days. Issues identified and mentored were: Identification of

TB and leprosy patients in early stage by using guidelines and diagnostic algorithms, filling and updating of TB and leprosy patients register, treatment cards and how to prepare quarterly HMIS reports.

4.3.1.8 Training on TB management for health care workers

Five days training on TB and TB/HIV management was conducted to health care providers in Unguja and Pemba. A total of 130 health care providers (70 from Unguja and 60 from Pemba) were trained. The objective of the training was to provide knowledge and skills on clinical TB and TB/HIV management to healthcare workers so as to improve providers' ability to diagnose and manage TB/HIV collaborative activities at facility level. This training also aimed at increasing capacity of newly employed providers. Following the training participants were expected to increase TB suspicious index, and improve diagnosis and management of TB, and TB/HIV patients.

4.3.1.9 Conduct sputum collection from peripheral health facilities

This activity was conducted by District TB and Leprosy Coordinators in Unguja and Pemba who collect sputum samples from peripheral health facilities with no laboratory services and send them to nearby TB diagnostic centers. The aim of this exercise is to increase case detection, early diagnosis and treatment of smear positive TB patients so as to prevent transmission of TB disease in the communities. During this reporting year, a total of 1,139 samples were collected in Unguja and Pemba whereby 65 (5.7%) were positive as it shown in the table below.

Table 4.2: Distribution of samples collected from peripheral health facilities per zone, Zanzibar, 2014

Zone	Samples collected	Positive Samples
Unguja	459	34
Pemba	680	31
Total	**1,139**	**65 (5.7%)**

4.3.1.10 Conduct sputum examination for all TB suspects

Zanzibar TB/Leprosy unit emphasizes diagnosis of TB patients by sputum examination which is a gold standard as recommended by WHO, therefore Laboratory smear microscopy is the corner stone of the unit. Currently there are 51 TB laboratories in Zanzibar providing sputum smear examination services (32 Unguja and 19 Pemba). A total of 5,392 suspects were examined in 2014, among them 410 were smear positive as stipulated in the table below:

Table 4.3: Number of sputum samples examined per zone, Zanzibar, 2014

	Unguja	**Pemba**	**Total**
Total samples examined	3,852	1,540	5,392
Positive cases	330	80	410
Negative cases	3,522	1.460	4,982
Total new TB suspects' samples examined	3,355	1,469	4,824
Positive new cases	269	71	340
Negative cases	3,086	1,398	4,484
Total follow up cases' samples examined	497	71	568
Positive cases	60	9	69
Negative cases	437	62	499

4.3.1.11 Workshop to develop TB suspect register and its guidelines for use in health facilities

A five days workshop was conducted for 24 participants from Unguja and Pemba with the objective of developing TB suspect register and its guidelines.

The specific objectives of the workshop were to:

- Prepare specific cough book to register the patients with TB symptoms for investigation
- Prepare guideline that will help health care providers to use cough book
- Integrate pediatric register in cough book.

At the end of the workshop, final draft of the cough book and guideline was developed. It was then printed and distributed to all health facilities of Unguja and Pemba for use.

4.3.1.12 Conduct TB/HIV training for College of Health Science tutors

ZIHTLP through TB and leprosy unit organized two days training for 40 College of Health Science (CHS) tutors. The objective of the training was to update CHS tutors on new emerging issues on TB and TB/HIV.

The specific objectives of the training were to equip the participants with knowledge and skills on:

- Understanding Tuberculosis
- Tuberculosis diagnosis
- Sputum collection
- Understanding HIV
- Clinical features, diagnosis of HIV infection and opportunistic infection
- Collaborative TB/HIV activities

At the end of the training, the agreed way forward was: To incorporate TB and leprosy components in their teaching sessions and to look for the possibility of reviewing the teaching curriculum to incorporate TB and leprosy information to all cadres.

4.3.1.13 Conduct Training of Trainers on TB/HIV collaborative activities

Five days TOT on TB/HIV collaborative activities for TB and leprosy coordinators and staff from DHMTs was conducted. A total of **20** participants were trained (5 from Pemba and 15 from Unguja). The objective of the workshop was to provide methodologies and principles of teaching on basic information on clinical management of Tuberculosis and HIV to expected facilitators in Zanzibar. At the end of the workshop, participants were able to demonstrate facilitation skills using methodologies and principles of adult learning.

Agreed way forward: The participants will plan and train health care workers according to their demands.

4.3.1.14 Conduct TOT on AFB microscopy EQA for laboratory personnel

Five days TOT workshop on AFB microscopy EQA for laboratory personnel was conducted. A total of 15 participants from TB diagnostic centers of Unguja and Pemba were trained (**10** from Unguja and 5 in Pemba). The main objective of the workshop was to equip participants with knowledge and skills on teaching methodologies. At the end of the training participants managed to demonstrate facilitation skills using methodologies and principles of adult learning. Following the training the participants were expected to train other laboratory technicians in strengthening TB laboratory in EQA implementation and use of standard operating procedures.

4.3.1.15 Conduct orientation meeting with home based DOT treatment supporters

Two days orientation meeting for home based DOT treatment supporter and other key community TB care providers was conducted in Unguja and Pemba. A total of

600 participants were involved (380 from Unguja and 220 from Pemba). The aim of the meeting was to orient the participants on TB disease including transmission, signs and symptoms and proper provision of DOT services within the communities. Expected output is to increase cure rate among diagnosed patient using home based DOT approach as well as risk reduction of developing MDR TB.

4.3.1.16 Conduct sensitization meeting to traditional healers, shehas and drug sellers on TB and TB/HIV

One day sensitization meeting for traditional healers, sheha, drug sellers and other key community TB members from different Shehias of Unguja and Pemba was conducted in four sessions. A total of 360 participants were sensitized on TB and TB/HIV. The main objective of the meeting was to sensitize the participants on TB signs and symptoms so as to create awareness in the community and facilitate the referral of TB suspects to health care facilities, support patients on TB treatment and educate the community on preventive measures through community meeting.

The expected output of the workshop was increased suspicion index in the community on presumptive TB, increased referral of presumptive TB to the nearest health facility for diagnosis and treatment as well as increase TB case detection and reduction of TB transmission in the communities.

4.3.1.17 Conduct workshop on developing training manual to be used for training of community

TB and leprosy unit conducted five days workshop to develop training materials on signs and symptoms of tuberculosis for referral of patient with chronic cough from community to health facilities. A total of 15 participants were involved (10 from Unguja and 5 Pemba). The objective of the workshop was to develop training materials that will be used to train key community members involved in TB control in Zanzibar.

At the end of the workshop the training materials were developed and ready for use by the program and other stake holders.

4.3.1.18 Conduct consultancy for assessment of laboratory EQA, norms and SOPs

ZIHTLP hired consultant to conduct assessment of the Tuberculosis diagnostic services in Zanzibar. The purpose of the assessment was to make a comprehensive and in-depth analysis of the TB laboratory services in Zanzibar. In addition, the assessment aimed at evaluating routine activities under TB related functions according to the ZIHTLP guidelines which are in line with the WHO standards. The

assessment concentrated on the performance of AFB smear microscopy, Quality Assurance and the use of Standard Operating Procedures with focus on development of strengthening plan, laboratory norms and SOPs so as to reinforce EQA for TB smear microscopy.

The main findings of the assessment were:

- Inadequate coverage of EQA system in the country
- There is only one culture laboratory
- There is no DST capacity in Zanzibar
- Inadequate laboratory information management system within the TB laboratory network
- No clear guidelines for sputum specimen referral within the network and to the CTRL
- Weak coordination between the CTRL and the PHL and inadequate supportive supervision from the CTRL

Due to the above findings the assessment recommended the following:

- Upgrade PHL to perform DST for both first and second line drugs in order to strengthen the routine surveillance
- Specimens should be transported to the laboratory as soon as possible in 1% Cetyl Pyridinium Chloride (CPC) to minimize contamination
- Mnazi Mmoja Hospital needs to oversee the EQA implementation within the network
- Strengthen information management system for TB laboratory network to facilitate planning, provision and expand coverage of EQA system
- The CTRL should strengthen feedback mechanism and collaboration with the PHL

4.3.2: Objective 2: Strengthen collaborative TB/HIV activities

Implemented activities

4.3.2.1 Provision of under one roof services for TB and HIV

ZIHTLP is providing TB and HIV services under one roof whereby clients receive comprehensive TB and HIV services at one place. Currently there are two sites which provide these services (Mnazi Mmoja and Chake Chake Hospital). In this reporting period a total of **441** TB cases were registered at TB/HIV under one roof clinic of which 76 were co-infected. Of them 74 were put on Co-trimoxazole prophylaxis, 70 (92.1%) started on ARVs, and 2 died as illustrated in the table below:

Table 4.4: Summary of TB/HIV co-infected patients at under one roof clinics by Zone, Zanzibar, 2014

