

**ZANZIBAR AIDS CONTROL PROGRAMME
(ZACP)**

MINISTRY OF HEALTH



HIV/AIDS/STDs SURVEILLANCE REPORT

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CONTENTS

<i>Topic</i>	<i>Page</i>
List of Abbreviation	i
Acknowledgement	ii
Executive summary	iii
1. Introduction	1
1.1 General socio-economic impact of the HIV/AIDS epidemic	
1.2 Global HIV/AIDS situation	
1.3 HIV/AIDS in sub-Sahara Africa	
1.4 HIV/AIDS/STDs in Tanzania Mailand	
2. HIV/AIDS Situation in Zanzibar	4
3. Surveillance of HIV/AIDS and STDs	5
3.1 Sentinel Surveillance of Pregnant Women	
3.2 Blood Donors	
3.3 AIDS Clinical Suspects Tested	
3.4 HIV Among STDs Clients and TB Patients	
4. Syphilis Screening Among Pregnant Women	11
5. STD Syndromes Reported	11
5.1 Gender/Age Distribution of STDs	
6. KAP and RAP Studies on HIV/AIDS/STDs	13
6.1 Survey on Women's knowledge, Attitudes and Practices Associated with HIV/AIDS/STDs	
6.1.1 Some of the Specific Objectives of the Study	
6.1.2 Findings and Conclusions	
6.2 Qualitative Study on Sexually Transmitted Diseases (Zanzibar Experience)	
6.2.1 Specific Objectives	
6.2.2 Major Findings	
7. The National Response Against the Epidemic ..	

LIST OF ABBREVIATIONS

AIDS	-	Acquire Immuno Deficiency Syndromic
ANC	-	Ante-natal Care
EC	-	European Community
HIV	-	Human Immunodeficiency Virus
KAP	-	Knowledge Attitudes and Practices
MTP-I	-	Medium Term Plan - I
MTP-II	-	Medium Term Plan - II
MTP-III	-	Medium term Plan - III
NGO	-	Non Governmental Organization
RAP	-	Rapid Assessment Procedure
STP	-	Short Term Plan
STDs	-	Sexual Transmitted Diseases
TB	-	Tuberculosis
UNAIDS	-	Joint United Nations Programme on AIDS
UNDP	-	United Nations Development Programme
WHO/GPA	-	World Health Organization on Global Programme on AIDS
ZACP	-	Zanzibar AIDS Control Programme

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EXECUTIVE SUMMARY

Twenty years since the outbreak of HIV/AIDS epidemic, the world is still grappling to halt the escalation and expansion of HIV infection and subsequently AIDS disease. The sub-sahara region is leading in having the highest number and rate of adults living with HIV/AIDS. In this region the prevalence of adult women living with HIV/AIDS is 55%, slightly higher than in men.

In Tanzania mainland it is estimated that about 1.5 million people have been infected with HIV since the epidemic started in 1983. Among blood donors and pregnant women (attending ANC services), two representative groups of the reproductive adult population, HIV prevalence ranges from 10 - 30%, in different regions.

Since the AIDS epidemic started in Zanzibar in 1986, a cumulative number of 1803 people have been reported to have contracted HIV infection, 1086 people have come down with AIDS and 362 deaths due to AIDS have been reported, until December, 1999. Among the blood donors and pregnant women (attending ANC services) HIV seroprevalence reached the highest rates of 1.4% and 0.7% respectively. This level of prevalence is still significantly lower than in the neighbouring eastern african countries.

With the data collected from public health facilities only and for various other reasons, HIV/AIDS is obviously under-reported. However, the data reveal clearly a trend of increase in the number people infected every year and in different geographical areas. Indeed, high prevalence of HIV is confirmed among patients suspected by clinical signs and symptoms, in TB patients and STDs patients.

A qualitative study (RAP) on knowledge, attitudes and practices on HIV and other STDs conducted in 1998 in Unguja and Pemba communities, showed that there are gaps and misconceptions with regard to knowledge of these diseases, the transmission factors and prevention and control measures. This was also confirmed in a quantitative study in women groups (Unguja and Pemba) which was done in 1999. To make an impact on the epidemic it is, therefore, necessary to address the gaps in knowledge of the disease and the factors influencing transmission of the infection, no matter what the complexities of that process may be due to various, social, cultural or religious values, attitudes and practices.

In this first HIV/AIDS/STDs surveillance report we have taken the opportunity to highlight some features of epidemiological significance and national response against the epidemic. We have presented briefly a KAP community based survey on women and a RAP study various sexually active groups in the communities regarding HIV/AIDS/STDs in Zanzibar.

Finally we have mentioned briefly the major determinants of HIV/AIDS epidemic in Zanzibar and the Priority Areas of Intervention in the Third Medium Term Plan (MTP-III - 1998 - 2000) - The strategic Framework for Multisectoral Response Against HIV/AIDS Epidemic in Zanzibar.

1. INTRODUCTION

1.1 General Socio-economic Impact of the HIV/AIDS Epidemic

HIV/AIDS epidemic is still escalating in developing countries, especially in Africa South of Sahara. The social economic impact of the epidemic in these countries is sadly clearly visible in countries of this region. For example, life expectancy in some of these countries has been reduced by 10 or 15 years, child morbidity and mortality have increased, thousands of young and experienced workers and professionals have been lost, millions of children have been orphaned and abandoned in the streets with severe consequences on crimes and other social maladies in the general society. Indeed HIV/AIDS is the human disaster of the century.

1.2 Global HIV/AIDS situation

UNAIDS has estimated that by the end of 1998, about 33.4 million people were infected with HIV. This number includes 13.8 million women, 18.4 million men and 1.2 million children below 15 years old. In 1998 alone 5.8 million people were newly infected with HIV and deaths due to HIV/AIDS were 2.5 million, bringing the cumulative number of deaths since the HIV outbreak in the world to 13.9 million.

Table 1: Regional HIV/AIDS Statistics and Features, December, 1999

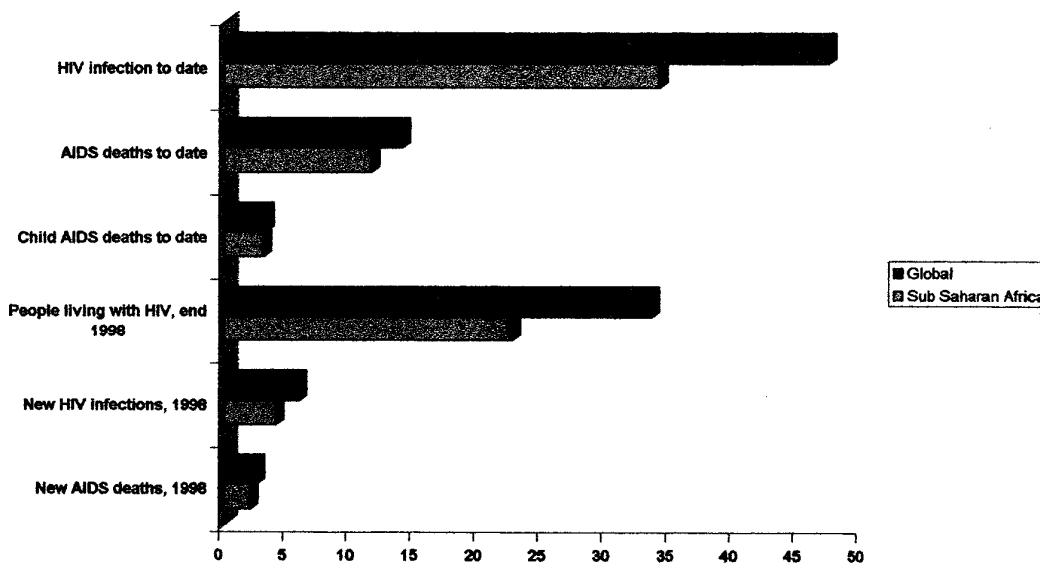
REGION	Adults & children with HIV/AIDS	Prevalence of HIV in Adults	Percent of HIV positive adult women
Sub-saharan Africa	23,300,000	8.00%	55%
North Africa and Middle East	220 000	0.13%	20%
South and South East Asia	6,000,000	0.69%	39%
East Asia and Pacific	530,000	0.07%	15%
Latin America	1,300,000	0.57%	20%
Caribbean	360,000	1.96%	35%
Eastern Europe and Central Asia	260,000	0.14%	20%
Western Europe	520,000	0.25%	20%
North America	920,000	0.56%	20%
Australia and New Zealand	12,000	0.10%	10%

Source: AIDS Epidemic Update: December, 1999, UNAIDS/WHO.

1.3 HIV/AIDS in Sub-Saharan Africa

According to UNAIDS(1), the Sub-Sahara region is the most affected by the epidemic, harboring about 70% of the people living with HIV/AIDS in the world. Since the beginning of the epidemic, 90% of infected children below 15 years old, 95% of all AIDS orphans and 83% of all AIDS related deaths has occurred in Sub-Sahara Africa. The southern part of the African continent is reported to be the most severely affected by the epidemic, with prevalence of HIV between 20 and 26% among adults aged 15 to 49 years. Figure 1 bellows compares various feature of the epidemic between total or global situation and sub-sahara region. For all these bad features of the epidemic, unfortunately the region shares more than 70% of the load.