Description	Unguja	Pemba	Total
Total TB patients registered	**350**	**91**	**441**
TB/HIV patients	**61 (80%)**	**15 (20%)**	**76 (17.2 %)**
TB/HIV patients on cotrimoxazole preventive services	**61 (82%)**	**13 (18%)**	**74 (97.35%)**
TB/HIV patient on ARVs	**57 (82%)**	**13 (18%)**	**70 (92.1%)**
TB/HIV patients who died	**2 (100%)**	**0**	**0 (2.6%)**

4.3.2.2 Provide IPT to HIV patients

Isoniazid Preventive Therapy (IPT) services to HIV patients started in 2011 through 3Is strategy in Chake Chake Hospital. The aim of IPT services is to prevent PLHIV from getting active TB. Currently a total of 170 HIV patients have been enrolled in IPT services, of which **137** completed treatment and 5 developed active TB as seen in table below:

Table 4.5: Trend of IPT enrolment from August 2011- December 2014

Year	Total Enroll-ment	Complete	Develop Active TB	Terminal AIDS	TB Suspect	Lost To F/ Up	T/ Out	Develop Side Effect	De-fault-ed
2011	84	63	3	2	3	2	6	4	1
2012	35	25	1	2	0	4	2	1	0
2013	18	11	1	0	0	1	1	2	2
2014	33	38	0	2	4	1	3	0	0
Total	**170**	**137**	**5**	**6**	**7**	**8**	**12**	**7**	**3**

Challenges:

- Frequent stock out of Isoniazid (INH)
- Patients do not afford X-ray cost for investigation
- Only one facility provides IPT services

Following the above challenges, TB unit is planning to procure X ray film to support PLHIV for TB screening. TB unit in collaboration with other partners are also planning scale up IPT centre at Mnazi Mmoja Hospital and strengthen availability of INH.

4.3.2.3 Documentation of under one roof TB and HIV services Best Practices

After five years implementation of under one roof TB and HIV services model, ZIHTLP decided to document the implementation of the model in Mnazi Mmoja Hospital. The aim of documentation was to better understand how effective the model is, and other aspects of best practice such as ethical soundness, cost effectiveness, relevance, replicability and sustainability of the model in order to decide whether the model should be scaled up to other health facilities. In line with this, ZIHTLP engaged a national consultant to support the TB&Leprosy Unit to conduct the documentation.

Through document reviews, interviews and discussion with different stakeholders, it was noted that the "under one roof" model has achieved success in its implementation. Some of these successes include:

- Increased number of TB notifications
- Increased ARV and CPT uptake among TB patients who tested HIV positive
- Increase in TB treatment success
- Reduction in deaths among TB patients
- Improved linkages for diagnosis, care and treatment of TB/HIV co-infected patients
- Improved capacity of health workers in TB clinics to provide HIV service package to TB/HIV co-infected patients
- Well-coordinated information system that ensures all HIV patients' files are updated in CTC2 database in HIV clinic every time such patients receive services in TB clinic.

Key challenges identified were:

- Poor infrastructure in providing integrated TB, TB/HIV services: The space for TB clinic in Mnazi Mmoja hospital is limited. Inadequate space may hinder effective TB infection control and the efforts to prevent patients and HCWs from being infected with TB.
- Limited scaling up of under one roof model: Since the beginning of implementation in 2009, the model has been scaled up only in one more health facility in Zanzibar.
- In adequate health care workers at TB/HIV clinic

This documentation recommended the following:

- Infrastructure improvement
- Scale up of "under one roof" model using participatory approach.

4.3.2.4 Conduct quarterly coordination DTLC meetings

Three meetings were conducted one per quarter, 2 in Unguja and 1 in Pemba. The meetings involved key program staffs that include DTLCs, DTHCs, RTLCs, RLTs, CTC coordinator, IEC officer and staff from ZIHTLP central office. Other stakeholders such as Zonal administrators also participated in the meetings. The aim of the meetings were to discuss various TB, TB/HIV and leprosy issues including successes, challenges and share best practices on implementation of planned activities.

Some of the main challenges discussed were:

- Delay transportation of specimen from Unguja to PHL
- Shortage of anti TB drugs especially RHZE
- Lack of MDR register
- Data discrepancy between laboratory and case reported by DTLCs

Proposed solutions for the above challenges were: RTLC to make follow up to DTLCs to transport specimen twice a week and make sure register for diagnosed MDR TB patients is in place. RTL in collaboration with RTLC to work together and make sure data from laboratories registers and district TB register are corresponding. Regarding shortage of anti TB drugs, plans for strengthening supply management system to avoid future stock out of TB drugs were made.

4.3.3: Objective 3: Prevent TB transmission in health facilities and other high risk congregate settings

Implemented activities

4.3.3.1 Conduct TB Infection Prevention and Control assessment in health care facilities

ZIHTLP hired the consultant to conduct TB IPC assessment in health facilities. The aim of the assessment was to establish baseline information on the status of TB IPC in Zanzibar and provide recommendation for proper planning to safeguard well-being of people accessing health care services against TB infection. The main findings were as follows:

Strengths:

- Availability of IPC infrastructures at ZIHTLP in terms of Strategies, Guidelines, Indicators and TB IPC focal person
- IPC parameters have been included in general supervision checklist
- All CTCs visited routinely screen clients for TB using uniform TB screening questionnaire
- ZIHTLP conducts trainings on TB and TB/HIV including IPC for district and health facility staff
- All facilities visited had an IPC plan even though the plans were not adequate.

Weaknesses:

- Health facilities have no proper TB IPC plans
- HCWs are not routinely screened for TB in all health facilities
- Limited number of HCWs have been trained on TB/HIV collaborative activities
- There are limited resources such as funds to implement TB IPC activities
- Construction of some health facilities did not adhere to principle of maximizing natural ventilation.

The assessment recommended the following:

- Develop sample TB IPC plan for different levels of health facilities
- Collaborate with health facility staff to identify IPC committees and develop TB IPC plans
- Develop, print and distribute job aids and SOPs on TB IPC
- Sensitize DMOs on TB IPC
- Conduct supportive supervision to assess implementation of TB IPC plans

By the end of December 2014 some of the recommendations were implemented such as: Development of sample TB IPC plans, establishment of IPC committees and supportive supervision on TB IPC in health care facilities.

4.3.3.2 Conduct Infection Prevention and Control (3Is) training

Three sessions of 3Is training were conducted to 90 participants (60 in Unguja and 30 in Pemba). The training involved program officers from ZIHTLP, health care workers providing TB and TB/HIV services at different level and officers from MOH departments.

The main objective of 3Is training was to equip health care workers with knowledge and skills on Tuberculosis Infection Prevention and Control within health care facilities.

The workshop specific objectives were:

- Develop, implement, and monitor infection control procedures at their facilities
- Identify organizational and infrastructure requirements to implement IC practices at the health facility level
- Use the Intensified Case Finding strategy to identify TB suspects and fast-track their waiting room time at the respective health facilities
- Describe TB modes of transmission and control procedures at their respective health facilities
- Assess risk of TB transmission in the health facility
- Assess environments where TB exposure occurs and be able to apply appropriate infection control measures in those settings
- Identify the role of health care workers in preventing the spread of TB
- Identify settings and patients in whom Isoniazid Preventive Therapy can be used

After training the participants developed TB IPC plans to be implemented back in their working area so as prevent TB transmission within health care facilities. Participants are also expected to practice Intensified Case Finding.

4.3.3.3 Conduct workshop for adaptation of TB IPC Guideline

Five days workshop was conducted for adaptation of Mainland IPC guideline, under the support of external facilitator from NTLP mainland. The workshop involved program staff, health care workers from facilities providing TB services, and staff from Zonal level of MOH. The objective of the workshop was to adapt mainland TB Infection Prevention and Control (IPC) guideline into Zanzibar context.

The workshop specific objectives were:

- Identify the current situation of TB IPC in health care facilities
- Develop suggestive strategies/interventions to address challenges of TB IPC within health facilities
- Develop guideline for TB IPC
- Review and adopt M&E tools for TB IPC into ZIHTLP context.

At the end of the workshop the participants managed to prepare a draft of TB IPC guidelines and reviewed Monitoring and Evaluation tools for TB IPC implementation. In the coming year, the guideline will be printed and distributed for use by health care providers and other stakeholders.

4.3.4: Objective 4: To strengthen management of MDR TB

Activities Implemented

4.3.4.1 Transportation of TB specimen to Central Tuberculosis Reference Laboratory (CTRL)

Public Health Laboratory (PHL) Pemba transported specimen for DST to Central Tuberculosis Reference Laboratory (CTRL) whereby a total of 49 sample/culture colonies of MDR TB suspects were sent. None of the specimen sent were detected as MDR TB or Mycobacterium Other Than Tuberculosis (MOTT).