Figure 1: HIV and AIDS Estimates, Global and Sub-Saharan Africa.



Source: AIDS Epidemic Update: December, 1999, UNAIDS/WHO.

1.4 HIV/AIDS/STDs in Tanzania Mainland

Basing on an estimated adult population of 16 million in Tanzania Mainland, the number of adults infected with HIV in 1997 was 1.5 million. Among pregnant women the prevalence of HIV-1 ranged from 7.3% to 44.4% in rural areas and 22% to 36% in urban population. In blood donors the prevalence of HIV infection was 2.8 - 19.8% and 2.6 - 49.6% in males and females, respectively.

By the same year (1997) the distribution of cumulative AIDS cases by regions, showed that Mbeya region had the highest case rate (per 100,000 population) of 858.3, followed by Dar-es-salaam (663.1), Kilimanjaro (496.9) and Coast (496.4). The lowest case rate was in Rukwa region, which was 116.5 cases per 100,000 population.

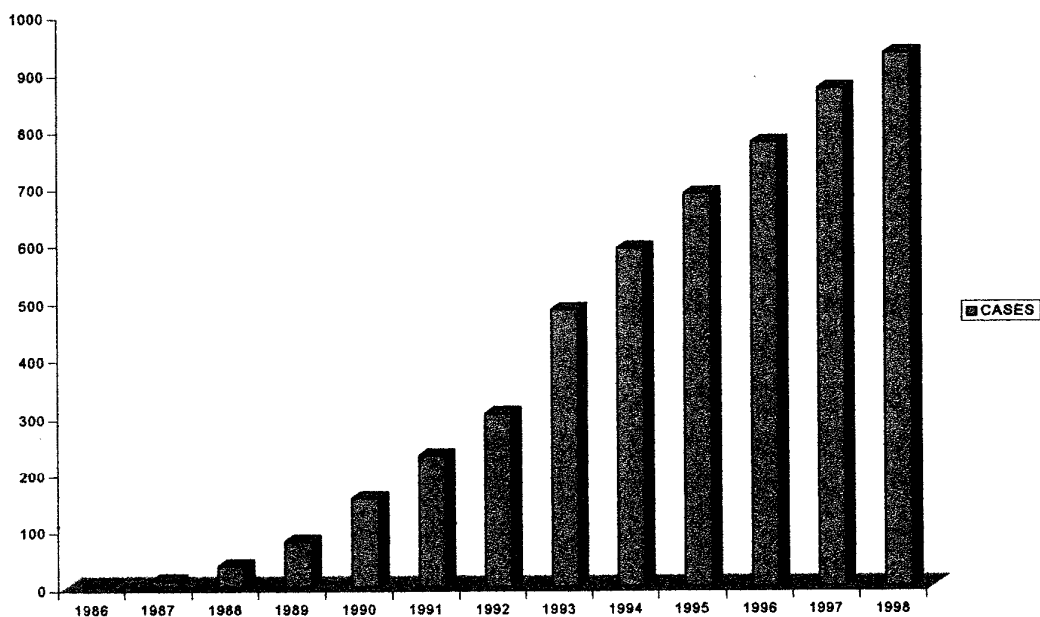
The HIV/AIDS situation in Mainland Tanzania and other neighboring countries are of great importance to the situation in Zanzibar, in view of considerable interactions of the populations in this area for a variety of social and economic purposes.

HIV/AIDS SITUATION IN ZANZIBAR

The first three patients of AIDS in Zanzibar, were identified in 1986 at Mnazimmoja Hospital. Since then HIV infections and AIDS patients have been increasing steadily. Until 1998 the cumulative number of HIV sero-positive persons and AIDS patients reported to ZACP were 1626 and 998, respectively. Figure 2, below shows the number of HIV sero-positive persons reported from 1986 to 1998.

This data was recorded in public health facilities only after confirmation by laboratory tests. In general from 1996 (ten years after the outbreak started) an average of 180 persons were diagnosed every year.

Figure 2: Reported HIV infections in Zanzibar



3. SURVEILLANCE OF HIV/AIDS AND STDs

The data on HIV/AIDS/STDs in Zanzibar is collected from public health facilities and through community surveys. The surveillance system consists of:-

- i) Sentinel surveillance of pregnant women;
- ii) Blood donors
- iii) Diagnosis of AIDS related conditions (AIDS suspects).
- iv) Testing clients attending STDs clinic;
- v) Testing TB patients

3.1 Sentinel Surveillance of Pregnant Women:

Regular surveys of pregnant women for HIV infection have been conducted annually since 1987. Samples are collected from selected health facilities which provide ante-natal care. From 1987 to 1992 the surveys were done consecutively from March to December, every year. Then, from 1993 to 1997 the surveys were done from September to December every year. However the sample sizes collected varied from site to site and from one year to another. In 1998 a protocol for conducting HIV sentinel survey (3) in pregnant women was reviewed for the purpose of standardizing the procedure, especially the sample size collected from each site and the period of the surveys, every year. This protocol was used for the 1999 survey.

Trends of HIV infection in pregnant women

Table 2 below shows the results of HIV tests from sentinel surveys of pregnant women from 1995 to 1996.

The prevalence of HIV among pregnant women has increased from 0.3% in 1987 to 0.7% in 1999. However there was unusual rise in HIV infection of 3.8% in 1995, especially at Micheweni (Pemba), with 8.9%. The reasons for this spike cannot be determined with certainty. In general it can be said that HIV prevalence in pregnant women in Zanzibar is significantly lower than in Mainland Tanzania and other Eastern and Southern African countries.

Table 2: HIV Sero-prevalence in pregnant women

Health Facility/ Year	1995	1996	1997	1999
Mnazimmoja Hospital	2.4% (454)*	0.2% (871)	1.6% (791)	0.5% (400)
Makunduchi	- **	-	0.07% (79)	-
Kivunge	6.3% (63)	0.0% (336)	1.9% (106)	0.8% (400)
Wete	-	0.0% (56)	-	-
Micheweni	8.9% (101)	0.0% (45)	-	1.1% (280)
Chake-Chake	-	2.8% (35)	-	0.6% (320)
Mkoani	-	5.4% (37)	-	-
TOTAL	3.80%	0.60%	1.40%	0.70%

* = In bracket is the sample size.

** = Screening was not done.

3.2. Blood Donors

There are 8 sites (hospitals that provide blood transfusion services), 3 in Unguja and 5 in Pemba. All these hospitals screen the blood against HIV before transfusion. The results of HIV tests on blood donors from 1995 to 1998 are shown in Table 3 below.

Usually a questionnaire is administered at the potential blood donors to exclude donors with high risk behavior and this which slightly reduces the HIV prevalence of this group. In Zanzibar, blood donors are practically all males.

**Table 3: HIV Prevalance Among Blood Donors
by Health Facilities**

Health Facility/Year	1995	1996	1997	1998
Mnazimmoja Hospital	1.3% (1883)*	1.0% (2019)	2.8% (612)	1.5% (2743)
Makunduchi	0.0% (9)	0.0% (35)	0.0% (35)	- **
Kivunge	2.0% (257)	0.0% (308)	1.5% (272)	0.0% (118)
Wete	0.0% (142)	0.0% (171)	0.0% (197)	0.0% (139)
Micheweni	0.0% (17)	0.0% (6)	0.0% (52)	0.0% (280)
Chake-Chake	0.0 (154)	0.5% (214)	0.0% (409)	0.1% (795)
Vitongoji	0.0% (11)	0.0% (39)	0.0% (25)	0.0%(5)
Mkoani	0.0% (199)	0.0% (316)	0.0% (581)	0.0% 364)
TOTAL	1.00%	0.70%	1.00%	1.50%

* = In bracket is the sample size.