4.3.5: Objective 5: To empower communities on TB, TB/HIV and Leprosy prevention, care and support through Advocacy Communication and Social Mobilization (ACSM)

Activities Implemented:

4.3.5.1 Conduct sensitization meetings on TB and leprosy to the community

Public health officers (PHOs) in collaboration with community leaders and community leprosy committees conducted health education and sensitization meeting within community on quarterly basis. The meeting involved members of health facilities committees, influential people, community NGOs involving in TB care and community members.

The aim of the meetings was to create community awareness on TB and leprosy so as to facilitate early health care seeking behavior and conduct screening for leprosy. The meetings were conducted in **12** villages of Unguja and Pemba whereby **1,008** people participated, of them 607 (63.2%) were in Unguja and 371 (36.8%) were in Pemba. During the meetings, a total of **11** suspects of leprosy were identified (5 in Unguja 6 in Pemba) and 1 (9%) was confirmed with leprosy in Unguja.

4.3.5.2 Establish leprosy committee

TB and Leprosy Unit established five leprosy committees, 4 in South and one in Central district. Total members of committees are 44 whereby each committee consists of 8 to 9 members. The objective of establishing the committee is to create community awareness through provision of leprosy education within the communities. The committees were imparted with knowledge on leprosy disease including sign and

symptoms, prevention as well as the mechanism for early referral of patients with leprosy symptoms. In turn the committees are expected to collaborate with PHOs in conducting sensitization meeting in their respective communities as well as providing referral of patients with leprosy symptoms.

4.3.6 Objective 6: Reduce disability grade 2 by 5% of new diagnosed leprosy patients

Implemented activities

4.3.6.1 Conduct Multibacilary contact tracing

Leprosy contact tracing was done by RTLCs and DTLCs of Unguja and Pemba on quarterly basis in their respective districts. The aim of this tracing was to follow up families living with Multibacillary leprosy patients so as to provide early treatment and hence prevent spread of the disease and disability caused by leprosy. In 2014 a total of **338** household members of 84 MB leprosy patients (69 in Unguja and 15 in Pemba) were traced in their homes, whereby 20 suspects were identified. Among them 4 were diagnosed with leprosy disease, 3 Paucibacillay and one Multibacillary and all had disability grade 0, as shown in table below.

Table 4.6: Number of Leprosy MB contact tracing, Zanzibar, 2014

Description	Frequency
Patients visited	**84**
Number of contacts	**338**
Number of suspect	**20**
Leprosy patients	**4**

4.3.6.2 Conduct house to house leprosy case finding

TB and Leprosy Unit in collaboration with DHMT in South district conducted leprosy active case findings in 15 villages which are in high endemic leprosy areas in South district. The activity was conducted in collaboration with DTLCs, PHOs, member of DHMTs, health facility staff and Sheha of respective community. The villages involved were: Nganani, Mzuri, Kajengwa, Kijini, Mkunguni, Dimbani, Kibuteni, Kiongoni, Muyuni, Paje, Jambiani, Kikadini and Kibigija. The aim of this exercise was to screen for leprosy disease so as to facilitate early cases finding and proper treatment. A total of 1,081 household members were screened, among them 41 were diagnosed with leprosy (16 MB, 25 PB). Among 41 cases identified 34 (82.1%) had disability grade 0, 5 (12.1%) had disability grade 1 and 2 (4.8%) had disability grade 2.

Table 4.7: Summary of house to house leprosy case finding, South District, Unguja, 2014

Description	Frequency
Number of villages	**15**
Number of houses visited	**217**
Number of household members screened	**1,081**
Number of MB cases	**16**
Number of PB cases	**25**

4.3.6.3 Conduct reconstructive surgery to patient with disability grade 2

Rehabilitation and reconstructive surgery was conducted to people affected with leprosy to correct disability caused by the disease. The surgery was conducted at Mnazi Mmoja Hospital under technical assistance of leprosy surgeon. During this reporting period five people affected with leprosy (3 male and 2 female) underwent surgery to correct disabilities. Among them; two had claw finger, one had septic foot and one had lower limb contracture. The surgery was conducted successfully and patients were discharged home with continuing monitoring under physiotherapy and DTLCs.

4.4 TUBERCULOSIS SERVICES INDICATORS AND TREND FROM 2012- 2014

INDICATORS		YEAR		
		2012	2013	2014
1.	Number of all registered TB cases	537	685	648
2.	Number of new smear positive TB cases	303	318	335
3	TB cure rate	86.8%	87%	90%
4	TB treatment success rate	86.8%	87%	90%
5	Number of TB patient tested for HIV	470	659	618
6	Number of HIV positive TB patients	79	115	113
7	Percent of HIV positive TB patient on ART	52	86	80%
8	Percent of HIV positive TB patient on CPT	75	97.4	96.5

4.4.1 Number of all registered TB cases

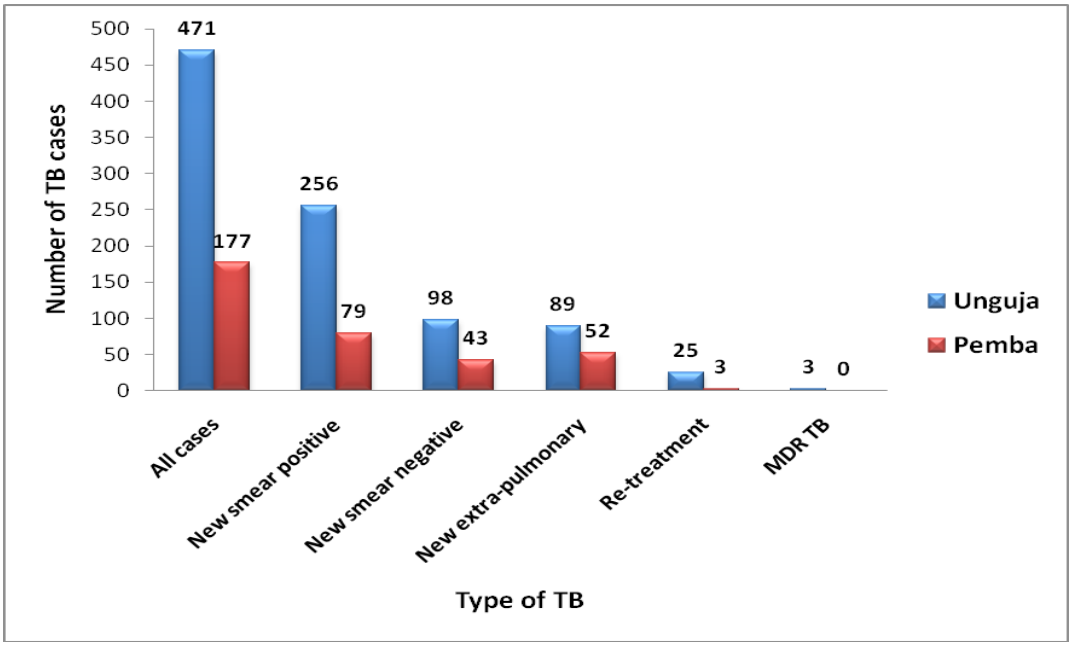
In 2014, total of 648 TB cases of all forms were notified and registered from public and private health facilities with **15.7%** being children below 14 yrs. There is a slight decrease in number of all TB cases notified from 685 in 2013 to the current 648, this decrease was due to inadequate funds for implementation of some activities such as contact tracing and sputum collection. The distribution of TB cases by type of patients and categories is as seen in table 8 below which shows that **56%** of all cases notified are smear positive.

Table 4.8: TB cases registered by type of patients and category, Zanzibar, 2014

Type of patients	AFB+	AFB-	Extra-pulmonary	Total
New	335	141	141	617
Relapse	12			12
Failure	6			6
Return to control	4			4
Others	0	6	0	6
MDR TB	3	0	0	3
Total	**360**	**147**	**141**	**648**

Among 648 patients notified in Zanzibar for the year 2014, **471 (72.6%)** patients were notified in Unguja and **177** in Pemba (Figure 4.1).

Figure 4.1: TB case notification by type of patient and Island, Zanzibar, 2014



4.4.2 Number of new smear positive TB cases

There is an increase in number of new smear positive TB cases by 5.3% compared to the previous year (318 in 2013 vs 335 in 2014). This shows that, there is still high TB infection in the general community. Most of the affected are young adults of the age group between 15-34 years (35%). Men are more affected (60%) than women (Table 9).

Table 4.9: Number of smear positive cases by age and gender, Zanzibar, 2014

AGE CATEGORY	MALE	FEMALE	TOTAL
0-14	7	5	12
15- 24	30	26	56
25-34	60	56	116
35 -44	51	25	76
45 - 54	27	10	37
55 - 64	14	10	24
65+	12	2	14
TOTAL	**201**	**134**	**335**

4.4.3 TB cure rate and treatment success

A total of 318 new smear positive patients were registered in 2013. Among them 287 (90.3%) were cured, 1 (0.3%) were failure, 10 (3.1%) died, 5 (1.6%) were out of control and 15 (4.7%) were transferred out. Therefore, cure rate for 2014 is 90.3% which is an increase from 87% of 2013. The treatment success rate for the year 2014 is also 90.3% because all 318 patients had sputum tested and their result was negative as it is shown in the table below.