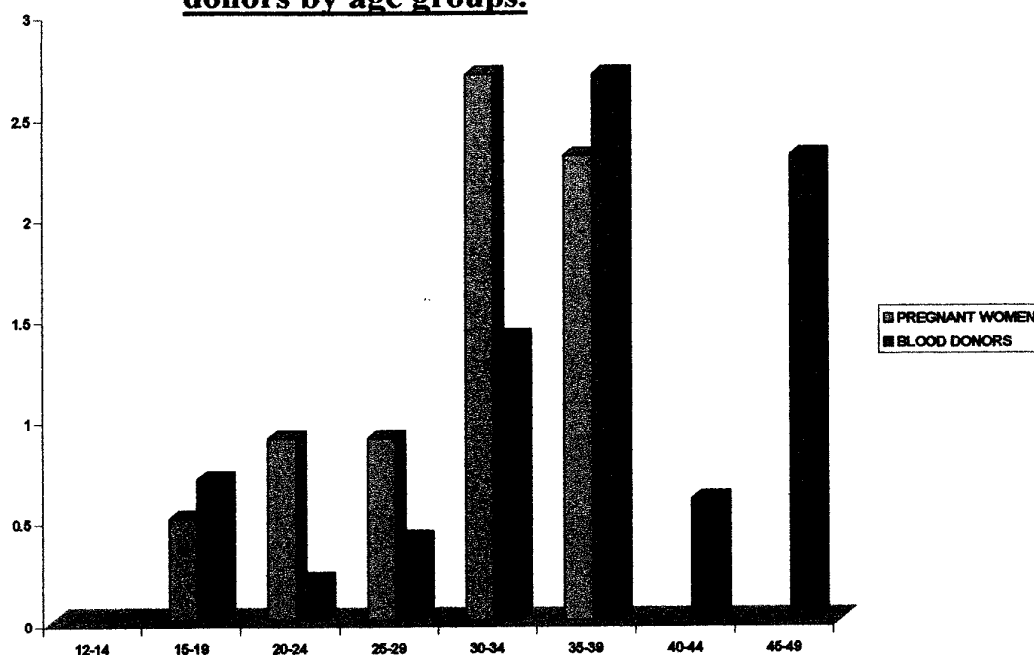
** = Screening was not done.

The HIV prevalence among blood donors has also increased from 0.5% in 1987 to 1.5% in 1998. In the first half of 1999 (January to June) the prevalence was 1.4%. Comparison of HIV infection among pregnant women and blood donors.

These two groups may be considered to represent healthy male and female adults in the population. However the sampling methods of these groups as described above, are not similar. Whereas the pregnant women are attracted to the sampling sites by the antenatal care services provided, the blood donors go to the sites to assist close relatives. In addition the pregnant women, by definition of their condition, is a group that practices unprotected sex, an HIV risk behaviour, while the blood donors' risk behaviour status cannot be determined.

Despite the fore-said differences in the groups, Figure 3 shows that in both, at the age between 20 and 34 years there is a higher proportion of females infected with HIV than males.

Figure 3: HIV distribution pregnant women and blood donors by age groups.



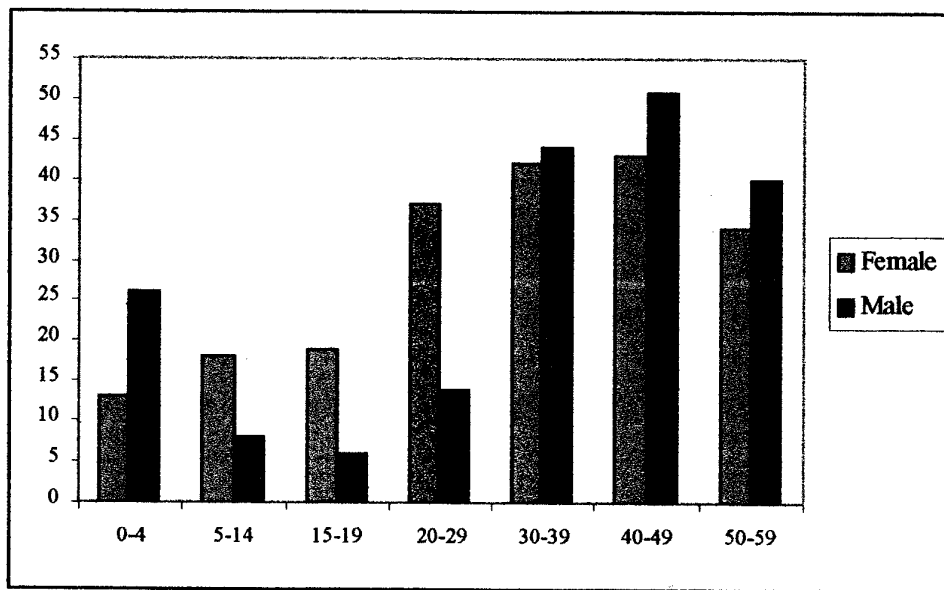
3.3 AIDS Clinical Suspects Tested:

Patients who present various types of illnesses indicative of underlying HIV infection are tested for confirmation. Therefore, they are considered to have AIDS if HIV is confirmed by laboratory test. Sampling of such patients is invariably passive and depends upon the practitioner's decision to request HIV test.