Table 4.10: Treatment outcome for all TB patients registered, Zanzibar, 2014

Type	Notified	Cured	T. completed	Failure	Died	Defaulted	T.O.	Total
S. positive	318	287	0	1	10	5	15	318
S. negative	145		139		4	0	2	145
Extra pulmonary	197		185		9	0	3	197
Relapse	18	14	0	1	1	0	2	18
Failure	2	1	0	0	0	1	0	2
Return	5	3	0	0	0	2	0	5
Others	0		0		0	0	0	0

4.4.4 Number of TB patients tested for HIV

A total of 648 TB patients were diagnosed in 2014, among them 618 (95.3%) were tested for HIV (Figure 4.2). Compared to 2013, the proportion of TB patients tested for HIV has decreased from 96.2% in 2013 to 95.3% in this reporting year

4.4.5 Number of TB/HIV co-infected patients

Among the 618 TB patients tested for HIV, 113 (18.2%) tested positive. There is an

increase in percentage compared to 17.5% of patients who were diagnosed to be TB/HIV co-infected in 2013.

Treatment outcome of TB/HIV patients reported in 2013 is as follows: In 2013, 115 TB/HIV patients were diagnosed, of them 43 were new smear positive and 72 were others. Among new smear positive patients 32 (74.4%) were cured, 2 (4.6%) died, 1 (2.3%) was lost to follow up and 8 (18.6%) were transferred out.

Out of 72 others, 4 (5.5%) were cured, 58 (80.5%) were treatment completed, 6 (8.3%) died, 3 (4.2%) were lost to follow up and 1 (1.4%) was transferred out.

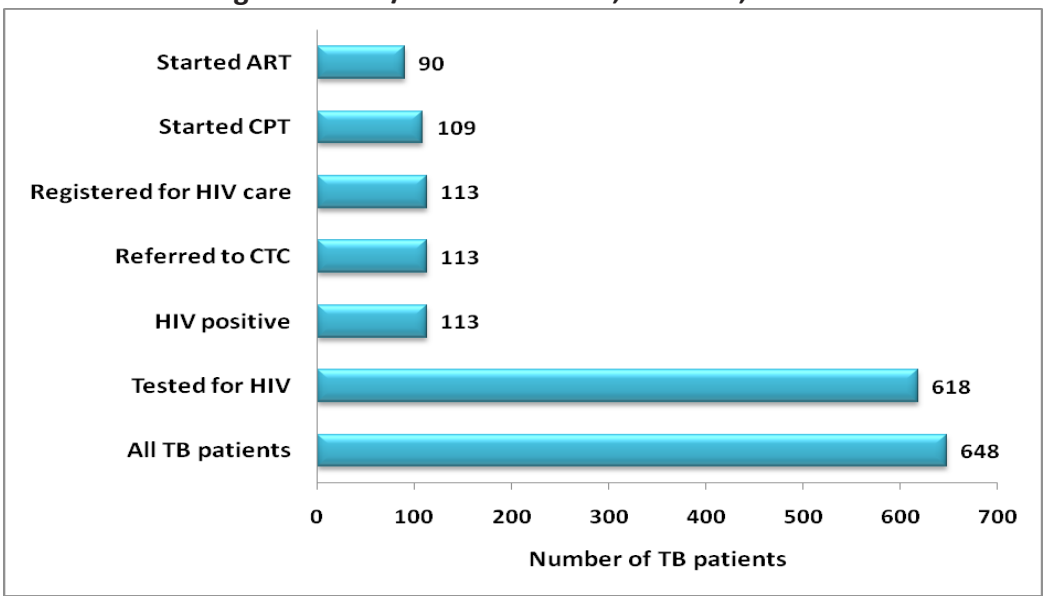
4.4.6 Percent of HIV positive TB patients on ART

Ninety (90) TB/HIV co-infected patients were started on ART. This is equivalent to 80% of all TB/HIV co-infected patients. This percentage shows a decrease from 86% in 2013 and is also below the WHO target of 100%. The decrease was contributed by 2 patients who died before starting ART, and others were still continuing with adherence counseling for ART initiation. .

4.4.7 Percent of HIV positive TB patients on Co-trimoxazole preventive therapy

The percentage of HIV positive patients who started co-trimoxazole preventive therapy is 96.5% in 2014 which is almost the same as that of 97% in 2013. Nevertheless the required WHO target of 100% not yet been reached.

Figure 4.2: TB/HIV notification, Zanzibar, 2014



4.5 LEPROSY SERVICES INDICATORS AND TREND FROM 2012- 2014

INDICATORS		Year		
		2012	2013	2014
1.	Number of all new registered leprosy cases	144	100	177
2.	% of MB cases among all new cases	60	76	56
3.	% Children among new cases	28.5	18	19
4.	% of WHO grade 2 among new cases	7	12	3
5.	% of female patients among new cases	31	38	36
6	% of MB leprosy patients completing 12 month of MDT amongst those expected to complete their MDT (calculated for 1 year cohort intake)	98.4	92.7	96.5

4.5.1 Number of all new registered leprosy cases

A total of 177 new leprosy cases were registered in 2014. This number is higher compared to 100 cases registered in 2013. This year data has been contributed by active case finding conducted in South district.

4.5.2 Percent of Multi bacillary (MB) cases among all new cases

Out of 177 new cases registered in 2014, 56.4% were Multi bacillary (MB). The proportion of MB leprosy cases has decreased as compared to 2013 whereby it was 76%. However, the high percentage of MB leprosy cases among the diagnosed patients is still problematic as many infectious cases in the population pre-dispose the community to the spread of leprosy infection.

Table 4.11: Leprosy cases diagnosed by type of patient and Island, Zanzibar, 2014

	MB	PB	Total
Unguja	98	76	174
Pemba	3	0	3
Zanzibar	**101**	**76**	**177**

4.5.3 Percent of Children in new cases

A total of 34 children were detected and registered in this year which is equal 19.2% of all new cases. This shows an increase of proportion of children diagnosed from 18% in 2013.

Table 4.12: Leprosy patients diagnosed by type of patient and age, Zanzibar. 2014

Type of patients	Adult	Child	Total
Multibacillary	88	12	100
Paucibacillary	54	22	76
Total	**142**	**34**	**176**

4.5.4 Percent of disability grade 2 among new cases

Among 176 new leprosy patients diagnosed in this year, 140 (79.6%) had disability grade 0, 30 (17%) had disability grade 1 and 6 (3.4%) had disability grade 2. This shows a decrease of disability grade 2 from 13% in 2013 to 3.4% in 2014. The decrease was attributed to active case finding conducted in south district in Unguja.

Table 4.13: Disability grade for new patients diagnosed, Zanzibar, 2014

Grade	Number of cases	%
0	140	79.6
1	30	17
2	6	3.4
Total	**176**	**100**

4.5.5 Percent of female patients among new cases

The percentage of female patients was 36.1% compared to 38% in 2013 among the total patients identified in 2014; this shows a slight decrease of female patient identified in 2014.

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

Among **86** Multibacillary leprosy patients registered in 2012, about 83 (96.5%) completed their treatment, 2 (2.3%) were out of control and 1 (1.1%) was transferred out. This shows treatment completion rate has increased from 92.7% (2013) to 96.5% (2014) and this is above WHO target which is 95%.

4.6 ACHIEVEMENTS

- Increased leprosy case notification and reduction of disability grade 2 from 13% to 3.4%.
- Reduction of TB/HIV death from 6.9% (2013) to 2.6% (2014)
- Development of five years TB and leprosy strategic plan (2015 – 2019).

4.7 CHALLENGES

- Low TB case detection including MDR TB
- Inadequate capacity to manage MDR TB patients
- Only two sites provide under one roof services
- Low leprosy case detection

4.8 PROPOSED WAY FORWARD

- Improve case detection through strengthening sputum collection system and use of Gene X pert machine
- Scaling up of under one roof services
- Capacity building on MDR TB management
- Implement house to house leprosy case finding in high endemic area

4.9 PLANS FOR 2015

- Strengthen TB case detection in TB key populations
- Strengthen MDR TB management
- Strengthen TB IPC in health care facilities
- Capacity building on leprosy to health care providers and strengthening active case finding

CHAPTER FIVE:
STRATEGIC INFORMATION

5.1 BACKGROUND

Strategic Information Unit has a mandate to monitor the trend and distribution of HIV epidemic and other STIs through:

- Sentinel surveillance on antenatal clinic attendees (ANC) to monitor prevalence of HIV infection among pregnant women as a proxy to the general population
- Integrated Biological and Behavioural Surveillance Surveys (IBBSS) among key populations at risk of HIV
- Other surveys based on needs from other surveillance findings.