Figure 4 below shows HIV positive patients (AIDS) among the suspects who were tested. The positivity rate is 33.3%. About 75% of the AIDS patients are between the ages of 20 and 45 years. There is approximately equal proportion of male and female AIDS patients. However, there is a higher proportion of young women of age 15 to 29 years old who came down with AIDS HIV than men of the same age group. This is consistent with the results of sentinel surveillance of pregnant women

care as shown earlier that women get infected at earlier age than men and therefore, come down with AIDS earlier. In the older age groups (30 years and above) the proportion of male to female AIDS patients is approximately equal. There is a significant proportion of children below the age of 5 years who come down with AIDS, which strongly suggests the occurrence of mother to child HIV transmission.

Figure 4: Age/Gender Distribution of AIDS Patients



3.4 HIV Among STDs Clients and TB Patients

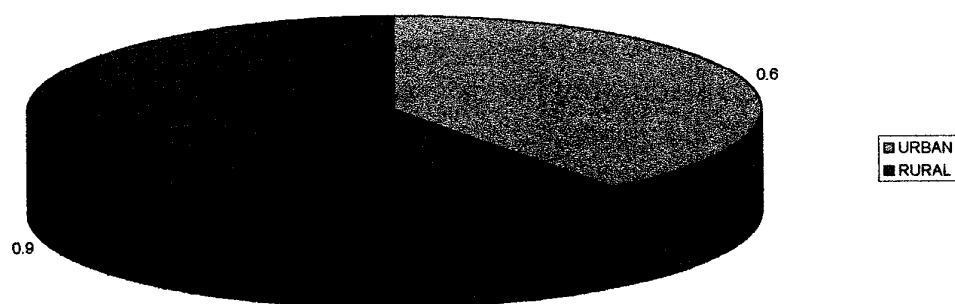
HIV infection in these groups are special kind of indicators due to the fact that STDs infection is indicative of high risk behaviour and HIV infected people are prone to opportunistic infections, including TB. However sampling of these groups were not systematic or regular. Nevertheless the data (Table 4) confirm high HIV infection rates among these groups of patients/clients, average of 20.3% and 24.9% in TB patients and STDs clients, respectively.

Table 4: HIV Sero-Positive in TB and STDs Patients

YEAR	TB		STDs	
	Number tested	% POSITIVE	Number tested	% POSITIVE
1994	267	18.7	41	22
1995	316	17.7	52	21.2
1996	77	23.4	41	31.7
1997	29	47.6	58	25.8
1998	2	50	9	55.5
TOTAL	691	20.3	201	24.9

Other indicators such as, HIV infection distribution by urban or rural, the role of level of education in relation to HIV infections need further exploration. However, recent data collected during the 1999 sentinel surveillance on HIV prevalence by urban/rural strata and level of education, indicate no significant differences on whether one resides at a rural or urban area (Fig. 5) or the person is educated or not.

Figure 5: Rural/Urban Distribution of HIV Among Pregnant Women



4. SYPHILIS SCREENING AMONG PREGNANT WOMEN

Syphilis screening is concurrently done with HIV during the sentinel surveillance among pregnant women. Data collected from the sentinel sites on syphilis show low occurrences of the disease in this specific population (pregnant women) compared to other countries. In 1993 the overall prevalence of syphilis among pregnant women was 0.32% (n=1255), 3% (n=791) in 1997 and in 1999, it was 1%.

In the 1999 sentinel survey syphilis was reported in Kivunge Hospital only, where 10 out of 400 (2.5%) pregnant women were reported positive. The findings at Kivunge requires further investigations around the hospital catchment area to determine the magnitude of the problem.

5. STD SYNDROMES REPORTED:

The three most commonly seen and reported STDS syndromes in Zanzibar are genital ulcer disease, genital discharge syndrome and pelvic inflammatory disease. About 75% of all reported syndromes were genital discharges (Figure 6).

5.1 Gender/Age distribution of STDs:

Data from Mnazimmoja Hospital and some primary health care units in Unguja, collected during 1998, show that more than 70% of clients who were attended for STDs related conditions were women. At Mnazimmoja Hospital alone, 363 cases of STDs attendants were reported, of which 72% were females and 80% of the clients were young people between the age of 19 and 39 years old (Fig 7). Out of 260 women were attended for STDs, about 50% were young women in the age group 20-29 years.

Figure 6: Proportions of STDs Syndomes Among Seen at Mnazi Mmoja Hospital, 1998.

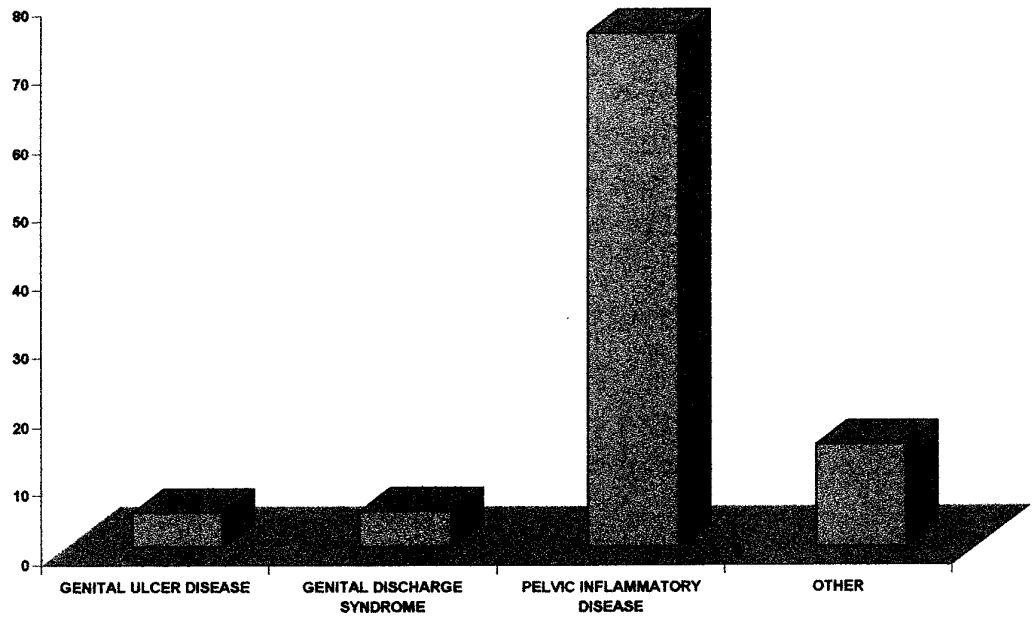
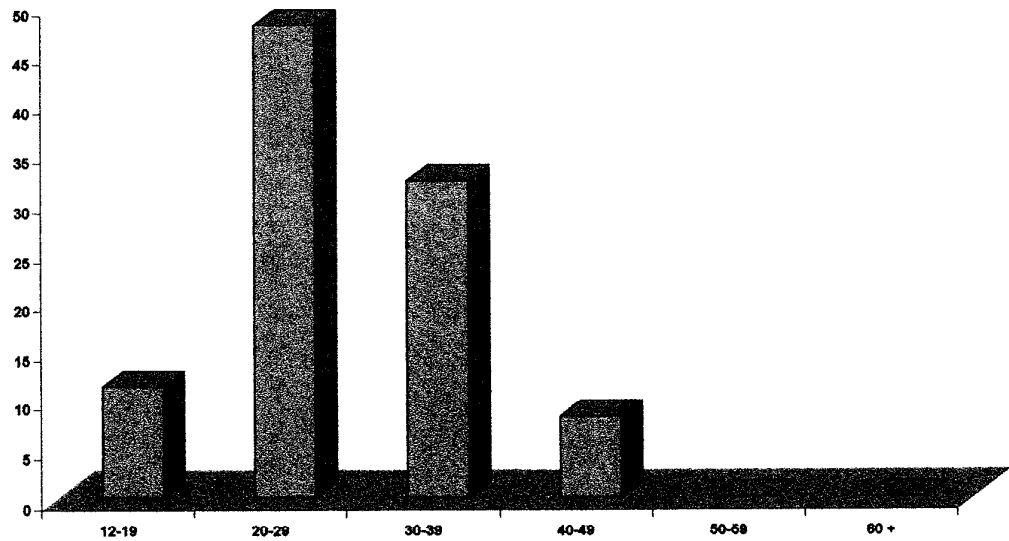


Figure 7: Sexually Transmitted Diseases by Age Group at Mnazi Mmoja Hospital, 1998



6. KAP AND RAP STUDIES ON HIV/AIDS/STDs

6.1 Survey of Women's Knowledge, Attitudes and Practices on HIV/AIDS/STDs

6.1.1 Objectives of the Study

- To identify women and girls behavior that may put them at risk to HIV/STDs.
- To assess women's decision making power on their sexuality.
- To establish men and women's knowledge, attitudes and practices on HIV/AIDS/STDs.
- To establish the means of communication through which HIV/AIDS/STDs information reach women.

6.1.2 Findings:

a) Awareness Sexually Transmitted Diseases Awareness

A large proportion of women interviewed, 50%, were familiar with sexually transmitted diseases. Only 10 of the interviewees confessed to have ever suffered from STDs, of whom 7 were treated in public health facilities.

About 40% of the women had, at least once received advice and information on the prevention of STDs from the health facility and /or radio.