In collaboration with the Health Management Information System (HMIS) Unit of Ministry of Health (MOH), Strategic Information Unit also monitor implementation of HIV, STI, TB and Leprosy interventions through:

- Development and distribution of services monitoring tools;
- Building capacity of health care workers on the use of the monitoring tools;
- Coordinating data management for the interventions;
- Conducting regular supportive supervision as well as data verification to ensure availability of high quality data and use at all levels.

The unit also provides leadership in conducting evaluations on various interventions as well as designing, conducting relevant operational researches, producing and disseminating programme's implementation reports to inform stakeholders on HIV/AIDS/TB and Leprosy control

5.2 GOAL

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

5.3 OBJECTIVES AND ACTIVITIES IMPLEMENTED IN 2014

5.3.1 Objectives 1: To ensure accurate, complete and timely, monitoring data collected and reported from the district level

Activities implemented

5.3.1.1 Conduct supportive supervision on HIV, STI, TB and Leprosy data management to district health management teams (DHMTs)

Supervision of DHMT staff at all **10** districts of Zanzibar was conducted biannually in both Unguja and Pemba. The objective of the supervision was to monitor how HIV data is handled at district level, availability of monitoring tools, storing of data, collection and completeness of the reports from sites, data entry, analysis and use at district level. During the supervisions some successes were noted including District Surveillance Officers' (DSOs) commitment in HIV, STI, TB and Leprosy data handling at district level. They are conversant with all sites that provide HIV, STI, TB and Leprosy services. HIV, STI, TB and Leprosy services reports are collected from all sites and data entered into District Health Information System 2 (DHIS2) database. However some challenges were observed including:

- Incompleteness of reports from facilities. i.e. facilities providing the services are more than the number of services reports available
- Repeated mistakes in monthly report forms
- Poor data verification done by DSO at site level
- Unreliable internet connection at district level forces DSOs to enter data at HMIS unit which causes a delay in data entry and accessibility at district
- Inadequate data cleaning to identify minor or major errors for data accuracy
- Inadequate analysis and use of HIV, STI, TB and Leprosy data at district level
- Frequent breakdown of motor cycles provided to majority of districts
- ICT accessories provided for data management are not functioning including monitor, computer, printer in most districts

All the above challenges were discussed with DSOs and way forward agreed upon including use of checklist for reports, checking of reports before collection from health facilities, and regular cleaning and analysis of data at district level. Furthermore, regarding motorcycles and ICT accessories and internet services; it was agreed that, DHMT and HMIS offices to plan replacing non-fuctional accessories with new ones. However, the problem of internet at DHMT level still remains unresolved and is waiting a solution at Ministerial level.

5.3.1.2 Conduct HIV, STI, TB and Leprosy data verification at health facility level

HIV, STI, TB and Leprosy data verification was conducted once to **116** health facilities in Unguja, which is equivalent to **74%** (116/156) of all sites providing HIV, STI, TB and Leprosy services in Unguja. The objective of this activity was to assess data accuracy, completeness, consistency, availability, and timeliness to determine the overall reliability of data collected. The methodology used was to cross check reported data from the sources at sites including registers for the period of 6 months prior to the day of data verification.

The key challenges from this activity were:

- Reports from some districts (North A, Urban and West) are being submitted to DHMT offices instead of DSOs collecting the reports from the facilities, as a result data checking and verification before collection is not done.
- Most of the service indicators were not 100% accurate, i.e. 26% and 10% of PMTCT sites were under reporting and over reporting PMTCT data respectively. Likewise 22% and 16% of HBC report from 116 facilities were under and over reporting respectively.

During data verification exercise, all the reports verified at the visited sites were corrected in the monthly report form. In addition, all issues noted were shared with health providers and DSO on site and strategies for improving their reporting agreed upon based on the issue observed.

5.3.2 Objective 2: To monitor trends in HIV epidemic and assess risk factors for transmission among general population and KPs groups

Activities implemented

5.3.2.1 ANC surveillance survey

5.3.2.1.1 Conduct training on ANC surveillance data collection

A two days training on ANC surveillance data collection was conducted in 2 sessions, one in Unguja and one in Pemba. The objective of the training was to orient the staff on the ANC surveillance survey protocol, train them on how to recruit participants, filling of questionnaires, collection and process blood samples as well as fill the lab request forms. A total of **27** HCWs participated in the training in Pemba and **42** HCWs participated in the training in Unguja.

5.3.2.1.2 Data collection for ANC surveillance 2014

Data collection for ANC HIV surveillance started on April 2014 in 20 sentinel sites (12 in Unguja and 8 in Pemba) and continued for 12 weeks (April - July, 2014). At each

site two RCH care providers and one laboratory technician were engaged in data collection. The methodology included linked anonymous testing; where results are returned to client and service provided for positive client. Study sites were selected based on geographical and ecological representativeness, population density and existence of well-established ANC services at the health facility etc. The study populations are pregnant women at any age, at any gravida and any gestational age.

A total of **6,200** ANC clinic attendees were expected to be enrolled (2,400 in Pemba and 3,800 in Unguja). By the end of data collection, **6,367** pregnant women (3,885 in Unguja and 2,482 in Pemba) had been enrolled in the survey which is equivalent to 102.7% of expected.

5.3.2.1.3 Conduct ANC surveillance data management

One day training on ANC surveillance data management for six **(6)** data entry clerks was conducted. The objective of the training was to orient the staff on the ANC surveillance tools (questionnaires and laboratory request forms), train them on how to enter the data into EPI INFO database, how to save the data daily as well as orient them on the process of cleaning the data. Following the training, the staff started data entry using double entry approach. Data cleaning took one week and data analysis was done for two weeks.

5.3.2.1.4 Conduct ANC surveillance survey 2014 report writing workshop

A five **(5)** days ANC surveillance report writing workshop was conducted in Unguja. The objective of the workshop was to produce ANC surveillance findings.

Some key findings from this survey are:

- The biological results showed that in this round HIV prevalence remained is 0.6%, Syphilis is 0.3%, HBV is 1.7% and HCV is 0.1% (Figure 5.1)
- High HIV testing among ANC participants who ever tested for HIV (Figure 5.2)
- High chances of being offered PMTCT services which is almost the same across the districts (Figure 5.3)
- Low condom use was reported among ANC participants (12.1%) during last sexual intercourse with an irregular partner.

Figure 5.1: Percent of ANC surveillance participants with blood borne infections in Zanzibar, 2014

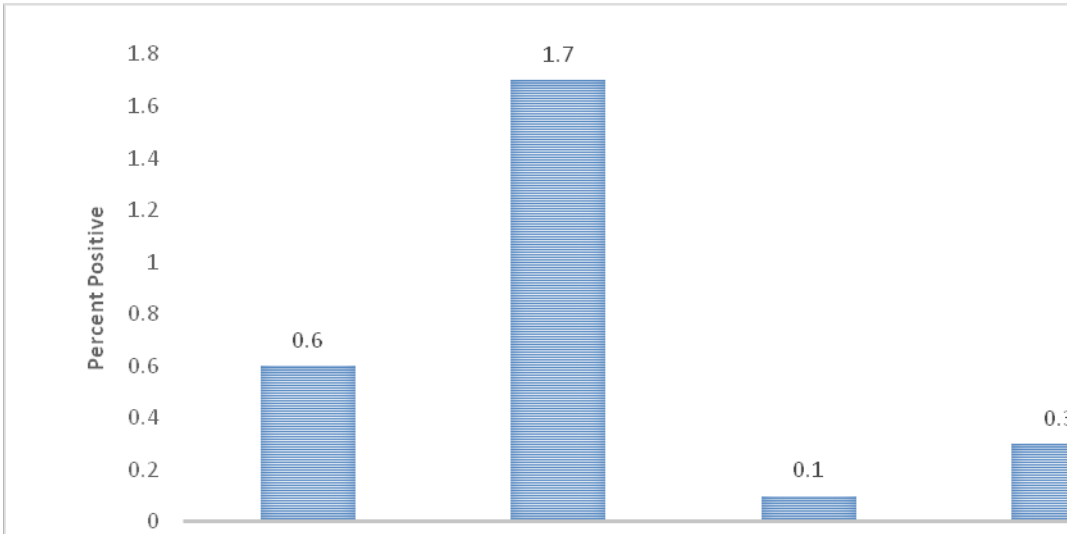


Figure 5.2: Proportion of ANC surveillance participants who have ever tested for HIV, Zanzibar-2014

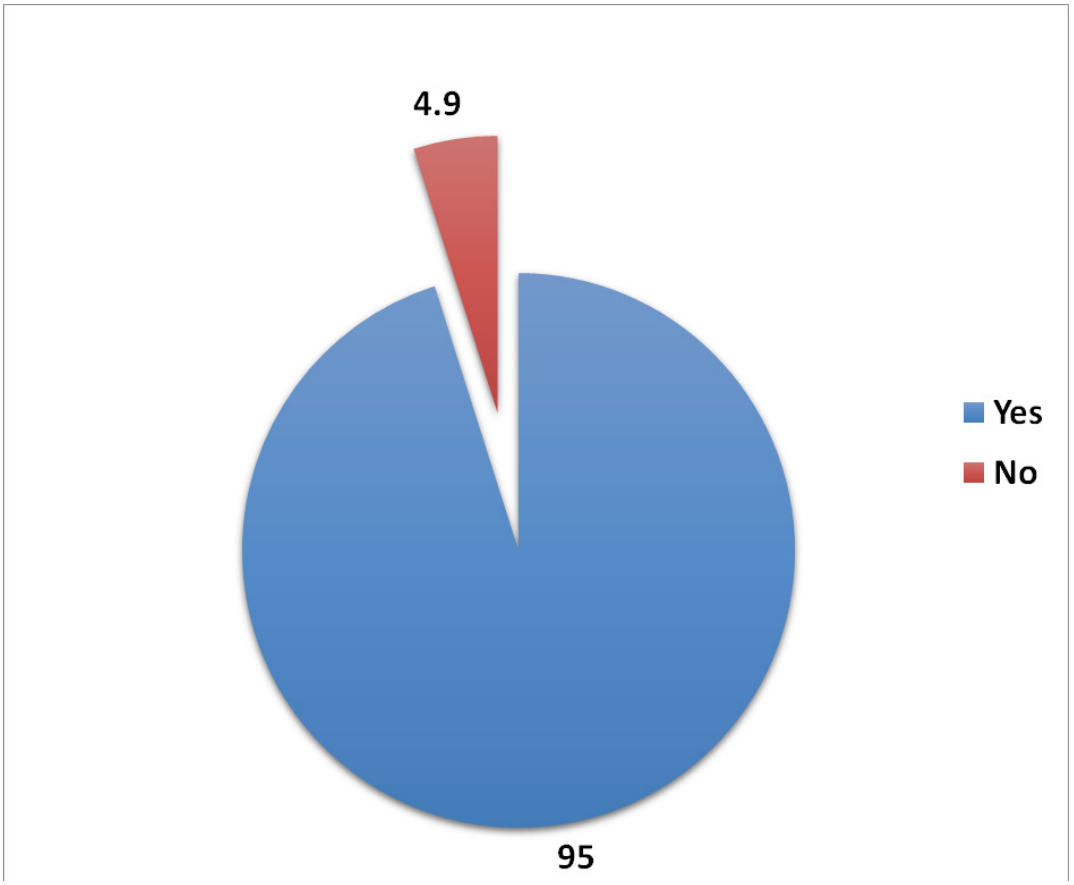
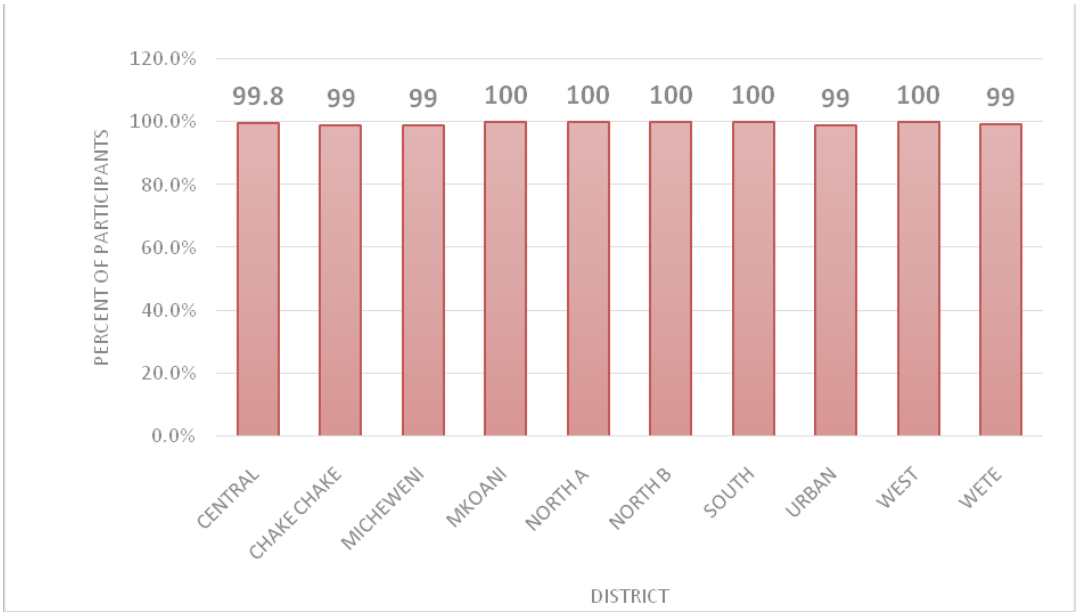


Figure 5.3: Percent of ANC surveillance participants who have been offered PMTCT services by district, Zanzibar, 2014



5.3.3 Objective 3: Enhance human capacity in SI among facility-level, district health management team, and ZIHTLP staff

Activities implemented

5.3.3.1 Conduct training for ZIHTLP staff on basic concepts of Monitoring and Evaluation

A five days training on Monitoring and Evaluation was conducted for **30** ZIHTLPstaff, (25 from Unguja and 5 from Pemba). The objective of the training was to orient the staff on the basic concepts of Monitoring and Evaluation, to build their capacity on developing an M&E plan, orient them on different methods of monitoring and evaluation techniques and their application in routine program activities. At the end of training all participants developed an M&E plan of their respective units.

5.3.3.2 Conduct training of health care workers and ZIHTLP staff on comprehensive supportive supervision and mentorship

A six days training on comprehensive supportive supervision and mentorship was conducted for **30** participants (10 SI staff, 20 HCWs). The objective of this training was to build capacity to HCWs on mentorship skills. By the end of the training participants are expected to provide mentorship for their fellow health providers who are not performing satisfactorily specifically on filling HIV, STI, TB and Leprosy monitoring tools. These mentors will be supervised by supervisors from SI and other unit within the program.

5.3.3.3 Conduct training on HBC monitoring tools for HBC providers in Unguja and Pemba

Two days training on HBC registration and follow up forms was conducted in Unguja and Pemba. A total of **5** sessions were conducted (3 in Unguja and 2 in Pemba). The training involved **156** HBC providers (96 in Unguja and 60 in Pemba). The objective of the training was to re-orient the staff providing HBC services at facility level on the registration form, follow up form and monthly summary report form. The training also gave a chance for participants to clear any doubts they had on the filling of these monitoring tools. Following this training, HBC monitoring tools are expected to be properly filled following guides provided during the training.

5.3.3.4 Conduct refresher training on PMTCT monitoring tools for HCWs from sites which get HIV positive pregnant women Unguja and Pemba

Two days refresher training for PMTCT registers and monthly summary report was conducted. A total of **4** training sessions were conducted (3 in Unguja and 1 in Pemba). The training involved **120** PMTCT health providers. The objective of the training was to re-orient the staff providing PMTCT services on the PMTCT registers especially on sites that identify HIV positive pregnant woman. Following this training PMTCT monitoring tools are expected to be properly filled.

5.3.3.5 Training on HBC monitoring tools for Community HBC providers in Pemba

One day training on HBC registration and follow up forms was conducted in 4 sessions in Pemba. The training involved **149** Community HBC providers. The objective of the training was to re-orient the CHBC providers on the registration and follow up forms. As a result of this training, the community HBC providers were expected to fill the HBC registration and follow up forms accurately.

5.3.4 Objective 4: Develop and implement health sector HIV, TB and Leprosy Monitoring and Evaluation (M&E) Plan

Activities implemented

5.3.4.1 Perform Evaluability Assessment for new HTC, PMTCT and Care and Treatment guidelines implementation

Evaluability assessment (EA) was conducted following PMTCT, HTC and Care and Treatment stakeholders meeting. In this meeting proposed evaluation questions; and checklist were developed. The objective of conducting the EA was to determine whether the planned evaluation is justified, feasible and likely to produce useful information. The EA was conducted through data collection, analysis and report preparation. The EA findings identified that it is feasible to evaluate Care and

Treatment, PMTCT and HCT programs. Thereafter, a stakeholders meeting was conducted to share the EA findings. Before the actual evaluation, there is a need to develop evaluation protocols and hence to direct process evaluation exercise on the identified program areas.

5.4 STRATEGIC INFORMATION INDICATORS AND TREND 2012 - 2014

Indicator		2012	2013	2014
1	Number and types of surveys conducted	1 (IBBSS among PWID, SWs and MSM in Unguja)	**0**	**1** **(ANC surveillance among pregnant women)**
2	Percent of facilities submitting complete, timely and accurate HIV reports*			
	Completeness	**87%**	**85%**	**85%**
	Timeliness	**40%**	**39%**	**37%**

*Source of this information is MOH-Z DHIS2 reporting rate summary report for the years 2012- 2014. Completeness and timeliness of HIV/STI data entered in DHIS2 has been used as a proxy for completeness and timeliness of reporting.