HIV/AIDS Awareness

Almost all women interviewed were aware of HIV routes of transmission, especially through sexual contact (93%), and its impact.

The main source of information for 52% of the women interviewed was radio, other sources of information were television, partners, women's groups and friends.

It was women of young age who were more likely to have received information on HIV/AIDS/STDs from their partners.

HIV/AIDS Prevention

Most of women interviewed reported taking protective measures against HIV/AIDS by being faithful to their partners, reducing number of sexual partners or abstinence. Only 6% women reported to have ever used condom, most of them women were in the 15-29 years, 52% of them were married and 24% were single, that is, without legalized husband. About 10% of women reported that they have not tried to protect themselves from HIV/STDs infections due to lack of knowledge.

Women's Power over their Sexuality

Approximately 48% of the women reported that they have never said "NO" to their husbands/partners on sex issues for the fear of losing their partners. Their discussions on sex issues with their partners was limited to faithfulness. Only 8%, of the women, reported to have at least once requested their partners to put on a condom during sexual intercourse.

Findings from men focus group discussions

Men's understanding of unsafe sex, was sexual engagement outside wedlock, and having sex without taking "precaution". The majority of men were worried of getting HIV/AIDS, because they thought that their wives were not faithful.

Most men reported to have never used a condom, reasons being, it is unacceptable, by religion (Islam), that condoms promote promiscuity and they hinder child birth.

Most men disagreed to empower women to discuss sex issues with their husbands/partners.

6.2 QUALITATIVE STUDY ON SEXUALLY TRANSMITTED DISEASES (ZANZIBAR EXPERIENCE)

6.2.1 Specific Objectives

Through focussed group discussions and selected in-depth interviews, the objectives of the study were:-

- To collect information on people's perceptions on STDs.
- To determine factors contributing to STDs spread.
- To assess how individuals management STDs.
- To identify high risk groups.

6.2.2 Major findings

Most of the study participants perceived STDs to be contracted from sexual contact outside marriage. Only a small proportion of them mentioned that STDs are infections (e.g. HIV, gonorrhoea and syphilis) acquired through sexual contacts.

Both men and women participants mentioned sexual intercourse as the major mode of transmitting STDs. However they knew more about HIV/AIDS than other STDs.

STDs were perceived as a very private matter which can only be shared with the doctor and "may be" the partner.

The factors that were mentioned to spread HIV/STDs included social gatherings, excessive alcohol consumption, promiscuity, delayed marriages, and lack of information on HIV/AIDS/STDs.

Most participants mentioned public health facilities as centers for STDs management. However, traditional therapy was mentioned as effective against STDs.

Participants reported knowing how to prevent STDs, but most reported not applying the skills to practice, and few emphasized the importance of sticking to one partner.

The use of condom was not a popular phenomenon among the participants.

7. THE NATIONAL RESPONSE AGAINST THE EPIDEMIC:

ZACP embarked on the Third Medium Term Plan (MTP-III) in 1998. MTP-III is a strategic frame work for multisectoral response against the epidemic in the islands. It is based on involvement and participation of all sectors (public and private), NGOs and communities. The plan was developed through multisectoral participatory approach in three interactive phases - Situation analysis, Programme review and Formulation of the plan.

The situation analysis revealed the following major determinants for the continued HIV transmission in Zanzibar:-

- Social decay and loss of cultural and religious values;
- Lack of HIV risk awareness among large segments of the population;

- Poverty, especially among women, youth and people with disability;
- Stigma towards HIV infected people;
- Increased casual sex contacts among mobile populations;
- Low compliance to professional conduct by providers of health services, especially traditional health practitioners;
- Unsafe blood transfusion; and
- Apparent increase of prevalence of sexually transmitted infections in the population.

With these major determinants of the epidemic in Zanzibar and with the review of the relevance effectiveness and constrains of MTP-II, MTP-III came up with the following Priority Areas of Intervention:-

- Improve blood transfusion services,
- Promote universal practices for sterile procedures in health service delivery;
- Revival of cultural, social and religious values in the society;
- Promote the integrity of the family.
- Promote appropriate HIV/AIDS risk awareness and safe sexual behavior among vulnerable population groups;
- De-stigmatisation and provision of care and support to people living with HIV/AIDS;
- Promoting society's accommodation and care of people living with HIV/AIDS;

- Promote safe sexual practices among mobile population and youth;
- Promote economic empowerment and protection of vulnerable groups, and
- Raising the social and economic status of women.

Under each priority area, specific objectives and strategies were formulated for activities to be implemented by various sectors according to their respective comparative advantages.