1. Number and types of surveys conducted

ANC surveillance was conducted in 2014. The objective was to monitor prevalence and distribution of HIV and other blood borne infection among pregnant women in the country. The result is used as a proxy indicator for HIV prevalence in the general population.

2. Percent of facilities submitting complete, timely and accurate HIV reports

The completeness of reports collected from the health facilities level has remained at 85% from 2013 to 2014. Staff turnover and shortage of staff at health facilities are the main contributing factors. Timeliness of entering reports into the DHIS2 database has dropped from 39% to 37%. One contributing factor to this is unreliable internet services at district level and hence district data managers are forced to travel to central level for data entry.

5.5 ACHIEVEMENTS

- Conducted ANC surveillance survey
- Conducted Evaluability assessment

5.6 CHALLENGES

- Improper filling of service registers and reports still persists
- Late entry of reports at district level causing delayed reporting at central level
- Unreliable internet services for DSOs

5.7 PROPOSED WAY FORWARD

- Conduct mentorship for HCWs to improve quality of data
- Conduct mentorship for DSOs at DHMTs
- Purchase internet modem which has wider coverage in all the districts as well as top up voucher

5.8 PLANS FOR 2015

- Dissemination of ANC surveillance findings
- Conduct IBBSS among fishermen
- Conduct formative assessment for KPs

CHAPTER SIX:
PROGRAMME MANAGEMENT AND FINANCE

6.1. OVERVIEW

The Management Unit is responsible for provision of Policy guidance within Health Sector and coordination of all activities implemented by the program. It also oversees all administrative and financial management aspects of the program including human resources, financial resources and procurements needs of the program and tracking of the procured goods and services. Program management is also responsible for preparing financial reports and, in collaboration with other units, compiling technical reports and submission of reports to the Ministry and stakeholders.

6.2 GOAL

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

6.3 PLANNING AND ADMINISTRATION

6.3.1 HUMAN RESOURCE

The Zanzibar Integrated HIV, TB and Leprosy Programme have a total of 80 Staff **(66** Government and 14 Programme direct employees). Government employees include all those employees on the programme that are under direct employment by the Ministry of Health and who have been assigned to work on the programme. They receive salary and all related benefits from the Government. Programme direct employees are employees on the programme whom are directly employed by the ZIHTLP with employment terms and conditions agreed.

During the reporting period no new staff was recruited and all staff recruited last year were retained and continue to provide services accordingly.

6.3.2 NATIONAL, REGIONAL AND INTERNATIONAL MEETINGS AND CONFERENCES

During the reporting period, the following ZHITLP technical staff managed to participate in country, Regional and International Conferences and meetings organized by different HIV and TB partners:

6.3.2.1 International and Regional Meetings/Conferences

Program staff had an opportunity to attend different regional and International meetings/conferences as well as trainings. To mention some of them:

- Two technical staff from TB unit participated in two weeks training on Monitoring and Evaluation – Pretoria, South Africa
- Two technical staff from Care and Treatment and SI units participated in one week workshop on new Global HIV targets – Johannesburg, South Africa
- Three staff from Program Management, KP and Care and Treatment units attended East Africa Regional meeting on HIV and AIDS – Kigali, Rwanda
- Two staff from SI and KP attended two weeks M&E training – Netherlands
- One staff from SI attended Global Fund Meeting on New Concept Note Writing – Kampala, Uganda
- One staff from Program Management attended WHO meeting on Viral Hepatitis: Geneva, Switzerland
- Two staff from SI and Care and Treatment participated in eMTCT meeting – Kigali, Rwanda

6.3.2.2 National Meetings/Conferences

- Program staff attended PMTCT/ART implementing partners meeting in Tanzania Mainland organized by CDC
- Key Programme staffs attended APR and EA meeting organized by CDC Office Dar es Salaam
- Biannual coordination meeting between two coordinating offices was conducted in Unguja and Pemba.

6.4 CONSULTANCY AND SERVICES

- Consultancy on TB Laboratory network in Zanzibar
- Assessment of Private Health Facilities' capacity to provide TB services
- Documentation of best practice for under one roof services
- Conduct TB Infection Prevention and control assessment in Health Care facilities

6.5 PROCUREMENT

In the year 2014 the ZIHTLP procured the following health and non-health equipment for Unguja and Pemba:

1. Two hundred bicycles procured to enhance diagnosis of TB in the community
2. Two double cabin pickup to support TB interventions including supervision, contact tracing etc.
3. Four motorcycles procured to facilitate monitoring of TB services at all level.

6.6 NATIONAL PARTNERSHIP AND SUPPORT

The ZIHTLP in collaboration with development partners has continued to support implementation of HIV, TB and Leprosy activities at all level in providing technical support for improving quality of services, enhancing capacity of programme staff and efficient implementation of the programme interventions. Outlined in table 6.1 below are the partners working together and providing support to ZIHTLP during the year 2014:

Table 6.1: ZIHTLP Technical Support by Partners, Zanzibar, 2014

NAME OF PARTNERS	TECHNICAL SUPPORT PROVIDED
• **1.Management Science for Health (MSH)**	• Continue to support development of performance management system of each program staff • Performance assessment of the Organization Capacity Building project • Training and installation of new version of financial packages including payroll, human resource, asset register
2.Pathfinder International	• Strengthening program's capacity in Behavior Change Communication in HIV and other related diseases in BC verse BCC, M- Health technology and ART adherence. • Supported to recruit consultant to develop new HBC guidelines
3.François Xavier Bagnoud (FXB)	• FXB supported in printing PMTCT job aids and pocket guides
4. Pangaea Global AIDS Foundation (PANGAEA)	• Continue to provide technical assistance in establishment of methadone services in Unguja

6.7 FINANCE

6.7.1 Financial Overview

A recent financial gap analysis conducted by a team of consultants showed that HIV and TB strategy implementation requires the investment of an estimated $ 19.9 million within the period of three years (2015-2017). In addressing this the Programme has written Global Fund Concept Note on HIV and TB for 3 years (2015-2017) and has also submitted a one year Continuation Application supported by PEPFAR through CDC.

The program's major funding support comes from the Revolutionary Government of Zanzibar and the development partners namely: PEPFAR, Global Fund, United Nation Agencies (UNDP, WHO, UNICEF) through United Nations Development Assistance Plan (UNDAP), Tanzania Health Promotion Support (THPS) and Germany Leprosy Relief Association (GLRA).

ZIHTLP received a total amount of **Tanzania Shillings 2,000,000.00** from the Government and **USD 3,076,656.59** from the development partners and incurred an expenditure of **USD 3,038,592.88** during the year 2014.

In addition, the ZIHTLP observed funds decreased in terms of income and expenditures in year 2014 compared to the year 2013 by 12% and 10% respectively. The breakdown of income, expenditures with areas of interventions in a broad picture is given in Appendix II, III and IV.

Table 6.2 Source of funds from the Government and development partners during the year 2014

No	Name of Partners	Project Title/Name	Area of Intervention Support
1.	President Emergency Plan for AIDS Relief (PEPFAR)	Enhance HIV prevention, care and treatment services in Zanzibar	• HIV Counseling and Testing • Prevention of Mother To Child Transmission of HIV • Access to HIV Care and Treatment • Enhancement of laboratory capacity and services • Home Based Care services • Services for Sexual Transmitted Infections & Key Population, • Faith Based Collaborations in promoting Abstinence and Being faithful • Information Education Communication and Behaviors Change (IEC/BCC) • Strengthening Strategic Information System and • Program management
2.	Global Fund R10 for Tuberculosis	Zanzibar Scaling up Detection and Control of Tuberculosis Services	• To pursue high quality DOTS expansion and enhancement • Strengthen collaborative TB/HIV activities • Prevent TB transmission in health facilities and other high risk congregate settings • Engage all care providers in TB control and empower people and communities in TB control.
3.	Tanzania Health Promotion Support	Provision of Comprehensive Care and Treatment Program in Zanzibar	• Strengthening of HIV Care and Treatment services to 11 sites (Mnazi Mmoja, Kivunge Cottage, Mwembeladu, Micheweni, Al Rahma, Chake Chake, Makunduchi, Mkoani ZAYEDESA and Wete Hospitals). • Key Population activities including MAT service • TB/HIV integrated services and Provider Initiated Testing and Counseling (PITC) • Gap filler to support Laboratory reagents and supplies

No	Name of Partners	Project Title/Name	Area of Intervention Support
4.	United National Development Program – Tanzania (UNDP, UNICEF)		• Provide bridge support on HIV health sector interventions including M&E, PMTCT, Key Population and Surveillance activities
5.	GLRA (German Leprosy Relief Association)		• Monthly supervision to the sites providing Leprosy services • Contact tracing for Multi bacillary Leprosy patients, • Health education on leprosy to the community, • Training on prevention of disability committees • Reconstructive surgery for leprosy patients • Follow up of existing self-care groups
6	**Government of Zanzibar**	Developing Program	• Support HIV,TB and leprosy programme activities

6.7.2 Budget

For the financial year 2015, ZIHTLP observed 90% of the budgetary support to the programme relied from HIV&TB development partners and 10% is from Government contribution. A budgetary amount of $3,033,105.00 and TZs 100,000,000.00 was made as per below mentioned table.

Table 6.3: Funds pledge for ZIHTLP for the Financial Year 2015/2016

PARTNERS	Funds Pledge
TB GLOBAL FUND R10	**USD. 401,066.00**
PEPFAR/CDC	**USD 2,552,039.00**
PEPFAR/THPS	**USD 80,000.00**
REVOLUTIONARY GOVT OF ZANZIBAR (SMZ)	**TZs.100,000,000.00**

6.8 CHALLENGES

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

6.9 WAY FORWARD

- Central Government should increase funds allocation for HIV, TB and Leprosy
- Ministry of Health should develop strategy to obtain funds to fill the HIV financing gap

CHAPTER SEVEN:

RECOMMENDATIONS

For the better performance of the programme and to improve quality of HIV, TB and Leprosy services and interventions, ZIHTLP will put effort on the following recommendations:

- Financial unit in Pemba should be operationalized and functional
- ZIHTLP should operationalize staff performance review based on their performance plan
- Increase coverage of clients receiving PITC services
- Conduct PITC training for new providers in existing sites to increase provision of services
- Strengthen linkage of HTC clients to CTCs
- All diagnosed patients should be attached with HBC providers and once enrolled in CTC, their HUWANYU number should be entered in CTC 1 and 2 cards
- ART refilling centers should be established in the districts
- Increase sensitization of male involvement in the community
- Scale up CTC services in PMTCT sites
- All HIV patients who are TB suspects should be tested for TB using gene X-pert
- Formative assessment should be done to determine methods that can be used to estimate number of KPs in Zanzibar
- Data verification should be conducted on regular basis so as to ensure quality of data and reports generated
- Establish mobile health technology for people living with HIV

APPENDICES

APPENDIX I: OUTREACH HTC SERVICES PROVIDED IN SPECIAL COMMUNITY AND NATIONAL EVENTS, ZANZIBAR 2014

No	Implementers	Event	Place	Total Tested	Total Positive
1.	DHMT- CHAKE ZAPHA+, ZAC	Community sensitization on HIV and AIDs	Mzambarauni, Sober house Wete, Chokocho, Fundo Lagon Hotel, Wesha kwa wavuvi, Micheweni Majenzi, Chonga, Mesi Wete, Mfikiwa Mesi, Mtambile, Changaweni, Tumbe, Ngomeni, Nyamboto, Uwandani, Wawi, Makangale, Kangagani, Mesi ya Jeshi.	431	4
2.	ZAPHA+ (Pemba), ZAC	Community sensitization on HIV and AIDS	Kipapo, Wawi, Matale, Pujini, Magereza wete.	529	1
		HIV sensitization	Wete and Chake Chake district	535	3
3.	ZANGOC- Unguja and Pemba	Revolution Day, Community sensitization on HIV and AIDS for Secondary school students	Amani,Mzambarauni secondary school, Ukunjwi, Uwondwe, Pandani, Kizimbani and Chasasa secondary school.	598	1
4.	DHMT- URBAN	Village Health Day	Gulioni shehia	80	0
5.	DHMT- WEST	Village Health Day	Dole shehia Chukwani shehia	247	0
6.	DHMT- CENTRAL	Village Health Day	Tunguu shehia	61	0
7.	DHMT- SOUTH	World AIDS Day	Makunduchi	204	0

No	Implementers	Event	Place	Total Tested	Total Positive
8.	VCT GOLDSTANDARD	Health Sector Planning	Beach Resort	44	0
		World AIDs Day	Ministry of Information, Culture and Sport Office	40	1
		Commemoration of the launching of Dhambi Film	Nungwi	83	2
9	ZAYADESA	World AIDs Day	Matrekta, Mjimbini and Jobwe village	393	2
		Community sensitization on HIV and AIDs	Meli 5, Nyarugusu, Fuoni, Nungwi, Meya, Jangombe, Urusi, Shakani, Ukutini Pemba, Michenzani and Mkoani.	584	4
10.	Zanzibar Youth Forum	Community sensitization on HIV and AIDS	Saateni Pinda mgongo, Malindi, Funguni, Mkokotoni and Kichungwani	325	1
		Community sensitization on HIV and AIDS	Malindi funguni, Saateni, Juwakali, Mkokotoni and Kichungwani Pemba	124	1
11.	Military Hospital Bububu	Revolution day	Amani and Beit-ras	1088	1
12.	Zanzibar Madras Centre	World's Children Day			
13.	KPs Network	Community sensitization on HIV and AIDS	Masingini, Kilimani, Chukwani, Fuoni, Mpendae, Kiembe samaki,Mtufaani, Paje, Kisauni, Muembe mimba, Kwaalinatu	338	9
14.	IRCH	Community sensitization on HIV and AIDS	Rahaleo, Mlandege and Muembe shauri	190	1

APPENDIX II: DISTRIBUTION OF ZIHTLP FUNDS RECEIVED BY DEVELOPMENT PARTNERS, ZANZIBAR, 2012 -2014

YEARS	Development Partner in USD $									
	PEPFAR(CDC)	COLUMBIA (ICAP)	UNDAP	TB GFR10	GLRA	GOVERN-MENT	WHO	UNICEF	HIV GFR6	TOTAL
2012	2,840,685.39	60,000.00	94,734.87	0.00	12,413.00	33,038.67	0.00	0.00	885,866.00	3,040,871.93
2013	2,539,365.00	45,301.51	15,545.87	924,511.00	16,793.62	23,978.00	0.00	0.00	0.00	3,565,495.00
2014	2,967,890.00	53,704.36	23,293.87	0.00	12,690.82	1,164.69	6,921.77	12,155.76	0.00	3,077,821.28
TOTAL	**10,429,075.45**	**271,458.87**	**252,393.01**	**924,511.00**	**41,897.44**	**66,078.36**	**6,921.77**	**12,155.76**	**885,866.00**	**12,890,357.67**

APPENDIX III: EXPENDITURES OF ZIHTLP BY CATEGORIES AND DEVELOPMENT PARTNER, ZANZIBAR-2014

Categories	Development Partner								TOTAL EXPENDITURE (US $)
	PEPFAR/CDC	ICAP	UNDP	TB GFR10	WHO	UNICEF	GLRA	GOVERNMENT	
Human Resource	1,186,539.32	17,533.91		77,331.88					1,281,405.11
Technical Assistance				18,088.80					18,088.80
Travel	150,092.84	8,495.84				1,593.82	4,360.61		164,543.12
Equipment/Furniture	12,810.62			62,648.46					75,459.08
Supplies/Commodities, Testing, Packaging	500,350.22	10,307.71							510,657.93
Subcontracts	75,127.27								75,127.27
Promotion & Advertising & IEC	58,000.00						2,605.77		60,605.77
Monitoring & Evaluation	280,000.00		23,293.87	26,248.15	6921.77				336,463.79
Training	127,104.75			164,179.89					291,284.64
Indirect Costs / Overhead	160,000.00	15,108.13		36,502.82		6,992.35	5,189.38	1,164.69	224,957.38
Total	**2,550,025.02**	**51,445.59**	**23,293.87**	**385,000.00**	**6,921.77**	**8,586.18**	**12,155.76**	**1,164.69**	**3,038,592.88**

APPENDIX IV: EXPENDITURES OF ZIHTLP BY PROGRAM AREA AND DEVELOPMENT PARTNER, ZANZIBAR-2014

Program Area	Development Partner								
	PEPFAR (CDC)	COLUMBIA (ICAP)	UNDAP	TB GFR10	WHO	UNICEF	GLRA	GOVERNMENT	TOTAL EXPENDITURE (US $)
PMTCT	389,184.46					5,980.41			395,164.87
Injection Drug Use & other MARPs	195,438.60					2,605.77			198,044.37
Palliative Care: Basic Health Care and Support	89,795.69								89,795.69
Palliative Care: TB/ HIV	27,546.83								27,546.83
TB and Leprosy				385,000.00	6,921.77		12,155.76		404,077.53
Counseling and Testing	348,696.42								348,696.42
ARV Services	489,886.68	51,445.59							541,332.27
Laboratory Infrastructure	129,820.70								129,820.70
IEC/BCC and Other prevention	102,438.02								102,438.02
Strategic Information	412,805.27		23,293.87						436,099.14
Oversight & Management	364,412.35							1,164.69	365,577.04
Total	**2,550,025.02**	**51,445.59**	**23,293.87**	**385,000.00**	**6,921.77**	**8,586.18**	**12,155.76**	**1,164.69**	**3,038,592.88**